Clinical Psychologists' Views and Experiences of Touch in Therapy

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Abstract

The importance and function of touch has been of interest to philosophers and scientists over many centuries. Research has uncovered remarkable neurobiological processes linking touch to enhanced physical, cognitive and social development. Conversely, the devastating effect of touch deprivation has been demonstrated through controversial animal experiments (Harlow & Zimmerman, 1959) and implicated in the failure to thrive of neglected orphan children (Blackwell, 2000). Psychological theory has promoted the importance of touch (Bowlby, 1975). However, the use of touch in therapy is notoriously controversial and historically defined by the contrasting positions of traditional Psychoanalytic and Gestalt orientated therapists, who perceive touch as something to be rigidly avoided or embraced respectively. The evidence base examining therapists' views is limited in terms of both quantity and quality of empirical research. This study employs a qualitative methodology to explore the views and experiences of eleven Clinical Psychologists in South Wales regarding touch in therapy. Classic grounded theory methodology identified that Clinical Psychologists perceive clear areas of acceptable and unacceptable touch, however difficulty arises in decision-making regarding more ambiguous areas. The process used to resolve this involves 'Cost-Benefit Analysis', whereby key categories of 'Individual Characteristics', 'Meaning of Touch' and 'Influence of Context' are weighed up with respect to the risk and reward of touch behaviour. A grounded theory was produced outlining the developmental process by which information is consolidated; allowing increased tolerance of ambiguity and confidence in this decision-making process to evolve. The findings of this study support previous research identifying the complexity of touch behaviour, the importance of a critical approach to touch in therapy, and the sense of 'taboo' generated by the topic's predominant omission from professional training and policy. The clinical, training and service implications of these findings are discussed, along with recommendations for future research.

Table of Contents

List of Tables

List of Figures

"Often the hands will solve a mystery that the intellect has struggled with in vain"

- *Carl Jung (1957)*

1. Chapter One: Introduction

1.1. INTRODUCTION

1.1.1. Overview of Thesis

This study explores the experiences and views of Clinical Psychologists regarding touch in therapy. It is intended that this research will provide an insight into how clinical psychologists view the function of touch, whether they use it in their practice, and how they perceive the acceptability of touch in therapy. The findings of this study should provide a valuable understanding of the phenomenon of touch in therapy with implications at an individual, professional and societal level. A qualitative design was utilised, in order to pinpoint the key touch dilemmas experienced by clinical psychologists, and to immerse the theory in real life data.

This thesis is comprised of four chapters:

- **Chapter 1. Introduction:** A critical appraisal of relevant literature is presented as background to the current research. This includes a systematic review of the evidence base regarding clinicians' views and experiences of touch in therapy.
- **Chapter 2. Methodology:** The rationale underlying the research design, recruitment of participants, data collection procedure and grounded theory analysis process are presented.
- **Chapter 3. Results:** A discussion of each key theme is presented, including direct supporting quotes extracted from the interview transcripts. A synthesis of these themes with regard to the resultant core variable and grounded theory is presented.
- **Chapter 4. Discussion:** A summary of the key research findings in relation to the existing literature is discussed, along with theoretical and clinical implications of the grounded theory. Limitations of the current study and recommendations for ongoing future research are also considered.

1.1.2. Overview of chapter

This chapter introduces the concept of touch and its biological, social and psychological underpinnings as a context for this study. The historical use of touch in therapeutic settings and its current application will be examined. Furthermore, the narratives and policies relating to touch between therapist and client will be explored. As discussed with participants in this study (see Chapter 2) touch unless otherwise stated, encompasses both that initiated by the therapist and that initiated by the client. For ease of understanding, the term therapy is used to encompass any clinical intervention that is felt to be therapeutic in nature and does not exclusively refer to the traditional format of psychotherapy. Existing research regarding touch in therapeutic settings will be presented, along with a systematic review of studies specifically focusing on clinicians' experiences of touch and their touch behaviour. Finally, the rationale and aims of this present study will be outlined.

1.1.3. Literature Review

1.1.3.1. Biological Foundations of Touch

1.1.3.1.1. The Development and Neurobiology of Touch

Touch is often referred to as the "mother of all senses" due to being the first sense to develop in the embryo at approximately 8 weeks gestation (Montagu, 1986). At this point, a foetus responds to touch of the lips and cheeks. By birth, touch is the most developed sensory modality and continues to contribute to cognitive, neurological and socio-emotional development through infancy and childhood (Field, 2002; Fosshage, 2000).

In the context of neurobiology, touch can be defined as "the special sense by which contact with the body of an organism is perceived in the conscious mind" (Gardner, 2001, p.1). It actually combines various somatic senses including temperature,

pressure, pain, proprioception and visceral senses. This information is processed in the postcentral gyrus, often referred to as the primary somatosensory cortex. This sensory information is gathered from the largest and most complex organ in the human body; the skin. Montagu (1986, p.17) describes skin as the most important organ system in the human body as, unlike other senses, humans cannot survive without the physical and behavioural functions performed by the skin; concluding that "among all the senses, touch stands paramount".

1.1.3.1.2. Function of Touch

Montagu (1986) discusses how touch helps regulate physiological states, aids normal biological development and plays a central part in social development. Along with other methods of non-verbal communication, touch is thought to have phylogenetic primacy, meaning that in the evolutionary history of our species its development preceded language. This evolutionary history has been proposed as the reason people tend to rely more heavily on nonverbal communication at times of stress (Burgoon, Buller & Woodall, 1996). Touch is also believed to have ontogenetic primacy, meaning that in early life the importance of non-verbal communication and in particular tactile stimulation surpasses that of verbal communication (Field, 2002). This is shown through the prevalence of holding, grasping and nursing in infants (Burgoon, Buller & Woodall, 1996).

Along with these physiological and developmental functions, touch also plays a significant role in communication. As the only reciprocal sense, it allows two individuals to communicate at a different level to that of verbal communication. Indeed, there has been research into the biological reaction to interpersonal touch demonstrating the release of oxytocin; sometimes referred to as the 'bonding hormone' due to its relation to decreased stress responses (Field, 2002). The depth of communication that can be conveyed through touch was demonstrated by Hertenstein, Keltner, App, Bulleit & Jaskolka (2006), whose study reported that human strangers could identify distinct emotions through a brief touch without any

other sensory input. This experimental study benefited from an extensive sample across cultures, clear novel research aims and well controlled conditions. However, it must be considered that it is difficult to conclude whether the true finding was communication of intention or emotion.

Whilst touch has been an area of interest for many years, with philosophical musings dating back to Plato and Aristotle in Classical Greece, there is still far less research into this sense than that of others such as sight (Hertenstein, 2002). This may be for methodological reasons, for example the majority of tactile interaction occurring in private or the difficulty of measuring a complex behaviour. The definition of touch also provokes debate, with extreme variations in action, intensity, location, frequency and duration (Hertenstein, 2002; Morris, 1971). Additionally, the ethical prohibitions regarding inducing or restricting human touch limit the possibility of studying touch in an experimental rather than observatory context (Major, 1981).

1.1.3.1.3. Beneficial Physiological Effects of Touch

One thing that has been demonstrated repeatedly through scientific research is the chemical response to touch, and the benefits this might have. Touch has been shown to trigger a cascade of chemical responses, including a decrease in stress hormones such as cortisol, and an increase in chemicals known to be mood enhancing such as serotonin and dopamine. Touch also enhances the immune system by increasing cytotoxic capacity to help maintain the body's defences against pathogens (Field, 2002). There is direct evidence that touch triggers the release of oxytocin, a hormone that decreases stress-related responses. This was initially shown through animal studies with rats before being replicated amongst humans, where it was shown that couples who engage in more interpersonal touch display higher levels of oxytocin in their blood and saliva (Holt-Lunstad, Birmingham & Light, 2008). It has been found that higher levels of oxytocin reduce the negative impact of everyday life stressors. Affectionate touch has also been associated with enhanced learning, language processing, improved problem solving, physical growth in infants,

reduced cardiovascular disease in adults and a decrease in pain in some chronic diseases (Hatfield, 1994; Field, 2002).

1.1.3.1.4. Deprivation of Touch

In contrast to the beneficial physical effects of affectionate touch, the absence of human touch - particularly in early growth - is associated with abnormal social behaviour, aggressive tendencies, emotional disorder, and attachment problems (Field, 2002). This is often referred to as 'failure to thrive'. The most notorious study into the effect of touch deprivation was conducted by Harlow and Zimmerman (1959), who demonstrated the effect of isolation on infant monkeys. When faced with choosing a wire mother with a milk bottle or a wooden mother covered with soft material, the infants clung to the soft mother ignoring the option for food. This implies that the desire for touch is stronger than that of the desire for food, and suggests that touch is more integral to mother-infant bonding than is food provision. Furthermore, all of the touch deprived monkeys demonstrated abnormalities in their development and behaviour, including self-clasping and rocking, dislike of touch, aggressive social behaviour, difficulty mating and disinterest in their environment. Some conclusions drawn from this include the idea that affectionate touch is vital to normal development. Whilst the findings of this study have been well replicated, it is important to recognise both the questionable ethics underlying such methodology as well as the limitations of generalising findings of animal research to human behaviour.

That being said, many implications were taken from Harlow's research for the human population, and several studies since have indeed supported the importance of touch in human infant development. Much of the research has focused on orphanages, where there has been shown to be a lack of nurture and sensory stimulation. Whilst it has been demonstrated that babies who are held often achieve better scores on physical, emotional and interpersonal scales (Klaus & Kennell, 1976), the opposite is true of abusive touch or touch deprivation. Studies into the outcomes of infants in orphanages where tactile contact is extremely limited have shown there to be severe

delays in physical growth and neurobehavioral development, as well as ongoing difficulties with antisocial behaviour and the development of normal interpersonal relationships (Blackwell, 2000). Research has also shown, however, that there is some opportunity for improved functioning when addressed at a later stage. For example, institutionalised infants receiving an additional 20 minutes of tactile stimulation per day for 10 weeks developed higher scores on developmental assessments (Casler, 1968). Whilst these studies are striking and do suggest a link between physical contact and development, it should be considered that other factors aside from touch may be contributory. These include inadequate access to basic resources and lack of a close relationship with a primary caregiver. Whilst conducting controlled studies regarding touch deprivation in humans would be unethical, there has been some correlational and observational research supportive of the impact of touch on development. Herzber and Ostrom (1990) detail in their textbook considering violent behaviour assessment and intervention that cultures known to display little physical affection towards infants to have higher rates of adult violence.

1.1.3.2. *Psychological Understanding of Touch*

1.1.3.2.1. Touch and Attachment Theory

Warnecke (2011, p.233) notes that "Touching is not just a skin to skin meeting, but involves and affects psyche and soma far below the surface". The notorious study by Harlow detailed above was conducted following the publication of a report by British psychiatrist John Bowlby (1975) who proposed the notion of attachment theory. Attachment theory referenced the importance of touch, suggesting that affectionate touch from sensitive caregivers allows infants to feel safe and secure, thus forming the basis for securely attached relationships and emotional security later in life. This was later supported by empirical research. Ainsworth, Blehar, Waters and Wall (1978) demonstrated that infants held tenderly by their mothers and for longer periods were more securely attached than those held reluctantly or awkwardly. This highlights the importance of the quality of contact, rather than the duration of contact alone, in developing secure attachment relationships. This study benefitted from a

simple, well controlled procedure which has been replicated across cultures; with the findings remaining extremely influential to this day.

1.1.3.2.2. Touch and Social Psychology

The social significance of touch has been a key interest of cultural anthropologists and experimental psychologists, particularly in recent decades. Fiske (1991) described touch as a key element of a communal sharing relationship, and one that occurs in all cultures between mothers and their children, and among members of a group with a shared identity. This universality of touch as an interpersonal mechanism is fairly unique, and references the reciprocal nature and evolutionary function of touch as discussed earlier in the chapter.

The influence and social consequences of touch have been examined extensively, often with surprising results. Touch has been shown to enhance individuals' willingness to share resources or to work harder on shared tasks. Crusco and Wetzel (1984) showed that brief touch by a waitress significantly increased tipping behaviour, a finding previously demonstrated in a similar study by Willis & Hamm (1980) who reported that touch increased the likelihood of members of the public signing a petition. Various other studies have used experimental designs to demonstrate the impact of touch on compliance, power, and the communication of emotion. However, Hertenstein *et al.,* (2006) note the importance of the confounding variable of context. The interpretation of touch is very dependent on the norms relevant to that situation, and it has been shown that touch is likely to have less beneficial or even negative effects when it violates cultural, social or personal norms (Thayer, 1986). Additionally, personal preference does make a substantial difference, and it is recognised that some individuals are aversive to touch and are likely to respond negatively when they receive uninvited touch (Wilhelm, Kochar, Roth & Gross, 2001).

1.1.3.3. Societal and Cultural Understandings of Touch

Whilst the universality of touch is recognised, there is vast variation in the frequency and type of touch individuals engage in. It has been identified that touch appears to vary by gender and age (Dibiase and Gunnoe, 2004) and that the acceptability of touch varies significantly between cultures (Frank, 1957). Andersen (2008) proposed that the cultural reflexivity of touch and the variation in touch across cultures suggest that approach to touch is a predominantly learned behaviour.

A well replicated finding is that warm climates tend to contain cultures that are more liberal about touching than colder regions (Andersen 2008, Lustig & Koester, 2003; Sussman & Rosenfeld, 1982). Hypotheses explaining this have included the perceived benefits of touch being greater when this involves direct contact with exposed skin, the effect of sunlight on mood increasing desire for social interaction and migratory patterns (Andersen, 2008). Societal influences within cultures have also been shown to impact on touch perception and behaviour. A textbook focusing on body politics suggests that high-status individuals are more likely to touch than to be touched by others, with the converse true of low-status individuals (Henley, 1977).

Even within the context of Western culture, attitudes towards touch are continuously changing over time. Lacroix and Nauton (2010) referenced the commonality in Medieval Europe of many individuals sleeping in bed together to keep warm during cold nights, recognising that in the present day this would be considered extremely unusual due to better living conditions and changing cultural values. Western society has been shown to be one of the least tactile cultures, with the United Kingdom and North America scoring as some of the most low-contact locations globally. Montagu (1986, p. 13) laments the reduction of physical contact in this culture, stating that "The impersonality of life in the Western world has become such that we

have produced a race of untouchables. We have become strangers to each other, not only avoiding, but even warding off all forms of 'unnecessary' physical contact".

Many reasons have been suggested for the gradual categorisation of touch as a taboo issue, including a risk adverse focus, sexualisation of touch and the emergence of modern technologies. An overview of the phenomenon of touch by Zur and Nordmarken (2011) discusses the abundance of "no touch" policies, for example in schools, which have flourished in the context of shocking but albeit rare cases of abuse of touch. It is recognised that this online resource, whilst comprehensive, does not represent a systematic review of the literature and therefore cannot be considered a robust presentation of the evidence base; particularly as there appears to be a bias in presenting the positive aspects of touch. However, Field (2002) also discusses in her commentary article the prevalent sexualisation of touch, which positions much physical contact in an area of discomfort in a culture where there is a lack of education and discussion about healthy sexual identity. Whilst this unstructured discussion of existing literature also lacks a systematic critical approach, it does hold strength in highlighting important discrepancy in the omission of cultural consideration when presenting research findings related to touch. Indeed, such cultural considerations seem particularly relevant regarding gender differences in relation to touch, with a textbook containing a review of the existing touch literature suggesting that men are more likely to sexualise touch unless it is violent or aggressive in nature (Smith, Clance & Imes, 1998). Finally, the technologisation of physical healthcare has also been proposed as contributory to the rise of a no-touch culture. This is suggested in the context of physical touch previously playing a key role in medical practice, whilst in the modern day technical tools and machines now take the primary role of evaluating and healing (Zur & Nordmarken, 2011).

1.1.3.4. Touch as Therapy

1.1.3.4.1. Historical Context of Touch as Therapy

Historically, touch was used frequently as a medical treatment or therapy, with medical records dating back as far as 25 centuries documenting the use of touch (Zur, 2007). It has roots in shamanic and religious practices, where touch was thought to heal the mind, body and spirit. Ancient civilisations in both the east and west viewed touch such as massages as beneficial treatments for relieving injury, pain and illness, and touch was viewed as a sacred system of natural healing. During the 17th century, as scientific and medical knowledge developed, there became a division between the mind and body. Touch healers who had previously been well respected in their communities were discredited by both medical and religious proponents (Cohen, 1987).

1.1.3.4.2. Modern use of Touch as Therapy

Whilst for some time touch within medicine became redundant in favour of a biologically based medical representation of the body as entirely separate from the mind (Hunter & Struve, 1998), in recent decades there has been a re-emergence of touch-based therapies in the context of a more holistic view of health and wellbeing (Caldwell, 1997). These include body psychotherapies such as Healing Touch, Therapeutic Touch, Reichian Therapy, Reiki, Shiatsu and Indian Head Massage. Whilst there are differences between these approaches, they largely view the body and mind as a continuum rather than separate systems, and utilise touch as part of their theoretically prescribed intervention (Forgues, 2009). The approaches aim to rebalance disturbed energy flow to address both physical and psychological disturbances (Smith, 2000). Whilst these techniques continue to grow in popularity, they remain controversial and the evidence base underlying them is inconsistent. A systematic review by Anderson & Taylor (2011) found that some studies support the potential effectiveness for healing touch on health-related outcomes in chronic disease, but that the quality of studies was low suggesting that the topic needs

further research. A Cochrane review also found no robust evidence that therapeutic touch promotes the healing of acute wounds (O'Mathuna & Ashford, 2012).

1.1.3.5. Touch in Psychotherapy

1.1.3.5.1.1. Historical Context of Touch in Psychotherapy

The debate regarding the efficacy of touch in psychotherapy can be dated back to the early psychoanalytic movement. Freud initially touched his patients, believing it to facilitate emotional expression and age regression in his patients. However, as the focus on transference phenomena – feelings and reactions about significant others from the client's past projected onto the therapist - grew, he developed the opinion that the therapist should present as an unbiased 'blank slate' in order to receive patients' projections, thereby ultimately withdrawing his support for the use of touch (Kertay & Reverie, 1993). Whilst some of Freud's closest followers such as Ferenczi and Reich chose to continue utilising touch - influencing later body-orientated approaches such as Gestalt therapy (Hunter & Struve, 1998) - touch remained on the whole taboo in psychotherapy. A textbook outlining the historical context of touch in therapy proposes that high profile incidents of inappropriate behaviour within such traditions contributed to its application being largely shunned (Smith, Clance & Imes, 1998). Along with the intrusion into transference, some particular arguments against the use of touch include the 'slippery slope' metaphor where some believe that touch makes therapists susceptible to further boundary violation such as sexual touch, and the ongoing predominant split between mind and body in medicine which delineates physical and mental treatments.

1.1.3.5.1.2. Modern use of Touch in Psychotherapy

1.1.3.5.1.2.1. Prevalence and Dominant Narratives

Stenzel and Rupert (2004) note that the literature demonstrates the topic of touch with clients to remain controversial within the field of psychotherapy. Some therapists

believe that touch should never be used, while others hold that it can enhance the therapeutic relationship. There remains a divide evident both between individuals and between camps according to theoretical orientation. Some strongly consider the potential value of touch, for example Wilson (1982), who referenced the evidence base underlying beneficial physiological and social effects of touch and proposed that "since touch so greatly influences human development, it's use as a psychotherapeutic intervention warrants careful attention". Conversely, some traditional psychoanalysts have been cited as promoting the notion that any touch beyond a handshake is clinically inappropriate, unethical or below the expected standard of care (Zur, 2007).

Glickauf-Hughes and Chance (1998) note that a cultural shift towards risk management and an emphasis on ethical practice in therapy has perhaps contributed to the judgement that touch between therapist and client is taboo. Harrison, Jones and Huws (2012) note that the association with risk, even for those who typically avoid touch or use it very lightly, may contribute to reluctance to discuss this for the fear of suspicion or misconduct. Touch in psychotherapy has also been long neglected in professional literature and traditional graduate training programs (Hunter & Struve, 1998), although attention has increased somewhat in the past twenty years (Field, 2002; Horton, Clance, Sterk-Elifson & Emshoff, 1995). Interestingly, while the overarching impression through professional literature, training and risk management principles is one of touch prohibition, many surveys report that most therapists do engage in touch with clients at least some of the time (Pope, Tabachnick & Keith-Spiegel, 1987). This particular survey benefitted from a large, randomly selected sample size which is likely to improve the reliability and generalisibility of the findings. However, the problems inherent within survey methodology remain, for example the reliance of self-report; a particularly relevant issue when talking about an issue that has been demonstrated to be considered somewhat "taboo". The absence of attention to touch in the therapeutic community and literature does seem to affect the opportunity for critical reflection on this touch behaviour, with Zur (2007) suggesting that many therapists do touch, but do not engage in detailed discussion of these occurrences either with the client or during supervision. However, it is recognised that this source does not make clear the

empirical evidence underlying such a claim or consider whether there is available contradictory evidence.

1.1.3.5.1.2.2. Theoretical Perspective

Theoretical perspective is one of the key variables determining therapists' attitudes towards touch. As noted earlier, the view of traditional psychoanalytic therapists is of opposition to touch and other non-verbal methods of communication. Projections and transferential dynamics underlie this debate, with touch often portrayed as either gratifying erotic desires or contaminating the transference (Smith, Clance & Imes, 1988). However, some modern psychodynamic psychotherapists believe that careful use of appropriate touch can be helpful under limited circumstances, and propose a distinction between regression and non-development (Fosshage, 2000).

Several therapeutic orientations do support the clinically appropriate use of touch, in particular the humanist and Gestalt movements (Bonitz, 2008; Perls, 1973). Rogers (1970) discusses the value of touch as healing, whilst Gestalt practices incorporate touch as an integral part of the therapy process to promote both grounding and healing, with the view that "meaningful whole exists throughout nature, in physical and conscious behaviour both in the body and the mind" (Perls, Hefferline & Goodman,1971, p. 257).

Other traditions fall somewhere in between the largely extreme positions of psychoanalytical and Gestalt orientations. Family therapists are known to sometimes use or discuss touch as a means of engaging with clients, and cognitive behavioural therapists may also do so when indicated by their formulation or intervention.

1.1.3.5.1.1. *Influence of Therapist Characteristics*

Whilst the prevalence of touch and attitudes towards touch do vary considerably between therapeutic traditions, there is also significant variation between individual therapists. Studies by Milakovich (1998) and Clance and Petras (1998) identified distinct characteristics which related to touch behaviour, finding that therapists who touch were more likely to be touched by their own therapists or supervisors who also believe in the legitimacy of touch as a therapeutic tool. Female therapists also tended to touch their clients more often than male therapists. Additionally, therapists with more training regarding touch hold more positive attitudes towards touch and report a higher frequency of touch behaviour in their clinical practice. The study by Milakovich (1998) applied thoughtful theory-practice links within their analysis of data collected through in depth telephone interviews with therapists, and gave good consideration to a variety of variables such as age, gender, therapeutic model and experience of the therapist. However, the use of snowball sampling may have left the research open to some selection bias. The survey approach utilised by Clance and Petras (1998) was also let down by sampling, with only a small and non-representative population recruited. However the study did contribute new knowledge by utilising a novel questionnaire focusing on a detailed understanding of decision making regarding touch rather than limiting exploration to the quantification of touch behaviour.

1.1.3.5.1.1. *Function and Types of Touch*

Zur and Nordmarken (2011) reference the many reasons that touch may be used in psychotherapy, for example to console, ground, restrain, express understanding or provide encouragement. Table 1.1 represents a typology of touch produced by Zur (2007) based on the taxonomy of touch proposed by Smith (1998) and the framework developed by Downey (2001) to represent the range of touch and functions that can occur in psychotherapy. Not included within this table are two further categories – aggressive and sexual touch – as these are widely accepted to be unethical in the therapeutic context. However, Zur (2007) notes that the meaning

of touch across all categories can only be understood within the context of the particular client, the therapeutic relationship and the setting, thereby emphasising the complex nature of categorising appropriate touch. Kertay and Reviere (1998) also stress that touch must only be employed to serve the conscious, agreed upon goals and direction of the therapy, and that boundaries defining benign touch are determined by context, intention and meaning.

Table 1-1. Zur (2007) Typology of Touch in Therapy

Category of Touch	Typical Expression
Ritualistic or socially accepted gestures for greeting or departure:	This form of touch is used as a greeting or departure ritual. This might include a handshake, embrace, a peck on the cheek, tap on the back, and other socially and culturally accepted gestures.
Consolation touch:	Holding the hands or shoulders of a client, or providing a comforting hug usually constitutes this kind of consolation touch, which is meant to be supportive and soothing. It is most often done in response to grief, sorrow, or distress
Reassuring touch:	This form of touch is geared to encourage and reassure clients and Usually involves a pat on the back or shoulders.
Grounding or reorienting touch:	This form of touch is intended to help clients reduce anxiety or dissociation. It usually involves helping a client be aware of his or her physical body by employing touch to the hand or arm.
Touch intended to prevent a client from hurting self or others:	This type of touch is intended to stop self-harming behaviours, such as head banging, self-hitting, self-cutting, or suicide attempts or gestures. It also includes the appropriate restraint of an out-of-control person.
Corrective experience:	This form of touch may involve the holding or rocking of a client by a therapist who emphasizes the importance of corrective experiences.

1.1.3.5.1.2.   *Positive Effects*

Much of the research into touch in therapy has identified positive consequences of appropriate touch. Hunter and Struve (1997) note that in the early stages of therapy, touch can be an effective means of establishing rapport with a client. Other benefits to the therapeutic relationship are also recognised. Zur (2007) proposed that handshakes and embraces may communicate a sense of teamwork, and the study by Horton *et al*. (1995) into client experiences of touch reported that it promoted a bond between therapist and client as well as an enhanced sense of trust and safety. Some participants in this survey even reported that touch reinforced their sense of the therapist's care for them, thereby allowing them to open up more in therapy and hence increasing the benefits of treatment. This study is notable in its attention to the patient experience of touch, though the survey method suffers from familiar limitations in relying solely on self-disclosure of experience. Furthermore, this study is likely to have been influenced by the self-selection of the sample, who have to first be reached through the initial recruitment method of anonymous contact via therapy centres and then to identify as having experienced a "significant" experience of touch. It is likely that non-respondents have the potential to offer very relevant contributions, however this missing data is not accounted for in the conclusions of the study.

Emotional support for the client has been suggested as a beneficial consequence of appropriate touch for clients. This includes providing calm and comfort (Smith, Clance & Imes, 1998), a sense of acceptance (Horton *et al*., 1995; Phelan, 2009), grounding in extreme distress (Zur, 2007), and reassurance of communication for older adults with reduced cognitive capacity (Huss, 1977). It must be noted that many of these concepts have been proposed by the above authors within text books or synthesis articles following non-systematic reviews of the literature, rather than the results of individual empirical studies. Strengths of the broad literature reviews by Phelan (2009) and Zur (2007) include the consideration of cultural and religious influences on touch behaviour and the focus on clinical implications. However, the lack of systematic process, ownership of author's position and lack of critique of

individual studies suggests that such claims must be considered with caution. These ideas should therefore be considered preliminary and require substantiating through high quality empirical research or systematic review of existing empirical data. Alongside these proposed emotional benefits, some therapists suggest that touch in therapy can also have an educational component of benefit to clients. Aquino and Lee (2000) propose that teaching children the use of touch can facilitate positive emotions, and for adults who have experienced abuse or a paucity of physical contact in their early relationships touch may serve to heal past emotional experiences through re-parenting and the message that touch is not typically unsafe and harmful (Hunter & Struve, 1997; Schlesinger & Applebaum, 2000).

1.1.3.5.1.3. *Negative Effects*

Whilst some therapists propose the potential healing effects of appropriate touch for survivors of childhood neglect or abuse, others suggest that the potential for re-traumatising clients through either touching or not touching is a key concern. As previously discussed, the possibility of discrepancy between intentions of touch and meaning of touch received increases such concerns. Indeed, the nature of the therapeutic relationship positions the therapist as holding a higher status and more power, potentially leading to the client feeling less empowered and dependent. Given this unequal power dynamic, it has been suggested within textbooks exploring ethics in psychotherapy that there is a risk a client may acquiesce to a therapist's suggestions even when it makes them uncomfortable (Welfel, 2012). Durana (1998) notes that touch may then not meet the desired end of enhancing empathy as found in reciprocal touch, but may be seen as showing dominance. Much of the concern regarding the use of touch in therapy regards the power differential between client and therapist as having the potential to lead to touch that can be dangerous or exploitative.

Another concern regarding the possible negative consequences of touch returns to the previously discussed notion of the 'slippery slope' reasoning that all touch, no

matter how innocent, may eventually lead to inappropriate sexual touch. It has been suggested that therapists recognise this concept and fear the appearance of wrongdoing, therefore avoiding all forms of touch (Welfel, 2012). However, a literature review by Bonitz (2008) summarises that non-erotic touch in therapy is not correlated with sexual behaviour with clients and research does not support the assumption that physical contact invariably results in unethical behaviour. This literature review provided a comprehensive overview of the field of touch in therapy with consideration to social and historical contexts. It should be noted that the papers reviewed were not selected systematically and were outlined in a descriptive rather than critical manner. Additionally, there was no statement regarding the author's position, therefore some of the selected papers or findings could be presented in a biased manner suggesting statements such as that outlined above should be considered with caution. Other researchers do corroborate the proposal that a culture of silence which fear of judgement fosters could ultimately lead to touch being used in more harmful ways. A conclusion drawn following a large scale survey of therapists by Pope *et al*. (2006) advocates that individuals grow and develop best in an atmosphere of openness, respect and encouragement to tackle difficult subjects.

An additional potential negative effect that may be of concern to therapists is that of making the decision to touch in spite of potential misinterpretation, yet that touch not being of any clinical significance or benefit. Research has not consistently supported the clinical efficacy of touch in therapy. In a controlled experimental study involving counsellors provided therapy to students Stockwell and Dye (1980) found that when controlling for other non-verbal cues such as eye contact and facial gestures, touch had no significant effect on client evaluations of counselling. Similarly, Bacorn and Dixon (1984) found no benefit of touch within an initial therapy appointment on judgements or requests for a second appointment when compared to a control group. A strength of both of these studies was the application of controlled conditions within a naturalistic setting, increasing the ecological validity of findings. However the surprising nature of these findings – which appeared to be at odds with existing literature and narratives regarding the important impact of touch – emphasised that much more exploration of this was needed.

Of course the ultimate consideration of touch in therapeutic settings is whether it is an ethical approach and whether it is of benefit to the client. A key question then is that of the motive underlying the decision to touch. Hunter and Struve (1997, p.141) ask "Who is likely to benefit from this? In all cases, the answer must be the client. If touch is being considered for the therapist's needs rather than for the client's needs, then it should not be used". Whilst this could potentially lead to the position adopted by traditional psychoanalytic theorists of the safest position being to not touch at all, Zur and Nordmarken (2011) raise the interesting suggestion that the rigid avoidance of touch, especially if it is avoided primarily out of risk management concerns, may be unethical in itself.

1.1.3.5.1.4. *Clinical Psychology Perspective*

1.1.3.5.1.4.1. Research

The above research is presented in relation to therapists of varying backgrounds and theoretical traditions. Regarding the perspective of clinical psychologists specifically, there is very little existing research. The sole study investigating clinical psychologists' views of touch in therapy was undertaken in the United Kingdom by Harrison, Jones and Huws (2012). A qualitative approach involving Interpretative Phenomenological Analysis (IPA) of interviews with six clinical psychologists was used in this research, contrasting the predominant reliance on questionnaire survey studies which limit the in-depth exploration of the rationale underlying touch behaviour (Milakovich, 1998; Clance & Petras, 1998). The results of this study by Harrison, Jones and Huws (2012) supported many of the perspectives outlined above with regard to the dilemmas facing clinical psychologists such as the cultural acceptability of touch in therapy, the efficacy of touch in therapy and the importance of individual context on decision-making. It was noted that clinical psychologists view their profession as one that does not advocate touch with clients, therefore touch was used sparingly and, when it was used, was unlikely to be discussed openly with peers or supervisors. The choice to touch was viewed as very individual to both the client and situation, but recognised that there were potential benefits to touch in therapy when used appropriately. Whilst valuable ideas were elicited through this

research, the authors recommended that further research was necessary in order to explore the views on this topic more widely. This study forms part of the systematic review and is discussed further in section 1.1.4.

1.1.3.5.1.4.2. Policy and Practice Guidelines

The professional practice guidance for clinical psychologists with regard to touch is similarly limited, perhaps echoing the literature which suggests that this is a topic avoided both due to the risk attached to touch and the difficulty of capturing the complexity of such a process within clear written guidance. It is notable that there is no reference to touch within the British Psychological Society (BPS) Code of Ethics and Conduct (2009), simply the statement that:

> *4.3 Standard of Maintaining Personal Boundaries. Psychologists should: (i) Refrain from engaging in any form of sexual or romantic relationship with persons to whom they are providing professional services, or to whom they owe a continuing duty of care, or with whom they have a relationship of trust.*

The regulators of the clinical psychology profession Health Care Professions Council (HCPC) Standards of Conduct, Performance and Ethics (2012) also do not include any guidance concerning touch, stating only that clinicians must behave in the best interest of the client.

The Professional Practice Guidelines of the Division of Clinical Psychology (DCP) (1995; 2001) do contain a small reference to physical touch, stating:

> *2.1.2.2 Psychologists should be aware of the issues involved in the use of physical touch and any form of physical contact within therapeutic relationships, and of the need to work within and recognise the significance of cultural norms. Touch can be acceptable and beneficial, but should be considered carefully in the context of the client's needs and vulnerabilities, the potential for misinterpretation, and the risk of intrusion.*

1.1.3.6.   Conclusions

In summary, the topic of touch is one that has been of interest over many centuries and has been shown to be approached and perceived extremely differently across cultures and time periods. Scientific investigation has uncovered the remarkable neurobiological processes that occur in response to a simple touch, and research has demonstrated the vital nature of touch for normal human growth and development through studies showing the devastating effects of touch deprivation. Additionally, the beneficial effects of affectionate and appropriate touch have been shown in relation to social, psychological and physiological thriving. The use of touch in psychotherapy has been and remains a controversial subject, historically defined by the opposing standpoints of psychoanalytic rejection of its efficacy and the Gestalt view of touch as a key part of holistic treatment. Whilst the dominance of arguments relying on theoretical standpoints may have eased slightly, contemporary cultural issues regarding sexualised touch and risk-averse policies mean that the issue of touch continues to be a highly sensitive concern for therapists. This is arguably exacerbated by the lack of discussion of touch in training or supervision, reinforcing the narrative of touch in therapy as unacceptable and taboo. In addition to these already complex factors, the importance of context – including such factors as the client characteristics, client history, therapist characteristics, therapeutic model, dynamics of the therapeutic clinical setting and social norms – has been shown to be key in considering the appropriateness of touch. Furthermore, whilst research has shown the potential for significant benefits when touch is used well, there is also research demonstrating the harmful effects of touch if received poorly, regardless of therapist intent. It is therefore clear that there are many issues for therapists to consider regarding touch in therapy. Despite existing research beginning to discover the nuances of therapists' attitudes and decision-making processes, further research is required both to open a dialogue about touch in therapy and to understand more about this phenomenon.

1.1.4. Systematic Review

1.1.4.1.   Overview / Aims

The present study explores clinical psychologists' views and experiences of touch in therapy. In order to identify and assess the quality of existing literature within this domain, a systematic review using formal frameworks was conducted. This review aims to assess existing literature regarding touch in a therapeutic setting, and to evaluate the quality of this evidence base.

The systematic review question was:

> *'What do we know about clinicians' views, experiences and behaviour with regard to touch in a therapeutic setting?*

Whilst broad, this question was chosen to reflect the limited literature base which – as outlined in section 1.1 – has focused on numerous viewpoints of touch in therapy. In this sense the literature base could be described as "thin and broad"; given that there appears to be brief focus on a variety of areas, yet little in depth knowledge on any one aspect of touch. For example, some studies have focused on touch attitudes, others on touch behaviour and others still on the effects of using touch. This systematic review will seek to discover what is already known about how and why touch manifests within a therapeutic relationship, and how this may be experienced from a psychologist's perspective. By applying systematic processes and stringent criteria to ensure that the most relevant papers are selected for in depth analysis, this review will identify the key papers related to psychologist use of touch in therapy. This will help to ascertain what areas of touch in therapy have been previously explored, and where the gaps are within the evidence base.

The following section includes a description of the systematic review process, an overview of the most relevant papers identified and a critical review of these papers individually and collectively.

1.1.4.2. Search Strategy

1.1.4.2.1. Databases

In order to identify all relevant papers, a selection of databases were searched on 31st March, 2015. In line with classic grounded theory methodology – as discussed further in Chapter Two – this process was conducted after data collection and analysis. The databases searched are listed below:

- Cochrane Review
- PubMed
- Scopus
- Ovid (Medline, PsycInfo, AMED [Allied and Complementary Medicine] and PsyArticles)
- ProQuest (ASSIA [Applied Social Sciences Index and Abstracts] and Sociological Abstracts)
- CINAHL (Cumulative Index to Nursing and Allied Health Literature)
- Web of Science
- Grey literature search – Google / Google Scholar

These databases and resources were selected in order to cover the range of subjects for which touch in therapeutic settings may be a relevant issue. This included psychological, sociological, biological and medical resources.

1.1.4.2.2. Search Terms

The following key search terms were used combined with Boolean operators to identify all relevant papers:

(Therap* OR psycholog* OR psychother*) AND (touch OR "physical contact")

These search terms were developed through both discussion with the academic supervisor and initial "dummy-run" searches of various databases. This highlighted

the terms commonly appearing in relevant papers and allowed removal of terms leading to an unhelpfully high retrieval incidence of irrelevant papers. Whilst simple, it was identified that these search terms identified a significant number of papers which could then by individually reviewed by the researcher through application of the developed inclusion and exclusion criteria. It was recognised that retrieval of a high number of papers given the use of basic search terms increased the workload through requiring manual exclusion of irrelevant results. However, it was felt that the benefit of ensuring that relevant papers were not omitted by making the search terms more stringent outweighed this disadvantage.

1.1.4.2.2.1.   *Inclusion of quantitative and qualitative papers*

The goal of a systematic review is to bring together all existing research studies focused on a specific question or intervention as a shortcut to the literature. Specifically, a systematic review integrates and interprets the studies' findings (Harden, 2010). In an attempt to ensure a comprehensive understanding of the evidence base underlying touch in therapy, it was decided that this review would examine both quantitative and qualitative research. The Joanna Briggs Institute (2014) proposes that by including diverse forms of evidence from different types of research, mixed method reviews are able to maximise the findings and the ability of those findings to inform policy and practice. Whilst there is ongoing debate regarding the utility of comparing quantitative and qualitative evidence, a suggested benefit is the combination of empirical statistical evidence generally focused on support of efficacy and in depth understanding of human experience and context developed through qualitative research (Harden, 2010). It has been suggested that any review which focuses exclusively on one form of evidence presents only half the picture and will therefore have limited applicability (Joanna Briggs Institute, 2014). The methods underlying mixed reviews are not as well established as other methods of review, therefore often rely on development of a synthesis after the analysis of existing quantitative and qualitative data. The use of complementary but separate initial frameworks to conduct the quality assessments allows the integrity of the research findings to be preserved, rather than converting qualitative findings into quantifiable

terms or vice versa. A technique to complete a mixed methods review has been outlined by the Joanna Briggs Institute (2014) and is outlined in Figure 1.1 and was followed during the systematic review process.
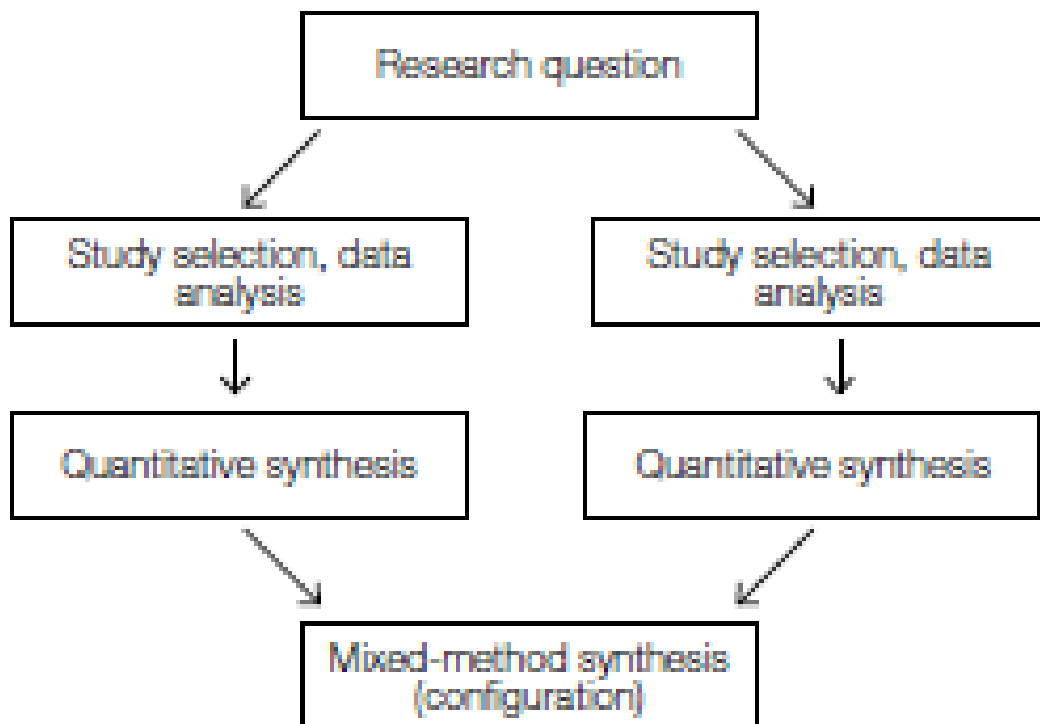
Figure 1-1: Mixed-methods systematic review process taken from Joanna Briggs Institute (2014)

1.1.4.2.2.1. *Development of criteria*

Meline (2006) details how eligibility criteria should be liberally applied in the initial stages of a systematic review, to ensure that no relevant studies are not excluded.

This allows only those clearly exempt to be dismissed and others to be available for more detailed review. It was important to ensure that the selection criteria was not too narrow in order to avoid an over-exclusion threat, whilst recognising that overly broad criteria may lead to difficulty in comparing and synthesising very different studies or introducing bias from poorly designed studies (an over-inclusion threat). Various inclusion and exclusion criteria were developed in this study to ensure that only the most relevant articles were selected for systematic review. These criteria were developed in collaboration with the research supervisor in order to both maximise the relevance of the results obtained and identify the highest quality existing research within the field. Each of the inclusion and exclusion criterion is detailed in section 1.1.4.2.3.2/3 along with the rationale underlying the development of such criteria.

1.1.4.2.2.2. *Inclusion criteria*

• Published in peer reviewed journal

Selected to maximise the scientific validity and reliability of papers given the completed process of quality review by experts in the fields.

• Adult focus

The present study focuses around adult settings (see rationale for this set out in section 2.3.1). It was felt that the existing literature relating to therapeutic work with adults was of highest relevance. Papers focusing on animals or children were therefore excluded.

• Qualitative or quantitative

See section 1.1.4.2.3.2 for detailed rationale underlying the mixed methods review process.

• English language

The decision to limit the retrieval of results to English language papers was to serve a practical function given that the time and resources were not available to the

researcher to translate from other languages. It should be noted this could result in a bias towards studies producing significant results which have a higher rate of translation (Egger, Smith, Schneider & Minder, 1997).

• Focus on touch within a psycho-therapeutic relationship

Dummy-run searches indicated that there is much research into the effects of touch on physical health outcomes within a medical setting; for example the "therapeutic touch" technique. The focus of this study was centred on touch used in psychotherapeutic settings as an adjunct, rather than as the intervention itself. It was therefore decided that papers related to touch in physical health treatment of specific touch therapies should be excluded in order to focus on the most relevant existing research.

1.1.4.2.3.3. *Exclusion criteria*

• Published more than 20 years ago

The decision to limit the systematic review to papers of the last twenty years reflects the aim to seek out and assess the quality of the most relevant papers to the current study. It was felt that the landscape of therapy within the profession of Clinical Psychology has evolved in the last twenty years, as have social and cultural attitudes to touch (as outlined earlier in Chapter 1). It was therefore felt that the more recent context was of primary relevance, with the additional benefit that papers published in the last two decades were likely to have built upon and referenced prominent existing research. In order to ensure that the historical context of touch in therapy was not lost by applying the 20 year cut off in the systematic review, this was covered in depth in section 1.1,3 as part of the general literature review.

• Not yet published in peer-reviewed journal (including dissertations, conference presentations, pre-publications, book chapters and 3rd sector research), Opinion / review articles / Book chapters / Non-published or abstract only articles.

As outlined above, the retrieval of articles published in peer reviewed journals only attempted ensure inclusion of the most scientifically robust papers. Additionally, it

was felt that it was not possible to fully critique studies if the full text was not available to the researcher.

• Duplicate articles

Due to the search of multiple databases, it was necessary to identify and exclude any duplicate articles already subject to review.

1.1.4.2.3.   Search Process

The initial search of databases retrieved a total of 3376 results. Through the process as identified in Figure 1.1, these initial results were screened against the inclusion and exclusion criteria, initially by title, then progressively by abstract and full text. The reference lists of retrieved papers were also searched. This systematic process resulted in six papers identified as the most relevant studies of touch in therapeutic settings. A full breakdown of the screening process including the number of papers excluded in relation to each criterion can be found in Appendix A.

Initial search of seven databases: OVID, PubMed, Web of Science, CINAHL, Proquest [ASSIA/Sociological Abstracts], Cochrane Library and Scopus

3376 results

Manual removal of 390 duplicate records or those retrieved from non-peer reviewed journal sources (where not done automatically within search)

2986 results

Titles reviewed for relevance to research question. 994 items removed

> *Irrelevant to the topic of touch in therapy: 915*

> *Duplicate articles (not filtered automatically): 67*

>*Non-English language (not filtered automatically): 12*

1992 results

Abstracts for remaining articles reviewed. 1938 removed due to:

> *Focus on touch treatments e.g. therapeutic touch: 1883*

> *Focus on non-psychotherapeutic setting: 31*

>*Non-adult focus: 34*

44 results

Full texts retrieved for remaining results. Reviewed in relation to the inclusion / exclusion criteria. Total of 38 discarded:

> *Opinion / review articles: 34*

>*Patient experience focus: 2*

>*Group therapy focus: 2*

6 results

Figure 1-2. Diagrammatic summary of systematic review process

30

1.1.4.3.   Systematic Review Papers

1.1.4.3.1.   Details of Included Studies

A total of six papers were included in the systematic review. These consisted of three qualitative studies and three quantitative studies using survey methodology. Two studies were conducted in the UK, three in the USA and one in India. The study samples consisted of clinicians working in psycho-therapeutic sessions with adults of working age. A full summary of each paper is included in Table 1.2.

Table 1-2. Summary of systematic review papers

Author, Date, Country	Aims	Participants	Methodology	Results / Themes	Conclusions
Harrison, Jones & Huws (2012) **UK - Wales**	Exploration of Clinical Psychologists' accounts of offering or excluding touch within therapeutic practice.	N = 6 3 male, 3 female Age 35-55 years Qualified Clinical Psychologists Post-qualification experience 8-25 years (mean 15 years)	**Design** Qualitative - Interpretative Phenomenological Analysis (IPA) **Recruitment** Purposive sampling of Clinical Psychologists working in adult mental health settings **Method** Semi-structured interviews **Analysis** Transcription of audio recorded interviews.	Themes: • Touch instinct – instinctual response without extensive conscious thought, yet still a thoughtful process • Professional boundaries – clinical psychologists as a profession generally seen as not touching • Individuality – touch behaviour varies depending on the individual client and context	Supported previous literature on rarity of touch in therapy. Touch usually occurring at beginning or end of sessions/therapy. Proposed 'vicious cycle' of the relation between risk and touch in therapy; therapists feel they shouldn't touch, therefore don't discuss it, which reinforces the belief that touch does not occur. Particular support for the idea that psychoanalytically aligned therapists tend to not touch. The potential value of touch was viewed as benefitting the therapeutic relationship and

			Analysis using IPA methodology.	• Value of touch – potentially beneficial for client, therapist and bookmarking endings. • Cost of touch – potential for misinterpretation, confusion or dependency	providing support to the client. Recommendations were made that future research be conducted to allow the topic to be more openly discussed. Also research into client views or the perspective of other professional groups.
Tune (2001) **UK - England**	Exploration of the views of experienced psychotherapists regarding the reasons for using touch in therapy and the type of touch used	N=6 White British 5 females, 1 male Qualified diploma level therapists registered with a professional body Post qualification experience range 3-10 years Work settings: Private practice (2), GP surgery (1), Holistic	**Design** Qualitative exploratory study **Recruitment** Purposive sampling of therapists known to the researcher **Method** Semi-structured open ended interviews **Analysis** Transcriptions of interviews analysed using	Themes: • Split between therapeutic and non-therapeutic space – touch more appropriate in 'social space' e.g. end of therapy • Ambivalence re. talking about touch – not openly discussed, confusing and anxiety	Supported previous literature regarding therapists' difficulty articulating their own thoughts and decision-making about touch behaviour. Also emphasised a lack of training in the use of touch for therapists. Strong theme of secrecy and touch in the social space highlighted a potential issue regarding messages given to the client. Acknowledgement

		health centre (1), Psychodynamic therapy centre (1), voluntary sector counselling service (1)	Grounded Theory methodology	provoking for therapists • Motives for touch – real contact, nurturing, containment	that this was a small exploratory study with a very limited sample hence needs further research. Recommendations made for further qualitative investigation; particularly across therapeutic traditions.
Pinson (2002) **USA – New York**	Exploration of how psychoanalytically trained therapists using supportive touch in therapy conceptualise their own and their clients experience	N=4 1 male, 3 female Licensed therapists with postgraduate training at an analytic institute Experience range 14-31 years Orientation: Rogerian/Psychodynamic (1), Relational (1), Psychoanalytic/Interpersonal (1), Psychodynamic/ Eclectic (1)	**Design** Qualitative exploratory study **Recruitment** Purposive sampling of analytic therapists who use supportive touch, recruited through word of mouth **Method** Structured 50 minute face to face interviews (4) and follow up	Themes: • Effectiveness & meaning of touch – potential positive effects of comforting, nurture, containment, safety and acceptance • Why therapists touch – theoretical orientations, personal history and training shape attitudes	Limitations due to size and selectiveness of sample. However highlights key issues regarding supportive touch in therapy. Previous literature regarding the potential efficacy of touch and positive effects of discussion about touch between therapists and clients. Client need and dynamic of therapist-client interaction determines decision

			15 minute telephone interviews (2) **Analysis** General thematic analysis of notes and audio tapes (not transcribed)	toward supportive touch • Knowledge of other therapists' use of touch – lack of familiarity and confidence in own approach in relation to peers • Comfort with touch – perceived 'permission' to touch • Discussion of experience – positive outcomes of dialogue re. touch between client and therapist • Supportive vs. sexual touch – potential discrepancy between intent	to touch. Taboo on touch did not preclude therapists touching in practice but did prevent timely consultation with supervisors. Touch in therapy is initially often an intuitive or even impulsive response. The decision to touch must be considered carefully with consideration of the client's receptivity and with conscious awareness of the therapist's motivation to touch.

				and attribution of meaning • Touch in treatment of sexually abused individuals – more caution but potentially higher benefit • Touch and dependency – fear of fostering dependency	
Stenzel & Rupert (2004) **USA**	Gather comprehensive information about non-erotic touch between psychologists and clients in a psychotherapy setting. Specifically: a) Descriptive information about the frequency of touch b) Exploring the usefulness of Smith's (1998) taxonomy of touch	N= 470 100% qualified licensed psychotherapy practitioners across USA working in adult private practice [Target population 9327 members of APA– 50% male/50% female, 95% white, average age 50 years]	**Design** Survey questionnaire measuring psychologists' touch behaviour and attitudes towards touch behaviour **Recruitment** Random sampling of APA register of licensed psychotherapists in adult private	a) High degree of caution re. physical contact (90% never or rarely offering touch). Handshake most likely to occur (80%). More likely to accept client initiated touch than offer touch. b) Factor analysis identified 3 out	Non-erotic touch does occur within therapeutic context for therapeutic purposes and warrants greater attention. Decisions to use non-erotic touch may be guided by social norms, theoretical considerations and professional training experiences. More attention needs to be paid to areas that may limit potential

	c) Investigate impact of psychologist /client characteristics on touch behaviour d) Descriptive information about when, why & how touch is offered	600 female & 600 male randomly selected from target population and sent surveys 39% response rate (16 surveys returned undeliverable, 3 not usable) 54% female,96% white, average age 51.32 years (s.d=7.72) Average post-qualification experience 17.13 years (s.d. 7.26) Theoretical orientations: 47% eclectic, 21% psychodynamic/	practice. Survey posted to 1200 out of 9327 in target population **Method** Five section survey developed specifically for this study. Mixture of open and closed items. Part 1 & 2: 18 items 5 point Likert scale based on Smith's (1998) taxonomy of touch. Part 3 presented a vignette regarding touch in relation to clients with sexual abuse, but was excluded from this study. Part 4: ratings of personal and professional touch experiences. Part	of 7 hypothesised categories within Smith (1998) taxonomy; touch as an expression of relationship, touch as technique and socially stereotyped touch. Partial support for Smith's (1998) taxonomy. c) Gender of therapist, gender makeup of the therapeutic dyad, theoretical orientation and touch experience of the therapist contribute to use of relationship	for misinterpretation such as gaining consent and discussion of touch within therapy. Additionally, further research on client initiated touch is needed along with an overall increase in dialogue surrounding touch in therapeutic settings.

		psychoanalytic, 19% cognitive-behavioural	5: psychologist demographics	and social touch	
			Analysis	d) Touch as a technique was reflected in respondents who used body work, relaxation, hypnosis or massage. Touch as an expression of the therapeutic technique was reflected through comfort or nurturing	
			a) Descriptive statistics of touch frequency		
			b) Confirmatory factor analysis		
			c) Multiple ANOVAs using client gender, theoretical orientation as within-subjects variable		
			Pearson correlation – psychologist experiences of touch /		

			taxonomy of touch d) Descriptive statistics re. how & why touch is offered		
Strozier, Krizek & Sale (2003) **USA**	Exploration of how, when and why social work therapists use touch with clients	N=91 Experienced (5 years+ post-qualification) social work therapists Median age range 40-59 years (84%) 83% female 91% Caucasian Drawn from sample of 100. Gender split representative of National Association of Social Workers (NASW) membership statistics showing 78% of	**Design** Exploratory survey questionnaire focusing on social work therapists' touch behaviour **Recruitment** Snowball sampling. Authors created list of experienced social work therapists. Each therapist contacted then asked to provide details of five more therapists. 100 surveys sent.	95% of social work therapists use touch with clients at least some of the time, 29% often or very often. Shaking hands or touching clients' arm, shoulder or back were most common. This happened most often at the beginning or end of a session. Reasons for using touch include empathy, healing, re-parenting, communicating acceptance or modelling. Reasons for not using touch included affecting transference, reading	Many social work therapists are using touch with their clients, but there is no clear consensus about why they do so when they do. There is a clear sense that touch can be both very beneficial and very harmful depending on when / how it is used. The characteristics of both the client and the therapist play a big part in the decision of when to touch or not touch. There is a lack of training and

		members to be female.	Response rate 91%. **Method** 'The Touch Questionnaire' – 30 item mostly closed-question self-report inventory developed for the purposes of this study. Questions focused on demographics, education, general use of touch, when/how touch is used, client characteristics, personal experiences of touch and other events. **Analysis** Descriptive statistics	subtle cues and fear that the touch may be misinterpreted. Touch most likely to be used with children or older adults, as well as physically unwell individuals or those of the same gender. Touch least likely to happen with clients diagnosed with borderline personality disorder, of the opposite gender or having boundary issues. Therapists identifying as eclectic were more likely to touch than those identifying as psychodynamic. A vast majority (82%) reported having no training on the use of touch.	discussion regarding the issue. Future research should consider other helping professions and focus more closely on what types of touch are used with clients and what training in the topic participants have received. Qualitative research would be particularly beneficial.
Joshi, Almeida & Shete (2010)	Understand the beliefs of therapists in India regarding the use of	N=61 Qualified counsellors and	**Design** Survey questionnaire	The majority of the therapists believed that non-erotic touch	Despite the fact that many therapists acknowledged

| India | touch in therapy. In particular, beliefs about the positive/negative effects of touch, therapist/client comfort with touch and beliefs about opposite gender touch | psychotherapists – recently qualified (last 5 years) & experienced (more than 6 years) 63% female Mean age 36 years Mean years of experience of 3.3 years for newly qualified group and 12.28 for experienced group | **Recruitment** Opportunistic sampling – 112 counsellors / psychotherapists identified from telephone directory of Mumbai district received a telephone invitation to participate. Those who agreed were sent the survey. A telephone reminder was given if the survey was not returned in 15 days.

Method 30-item survey of attitudes towards touch developed for this study through review of literature and consultation with experts in | is beneficial for clients. There was a significant main effect [$F_{(1,57)}=6.4$, p,.05] of touch frequency and therapist gender; experienced female therapists touching most often and inexperienced male therapists touching less often. Similarly, female experienced therapists were more likely to agree with statements regarding positive effects of touch whilst male inexperienced therapists were more likely to agree with statements about the negative effects of touch. Level of experience alone did not have a significant effect on attitude towards or frequency of touch. | potential benefits of touch, very few incorporated it into their therapy. This perhaps reflected that most therapists viewed clients as largely uncomfortable being touched and therefore would be very cautious in doing so. Set-up of therapy rooms was also noted as a barrier. Female therapists were more agreeable to positive effects of touch and did use it more frequently. However there was no clear link between attitudes to touch and frequency of touch. Recommendations include more open discussion about touch and its effect on clients. |

| | | | psychotherapy. All items scored on 5-point Likert scale ranging from strong disagreement to strong agreement. Total attitude score derived by adding scores for all 30 items.

Analysis
Two-way ANOVA and descriptive statistics | | |
| --- | --- | --- | --- | --- | --- |

1.1.4.3.2.   Quality of Included Studies

A systematic review not only uses explicit and systematic methods not only to identify relevant literature, but also to appraise and summarise this literature. The use of a formal quality assessment framework allows the process of evaluation and synthesis of the research findings to be thorough, fair and detailed (Kitchenham 2004).

1.1.4.3.2.1.   *Quality Assessment Framework*

Given that the six included review papers consisted of both quantitative and qualitative methodologies, two different quality frameworks were used to assess the quality of these studies. Both tools used were retrieved to identify the best fit for this research and ease of use for the researcher.

A framework specifically designed by Cardiff University's Support Unit for Research Evidence (SURE) to assess qualitative studies was applied against the three studies that utilised this approach (Cardiff University, 2012). The results of the quality assessment can be seen in Table 1.4. This framework has been designed based on work reviewing the error and bias inherent in existing quality checklists, and builds strongly on renowned frameworks such as the Critical Appraisal Skills Programme (CASP), Health Evidence Bulletins Wales (HEBW) Checklists and the NICE manuals. It is recognised that checklists such as CASP are more widely used and therefore may perhaps be more accessible and familiar to readers. However, various strengths of the SURE framework led to its selection in this study. The development based on a number of existing frameworks allows for correction of identified weaknesses, for example the consideration of conflict of interest and sponsorship excluded from the CASP framework. Additionally, the consideration of the description of methodology and more in depth focus on the credibility and critical evaluation of the researcher's findings are of benefit. Finally, the clear and more

43

detailed guidance regarding how to assess each quality marker were found to be helpful to the researcher.

As the three quantitative studies all utilised a survey questionnaire design, a quality checklist most appropriate to this style of research was sourced. A framework designed by Boynton and Greenhalgh (2004) to assess questionnaire based research was applied to these three studies, as outlined in Table 1.3. This particular framework was chosen by seeking out relevant quality checklists for survey methodology, and screening the questions to identify which offered the best fit for the retrieved studies. Whilst a SURE quantitative framework would have been preferred in order to promote consistency between the quality review processes, unfortunately many of the questions included would have generated a "non-applicable" response (for example details of control group, trial protocol, blinding of researchers). The Boynton and Greenhalgh (2004) framework demonstrated strengths in being brief, focused and most importantly applicable to the retrieved papers, thereby giving optimal chance for the assessment of research quality to be accurate.

Neither of the quality frameworks used incorporated a scoring scale to weight the quality of the evidence. This was viewed as a benefit, as it was possible to develop a scoring criteria that could be used across both frameworks in order to help synthesise the data. Therefore, a simple numerical scoring system was added to both tables in order to enhance the quality assessment of each paper. The scoring of papers was cross-checked with the research supervisor in order to enhance the reliability of the scoring process. Whilst it is important not to rely solely on the scores alone, the addition of the numerical system allowed the clinical significance of findings to be weighted and contextualised across both quantitative and qualitative methodologies in a way not possible using the existing frameworks alone. Given that the frameworks use different criteria, percentages were calculated in relation to highest possible score to facilitate this comparison.

- Good = score of 2
- Mixed = score of 1
- Poor or not reported = score of 0

44

Table 1-3. Quality assessment of quantitative papers using Greenhalgh and Boynton (2004) framework

SCORING GUIDANCE: 2 = GOOD, 1 = MIXED, 0 = POOR, NR = NOT REPORTED, N/A = NOT APPLICABLE				
		Stenzel & Rupert (2004)	Strozier, Krizek & Sale (2003)	Joshi, Almeida, & Shete (2010)
1. Research Question & Design	1a. Was there a clear research question?	Yes – four main research questions clearly outlined	Yes – how, when and why social work therapists use touch with clients	Yes – therapists attitudes toward touch and frequency of touch use
		2	2	2
	1b. Was the research question important and sensible?	Yes – limited number of large scale studies or studies focusing on therapists reasons for implementing touch	Yes – highlights lack of research focusing on direct description from clinicians about their touch choices	Yes – modest research into this area highlighted. Clear rationale for the research question
		2	2	2
	1c. Was a questionnaire the most appropriate design for this research question?	Yes – due to large sample size and depth of information required	Appropriate but a mixed methods design may have produced more data relevant to the research aims	Yes, though a mixed methods design may also have been appropriate
		2	1	1
2. Sampling	2a. What was the sampling frame and was it sufficiently large and representative?	Yes – relatively large, randomly selected sample of 470 psychologists representative of the target population of 9327 licensed psychotherapists	Partial – adequate sample size but use of snowball sample limits representativeness (91)	Poor. Relatively small sample size and representativeness in relation to target population not addressed
		2	1	0

	2b. Did all participants in the sample understand what was required of them, and did they attribute the same meaning to the terms in the questionnaire?	Room for misinterpretation (e.g. asked to rate questions based on 'typical practice over past 5 years'). Opportunity to contact researcher/make edits to questions not detailed	Room for misinterpretation e.g. in understanding of frequencies 'seldom, sometimes, often', definition of touch types 'e.g. patting/stroking' or other terms e.g. 'healing'. However pilot questionnaire was undertaken	Room for misinterpretation within Likert scale. However, pilot of questionnaire was undertaken
		0 (nr)	**1**	**1**
3. Instruments	3a. What claims for reliability and validity have been made, and are these justified?	No – validity and reliability of developed survey not discussed.	Pilot study conducted but no evidence of changes made or assessment of reliability of developed survey	Pilot study and consultation imply efforts to assess validity but no measures of survey reliability
		0	**1**	**1**
	3b. Did the questions cover all relevant aspects of the problem in a non-threatening and non-directive way?	Partial – full details of questionnaire not included in paper. However questions detailed appear to be comprehensive and presented appropriately	Partial – full details of questionnaire not included in paper. However questions detailed appear to be balanced and presented appropriately	Partial – full details of questionnaire not included in paper. However questions detailed appear to be balanced and presented appropriately
		1	**1**	**1**
	3c. Were open-ended (qualitative) and closed-ended (quantitative) questions used appropriately?	Yes – both used appropriately to explore different hypotheses	Yes – both used appropriately to explore different hypotheses	All closed-ended questions. Opportunity for some open-ended questions may have benefitted the analysis.
		2	**2**	**1**

4. Response Rate	*4a. What was the response rate?*	Response rate of 39%. Comparable to 45-50% response rate of comparable surveys of psychologists (Borys & Pope, 1989)	91%	53%
		2	**2**	**2**
	4b. Have non-responders been accounted for?	Yes	No	No
		2	**0**	**0**
5. Coding and Analysis	*5a. Was the analysis appropriate (e.g. statistical analysis for quantitative answers, qualitative analysis for open-ended questions) and were the correct techniques used?*	Yes – combination of descriptive and a variety inferential statistics used appropriately	Descriptive statistics used only	Yes descriptive and inferential statistics used
		2	**1**	**2**
	3b. Were adequate measures in place to maintain accuracy of data?	Yes – consideration of the effect of items containing low variability on factor analysis leading to exclusion of these items. Similarly, items with no meaningful factor loadings also excluded to ensure validity.	Not evident from paper	Not evident from paper
		2	**0**	**0**
6. P r	*6a. Have all relevant results ('significant' and 'non-significant') been reported?*	Yes	Significance of results not assessed	Yes
		2	**0**	**2**

6b. Is there any evidence of 'data dredging' (i.e. analyses that were not 'hypothesis driven')?	No	No	No
	2	2	2
TOTAL SCORE	**23/28**	**16/28**	**17/28**

Table 1-4. Quality assessment of qualitative papers using Cardiff University (2012) SURE framework

SCORING GUIDANCE: 2 = GOOD, 1 = MIXED, 0 = POOR, NR = NOT REPORTED, N/A = NOT APPLICABLE			
	Harrison, Jones & Huws (2012)	**Pinson (2002)**	**Tune (2001)**
1. Does the study address a clearly focused question/hypothesis?	Yes – investigation of the views of CP's in the UK regarding touch in therapy	Yes – exploration of psychoanalysts' conceptualisations of touch in therapy for themselves and their clients	Yes – exploration of therapists' reasons for using touch and type of touch used
	2	**2**	**2**
-Setting?	Yes – adult mental health, individual therapy	Yes – long term analytic therapy with adults in private practice	No – varied across different settings
	2	**2**	**0**
-Perspective?	UK Clinical Psychologists	Experienced analytic therapists	Experienced qualified therapists
	2	**2**	**2**
-Intervention or Phenomena	Yes – touch in individual therapy	Yes – supportive touch in individual therapy	Yes – touch in individual therapy
	2	**2**	**2**
-Comparator / control (if any)?	-	-	-
	N/A	**N/A**	**N/A**
-Evaluation / Exploration?	Yes – exploration	Yes – exploration	Yes – exploration

	2	2	2
2. Is the choice of qualitative method appropriate?	Yes	Yes	Yes
	2	2	2
Is it an exploration of e. g. behaviour / reasoning / beliefs)?	Yes – IPA used. Research question focused on meaning that participants assign to the topic.	Yes	Yes
	2	2	2
Do the authors discuss how they decided which method to use?	Yes – to elaborate on previous studies which have used questionnaire designs	No	No
	2	0	0
3. Is the sampling strategy clearly described and justified?	Partial – described but the choice to sample purposively was not clearly justified	No – described but not justified	No – simply states purposive selection
	1	0	0
Is it clear how participants were selected?	Yes – purposive sampling	Yes – purposive sampling	Yes – purposive sampling
	2	2	2
Do the authors explain why they selected these particular participants?	Yes – related back to IPA aims of selection according to homogeneity	No	No
	2	0	0
Is detailed information provided about participant characteristics and about those who chose not to participate?	Yes – demographics, experience, therapeutic orientation described	Yes	Partial – information about those who participated. Not clear if any participants declined.
	2	2	1

4. Is the method of data collection well described?	No – details of the semi-structure interview or its development not included.	No – details of the structured interview not provided	Yes – example questions from semi-structured interview provided
	0	**0**	**2**
Was the setting appropriate for data collection?	Yes	Yes	Yes
	2	**2**	**2**
Is it clear what methods were used to collect data? Type of method (eg, focus groups, interviews, open questionnaire etc) and tools (eg notes, audio, audio visual recording).	Yes – audio recorded semi-structured interviews	Yes – structured interviews. 3 audio recorded, 1 notes taken	Yes – audio recorded semi-structured interviews
	2	**2**	**2**
Is there sufficient detail of the methods used (e.g. how any topics/questions were generated and whether they were piloted; if observation was used, whether the context described and were observations made in a variety of circumstances?	No – does not appear to have been a pilot interview completed	No – development of interview schedule not detailed and no mention of pilot interview	No – development of interview schedule not detailed and not mention of pilot interview
	0	**0**	**0**
Were the methods modified during the study? If YES, is this explained?	No	No	No
	0	**0**	**0**
Is there triangulation of data (i.e. more than one source of data collection)?	Yes – use of memos, researcher reflection with peers and credibility checks	No	No

	of data analysis by additional researcher		
	2	**0**	**0**
Do the authors report achieving data saturation?	No – not reported	No – not reported	No – not reported
	0	**0**	**0**
5. **Is the relationship between the researcher(s) and participants explored?**	Yes – influence of researcher on analysis discussed in relation to IPA methodology	No	Partial – noted that participants were known to researcher though not current colleagues or sharing supervision. However, impact of this not considered.
	2	**0**	**1**
Did the researcher report critically examining/reflecting on their role and any relationship with participants particularly in relation to formulating research questions and collecting data).	No	No	Partial – researcher provided narrative recognising own interest and perspective. However was not reflected upon with regards to the themes.
	0	**0**	**1**
Were any potential power relationships involved (i.e. relationships that could influence in the way in which participants respond)?	Yes – consideration in discussion that participants may have feared judgement by their peers conducting the research. This related to the themes generated of touch in therapy being 'taboo' therefore possibly	Not known	Not known

	participants may have been tempering answers to avoid this potential negative judgement		
	1	0 – N/R	0 – N/R
6. Are ethical issues explicitly discussed?	Yes	No	No
	2	0	0
Is there sufficient information on how the research was explained to participants?	Yes	Partial – mention of consent form but no further details	No
	2	1	0
Was ethical approval sought?	No	No	No
	0	0	0
Are there any potential confidentiality issues in relation to data collection?	Partial – the possibility of being identifiable through information within direct quotes was discussed with participants and consent for full quotes to be used was gained	Not known	Not known
	1	0 – N/R	0 – N/R
7. Is the data analysis/interpretation process described and justified?	Yes – detailed explanation of coding procedure and credibility checks	No – lack of clear qualitative analysis methodology used	No – lack of explanation regarding the analysis process. Stated only as 'form of grounded theory'
	2	0	0

Is it clear how the themes and concepts were identified in the data?	Yes	No	No – key themes not clearly presented or supported with direct quotes
	2	0	0
Was the analysis was performed by more than one researcher?	Yes	No	No
	2	0	0
Are negative/discrepant results taken into account?	Yes	Yes	No
	2	2	0
8. Are the findings credible?	Yes	Yes – supports previous literature	Yes – supports previous literature
	2	2	2
Are there sufficient data to support the findings?	Yes – direct quotes reflect the themes	No – lack of direct quotes, unclear proportion of interviews included within the analysis	No – lack of clear data presented in the paper
	2	0	0
Are sequences from the original data presented (e.g. quotations) and were these fairly selected?	Partial – quotes presented to ground each theme. However notable that one participant was quoted significantly less than others.	No – summaries only no direct quotes	Partial – quotes presented but unclear how many participants they were selected from as no pseudonyms
	1	0	1
Are the data rich (i.e. are the participants' voices foregrounded)?	Yes	No	Yes
	2	0	2

Are the explanations for the results plausible and coherent?	Yes – concise narrative summary of each theme	Yes	Yes – plausible, coherent and reflective of previous literature.
	2	2	2
Are the results of the study compared with those from other studies?	Yes	Yes	Yes
	2	2	2
9. **Is any sponsorship/conflict of interest reported?**	N/A	N/A	N/A
10. **Did the authors identify any limitations?**	Yes – possible inhibitory effect of discussing a taboo subject.	Partial – limited size and selectiveness of sample noted but no recognition of limitations in methodology	Yes – small sample size, participants taken from one country and one ethnic community. Potential that voluntary nature of the study provided a skewed sample.
	2	1	2
Are the conclusions the same in the abstract and the full text?	Yes	Partial – abstract only discusses positive vs. negative outcomes rather than the wider themes	Yes
	2	1	2
TOTAL SCORE:	60/ 76	33/76	38/76

1.1.4.3.3.   Synthesis of Systematic Review

A narrative synthesis of the six papers critiqued above will be presented below, including a summary of prominent findings, critical review of the methodology and implications for future research.

1.1.4.3.3.1.   *Recurring Results and Themes*

1.1.4.3.3.1.1. Regularity of Touch

The findings regarding regularity of touch have been varied and conflicting between studies. Some research has found that whilst the majority of therapists initially report that they do not use touch, when explored further it appears that touch does happen in practice. Tune (2001) noted that all participants on discussion acknowledged that touch has occurred in their practice, and Strozier, Krizek and Sale (2003) found that 95% of therapists use touch with their clients at least some of the time. Contrastingly, other studies have found that many therapists approve of touch in principal yet rarely use it in their practice (Joshi, Almeida & Shete, 2010). In a large scale study, 90% of therapists reported never touching a client (Stenzel & Rupert, 2004), and qualitative research by Harrison, Jones and Huws (2012) supported the idea of rarity and caution in the use of touch in therapy. These latter two studies have been demonstrated in section 1.1.4.3.2.1 to be of higher quality among the reviewed papers and also focused specifically on psychologists and psychotherapists. This therefore suggests that we may give more weight to the findings of touch being used rarely and with caution by psychologists.

These contrasting reports of frequency suggest that there could be significant variation in touch behaviour across different professions or settings, or that the definition of touch has varied considerably between studies. What does seem clear is that there is a discrepancy between attitudes towards touch and actual touch behaviour. Indeed, there was a lack of correlation noted between these two variables in the study conducted by Joshi, Almeida & Shete (2010). This suggests that there

are significant barriers for therapists in practising congruently with their attitudes. Whilst it should be noted that the reliability of this particular study is questionable due to the relatively small sample size, this discrepancy between opinions regarding touch efficacy and application of touch in practice has been noted within other studies (Harrison, Jones & Huws, 2012; Tune, 2001) suggesting this is likely a consistent issue.

There was agreement across both quantitative and qualitative studies that the majority of touch occurs near the end of either individual sessions or the course of therapy (Harrison, Jones & Huws, 2012; Tune, 2001; Strozier, Krizek & Sale, 2003). It was suggested that this represents a divide between the therapeutic and non-therapeutic or social space, and that therapists feel more comfortable touching within the social rather than the clinical context.

1.1.4.3.3.1.2. Reasons to Touch

A common theme particularly evident within the qualitative explorations into this topic was the reliance of human instinct in identifying appropriate times to touch. This was described as a response not consciously thought about or easy to articulate, but one that feels 'right' and often relies on non-verbal cues (Harrison, Jones & Huws, 2012; Strozier, Krizek & Sale, 2003). This was often particularly true of touch provided at times when distress levels were high.

The majority of studies identified the primary reasons for touch as relating to improving client experience or outcomes (Strozier, Krizek & Sale, 2003; Harrison, Jones & Huws, 2012). Pinson (2002) added that whilst characteristics of the therapist were usually congruent with attitudes toward touch, actual touch behaviour did not appear to be fully governed by these attitudes and that the behaviour was instead based on the perceived need of the individual client at that time. The focus on client experience across the various studies suggests that this could be considered as a well replicated finding.

Reports of commonality of touch as initiated by client or therapist differed across studies. Tune (2001) found that client-initiated touch was more likely to be perceived as problematic or taken to supervision than therapist-initiated touch. This is in contrast to data by Pinson (2002) who found that therapists are more likely to respond to client-initiated touch than to initiate it themselves. As noted in section 1.1.4.3.2.1, both of these studies suffer from significant methodological flaws; including a lack of rationale underlying the methodology, unclear method of qualitative analysis and a lack of triangulation of themes. This raises questions regarding whether such discrepancies may be impacted by poor theoretical sensitivity, unrepresentative sample populations or researcher bias. Stenzel & Rupert (2004) do support the position held by Pinson (2002) - finding that therapists were more likely to accept than to offer touch - helping to provide more weight to this perspective. It was suggested that this accepting touch may reflect reduced anxiety about potential misinterpretation, given that it has been initiated by the client. Stenzel & Rupert (2004) highlight the lack of specific research separating therapist and client initiated touch, thereby also recognising the limitations of their own study, and suggest that this could be usefully examined further in future research.

1.1.4.3.3.1.3. Decision-making about Touch

The studies reviewed suggested that the decision-making process regarding touch appeared to be very individual and specific to the particular client and immediate context (Strozier, Krizek & Sale, 2003). This includes considering the timing of the touch in relation to the stage of therapy, who the touch was initiated by, what previous touch that client may have experienced and the quality of the therapeutic relationship (Harrison, Jones & Huws, 2012). The nature of these nuanced decisions of whether to touch from client to client mean that identifying clear markers of when touch is deemed appropriate or not is very difficult. Indeed, Tune (2001) highlighted the fact that clinicians have difficulty articulating how they came to the decision to use touch with a particular client.

Joshi, Almeida & Shete (2010) reported that gender influenced touch decisions, with females more likely to touch. However, Strozier, Krizek and Sale (2003) reported no difference in the incidence of touch between males and females, and respective gender of the client or therapist did not appear to be a prominent issue raised within the qualitative studies. It is important to consider that both of these studies contained samples with a high proportion of female respondents – 63% and 83% respectively – implying that data regarding gender differences should be treated with caution. Furthermore, the consideration of non-responders and non-significant data was omitted from both papers. A much larger scale study with more sophisticated statistical analysis of data and consideration of all results by Stenzel & Rupert (2004) proposed the demographic make-up of the therapeutic dyad as most important, with female-female dyads most likely to experience touch. As well as being considered a high quality study, these findings also reflect other research and more general societal stereotypes of females being generally more prone to be the providers or recipients of touch (Major, 1981).

1.1.4.3.3.1.4. *Potential Effects of Touch*

1.1.4.3.3.1.4.1.   Positive

Across all reviewed studies, participants were able to identify potential positive consequences of appropriate touch in the therapeutic setting. Most commonly noted and therefore considered a fairly reliable theme was that of benefit for the client. It was suggested that touch can be a grounding mechanism in states of heightened distress (Pinson, 2002; Harrison, Jones & Huws, 2012), that it can provide nurturing, calm or containment (Joshi, Almeida & Shete, 2010), that it can model appropriate touch behaviour (Stenzel & Rupert, 2004) and that it can allow further exploration and integration of self-states through catharsis (Pinson, 2002). It is evident that both quantitative and qualitative papers were able to elicit ideas around reasoning underlying the use of touch; however it must be recognised that there is a fairly thin literature base into this topic and the quality of several of these papers has been judged to be relatively low in section 1.1.4.3.2.1. These therefore should be considered preliminary ideas to be confirmed through further research.

It was also recognised that touch could bring benefits to the therapist or the therapeutic relationship. For example, touch may provide the therapist with a way of managing distress in moments of high expressed emotion (Harrison, Jones & Huws, 2012). The research undertaken by Harrison, Jones and Huws (2012) was of notably higher quality than the other qualitative studies therefore may have allowed the development and refinement of more in depth themes such as this. Additionally this research focused specifically on clinical psychologists, so can be considered of particular interest in relation to the current study with regard to the exploration of corroborating or conflicting data. Other studies did support the idea that touch could provide some benefit to the therapist, suggesting that touch may allow the marking of endings, strengthening of the therapeutic bond through conveying of acceptance (Strozier, Krizek & Sale, 2003) or adding a further level of communication (Joshi, Almeida & Shete, 2010).

1.1.4.3.3.1.4.2.   Negative

Strozier, Krizek and Sale (2003) highlighted the fact that there was far more variability in the potential for negative outcomes of touch. Similarly to the potential positive effects, these largely focused on the wellbeing of the individual client. These concerns included the client feeling threatened by the touch, touch being re-traumatising and feelings of confusion for the client. Such findings by Strozier, Krizek and Sale (2003) should be considered of limited value due to sampling issues. This includes the small sample size consisting specifically of social work therapists and recruitment via snowball sampling, which could lead to a potential bias in data. However there is support for similar therapist anxieties found in other more robust studies, such as that of Harrison, Jones and Huws (2012) and Stenzel and Rupert (2004). There was also a further worry about creating a spiral of dependency between the client and therapist if it was felt that an occasion of touch set an unhelpful precedent outlined by Pinson (2002). However this was not verified by other studies and therefore should be considered with caution due to the lack of clear qualitative methodology, omission of processes suggesting that data saturation

60

was achieved and a lack of consideration of researchers' influence on the data in this study.

There was also some trepidation in the use of touch for fear of negative consequences for the therapeutic relationship or the therapist themselves. The most prominent of these was of the touch being misinterpreted, leading to either legal issues or irreversible damage to the therapeutic relationship (Harrison, Jones & Huws, 2012; Pinson, 2002). This appeared to be a prominent concern in therapists' minds, as it was regularly suggested that no matter how benign the intent of the therapist touch may still be perceived differently – for example sexually – by the client (Harrison, Jones & Huws, 2012; Pinson, 2002). It is notable that this was most strongly identified in the qualitative studies, suggesting that such methodology allows more in depth exploration of the perceived consequences of touch behaviour. However, the finding is further substantiated by Joshi, Almeida and Shete (2010), who also proposed this as a very prominent dilemma, citing that the majority of therapists interviewed stated that they had known somebody accused of malpractice by a client. It should be recognised that this latter study did not provide full details of the questionnaire used, therefore the non-directive nature of questioning cannot be assured and may have therefore impacted on the results. However, the presence of similar findings in more robust studies such as that of Harrison, Jones and Huws (2012) suggests that consideration of negative consequences of touch for the therapist is worthy of exploration in future research.

1.1.4.3.3.1.5. Barriers to Touch

Several common barriers to providing or accepting touch were identified. The therapeutic model subscribed to by therapists does appear to play a part, with several studies reporting that therapists influenced by psychodynamic ideas are least likely to touch, and humanistic or eclectic therapists are most likely to touch (Harrison, Jones & Huws, 2012; Strozier, Krizek & Sale, 2003). Regardless of their own therapeutic orientation, the view of psychodynamic approaches being incompatible with touch was common across studies and some participants even

described touch in such models as "forbidden" (Stenzel & Rupert, 2004). In respect to this last point, it must be considered that such descriptions resulted from a quantitative study based on survey data, with no details regarding whether such views were reflective of a wide variety of respondents or whether such themes arose within open or closed questions (and if within closed questions what the 'scaling' available to participants consisted of). However, this does appear to reflect a wider narrative suggesting a particularly significant barrier to implementing touch in therapy, regardless of individual therapist beliefs regarding its efficacy. Professions involved in providing psycho-therapeutic input are viewed as people who don't or shouldn't touch, with some believing that, even if touch might be beneficial, it is outside of the professional remit (Harrison, Jones & Huws, 2012). Pinson (2002) supported this idea, reporting that participants expressed feeling very unsure about the appropriateness of touch despite apparent clinical effectiveness because they felt that touch was not common practice. Tune (2001) additionally reported that touch was generally regarded as a hidden topic that was not easy to talk about comfortably with clients, supervisors or during training. This well replicated view is suggested as being perhaps developed through the omission of any discussion regarding touch during training. Quantitative data supports this idea, with Strozier, Krizek and Sale (2003) reporting that 82% of participants responded 'no' when asked if the topic of touch had come up during training. Harrison, Jones & Huws (2012) proposed the idea of a "'vicious cycle" relationship between risk and touch in therapy. The dominant narrative that therapists shouldn't touch leads to fear of judgement from others, so therefore therapists don't discuss occurrences of touch, reinforcing the belief that therapists shouldn't touch and maintaining the taboo nature of the topic. As previously mentioned, this study was identified as being particularly methodologically sound with regard to the data collection and analysis process, thereby allowing the development of more in depth and refined conceptual ideas. However, the sample size used was small and reflects the only study specifically recruiting clinical psychologists therefore the reliability of findings need to be increased through further research.

1.1.4.3.3.1.6. Summary

In summary, there are many commonalities to be found across the results of the studies reviewed. In particular, the sense that touch is generally outside therapists' remit, difficulty in discussing the topic openly, decision-making about touch behaviour occurring on a very individual basis and the key concern in weighing up potential positive or negative outcomes of touch being the wellbeing of the clients. Some interesting conflicting results were also apparent. The regularity of touch in therapeutic settings remains unclear, with some studies reporting a high rate yet other more robust studies indicating that it is rare. The lack of correlation in the relationship between attitudes to touch and actual incidence of touch behaviour was also very thought-provoking, pointing to the complexity of the decision-making process. The conclusions from all of the studies support the need for further research to clarify some of these conflicting ideas, improve the reliability of research through addressing methodological concerns and deepen our understanding particularly of the decision process underlying touch in therapeutic settings.

1.1.4.3.3.2. *Methodological Issues*

1.1.4.3.3.2.1. Sample

1.1.4.3.3.2.1.1. Sample Size and Characteristics

The quality of sampling across the six reviewed studies varied considerably. Stenzel and Rupert (2004) provided the largest large scale quantitative study, and provided a helpful perspective on how the respondent population represented the target population with respect to demographics, theoretical orientation and experience. Other quantitative studies failed to utilise a similarly large sample and also failed to situate their sample within a clear target population, thereby making it hard to judge the representativeness of the respondent group. In the case of Joshi, Almeida and Shete (2010), the target population of qualified counsellors in India was not specified, but can be justly assumed to be a large group. However, the interviewed sample consisted of only 61 individuals, the characteristics of whom were detailed

but were not compared with the characteristics of the profession nationally. This raises doubts about the generalisability of the findings across the target group that the paper claims to represent.

Appraisal of adequate sample size is far more nuanced and controversial within qualitative research. Marshall and Rossman (2004) suggest that an appropriate sample size for a qualitative research study is simply one which adequately answers the research question, and that the number of participants required usually becomes apparent during the process at the point of data saturation. Unfortunately, none of the qualitative papers detail their analytic process as reaching the point of saturation so it is not possible to use this as a marker of appropriate sample size. Harrison, Jones and Huws (2012) used Interpretative Phenomenological Analysis (IPA) and recruited six participants. This is a number consistent with recommendations regarding this methodology, which state that depth of description can be gained even with very few participants (Reid, Flowers & Larkin, 2005; Smith, Flowers & Larkin, 2009). The lack of clear qualitative methodology used in studies by Tune (2001) and Pinson (2002) make the adequacy of the sample more questionable still, particularly in the context of a lack of supporting studies within the field. This suggests that further research with a more identifiable sample and methodology would be helpful in assessing the generalisability of findings.

Of additional note is the characteristics of the samples that were used within these six studies. The majority of the studies appeared to contain an over-representation of experienced as opposed to newly qualified clinicians. For example, Harrison, Jones & Huws (2012) only interviewed experienced psychologists with a minimum of eight years post-qualification experience and a mean of 15 years' experience. Similarly, the experience range of psychologists interviewed by Pinson (2002) was between 14 and 31 years. Whilst a focus on experienced therapists was justified in some of the papers by the nature of the research question – for example Tune (2001) who selected experienced therapists due to the perception that they would have a greater understanding of their own propensity to touch and more extensive experience to draw on - this was not explicitly intended in other studies and perhaps reflects some

bias in recruitment. Interestingly, Joshi, Almeida & Shete (2010) did include and delineate newly qualified therapists within their study, and analysed the factor of experience when examining interactions in the data. They identified an interaction between experience and gender of therapist on frequency of touch. This suggests that years of experience may well play a part in touch behaviour that may have been overlooked in the other included studies, and would warrant further research.

1.1.4.3.3.2.1.2. Recruitment and Data Collection

Methods of recruitment were identified as a strength in only one of the three quantitative studies. Stenzel & Rupert (2004) identified a clear target group then conducted random sampling, with consideration of the research aims and design. This process was appropriate given the relatively broad aim of gathering information about touch between psychotherapists and clients, and allowed the resultant data to be considered generalizable across the population. The other quantitative studies used less stringent methods of recruitment, which on one hand failed to provide similarly generalizable results but conversely did allow focused attention of a more specific research question.

Whilst the process of random selection is relatively well defined and rigorous in quantitative studies such as randomised control trials (RCT's), qualitative and survey based research faces more challenges in recruitment. Marshall (1996) discusses that in a small sample as required in qualitative research, the sampling errors of a random sample are likely to be large. Additionally, the characteristics of an entire population should be known in order to select a truly random sample. However, this is a task often difficult to achieve when considering the complex and dynamic characteristics of interest in qualitative research – for example values, beliefs, attitudes - particularly given that these characteristics may not be normally distributed within the target population. Finally, it is recognised that certain informants are likely to provide richer understanding and insight than others with regard to the topic being studied. Given this, the three qualitative studies did appear to justify their own sample selection on the basis of the characteristics of interest and

those who could best answer the research question. For example, Pinson (2002) sought out participants known to have used supportive touch in order to explore their justifications for this.

Purposive sampling, as used by all of the qualitative papers and the survey by Joshi, Almeida and Shete (2010) is beneficial in selecting the most productive sample to answer the research question and in minimising the time spent collecting or analysis irrelevant data. However, this method of recruitment also increases the probability of researcher bias through disproportionate attention to hypotheses developed *a priori*. In the case of snowball sampling as used by Joshi, Almeida and Shete (2010) and Strozier, Krizek and Sale (2003) or recruitment of therapists known to the researcher (Tune, 2001) the respondent group may be biased towards an existing perspective due to their existing association with others with whom they work closely or share similar views. Individuals with less extreme views may also be overlooked in favour of those who hold a more clear position. This apparent weakness in recruitment across the studies is exacerbated by the lack of information regarding non-respondents, depriving the reader of the opportunity to consider the significance of that group.

1.1.4.3.3.2.2. Research Aims and Design

A hallmark of good quality research is that which is relevant, timely, significant, interesting, or evocative (Tracy, 2010). A strength of the papers included in this review was the clarity regarding the aims and motivation underlying the research. All the reviewed papers provided clear research questions situated in relation to previous research. This included identifying a gap in the literature regarding a specific issue, as in the case of Strozier, Krizek and Sale (2003) who noted a lack of direct description from clinicians regarding decision-making about touch. Also, previous methodological weaknesses in the existing literature were targeted, for example expanding on previous studies of small samples (Stenzel & Rupert, 2004) or using a qualitative methodology to focus on personal experience and meaning (Harrison, Jones & Huws, 2012).

66

It is notable that all of the research questions were explicitly exploratory rather than hypothesis driven, perhaps reflecting a sense that - despite being a topic of interest and of research dating back to the 1980's and early 1990's– there is still little understanding of how the phenomena of how touch is approached in therapy. This purely exploratory position may account for the somewhat loose definitions within the qualitative studies and the reliance on cross-sectional survey design in the reviewed papers. Whilst this does provide us with interesting descriptive data, there is a lack of in-depth exploration, rigorous integrated results or explanatory ideas that could progress our understanding.

Though all the reviewed papers centred on the theme of touch, each differed slightly in their focus, with some targeting either touch frequency or touch function and others analysing specific characteristics such as client or therapist gender. This limits the comparability of the results as a whole due to the significantly different foci, methodologies, instruments used and results. Additionally, in relation to the current study, it is notable that there is very limited data specifically regarding clinical psychologists and their views on touch. The research base regarding this specific group currently consists of only one small scale paper using qualitative methodology. This suggests that further research with clinical psychologists looking broadly at experiences of touch in therapy would be beneficial.

1.1.4.3.3.2.3. Data Analysis

A clear weakness identified through assessment of the qualitative studies was that of the methodology underlying the data analysis. Only one qualitative study (Harrison, Jones & Huws, 2012) unequivocally stated a model underlying their data collection and analysis – IPA – and employed rigorous processes inherent within this approach to ensure reliable analysis. This included line by line coding, recording of memos, constant comparative analysis and use of credibility checks with additional researchers. Research by Pinson (2002) and Tune (2001) used vaguely specified

methodologies such as a 'form of grounded theory', and did not justify their choice of approach in the context of existing literature. The quality of data reported was poor, including only summaries and often lacking direct quotes to provide grounding in data (Pinson, 2002). Tune (2001) provided a selection of quotes, however these were not labelled with pseudonyms making the range of sources unclear and detracting from the voice of participants. Additionally, none of the qualitative papers reported achieving data saturation. This refers to the process of gathering and analysing data until the point where no new insights are being observed and is a measure of content validity through addressing whether there is sufficient evidence underlying claims (Francis, Johnston, Roberston, Glidewell, Entwistle, Eccles & Grimshaw, 2010). However, it must also be recognised that there remains ongoing debate around the utility of data saturation as a marker of quality, given its varied meanings which limit its utility as a criteria for reliably assessing validity or transparency (O'Reilly & Parker, 2012).

Quantitative analysis of the results in the three survey design studies was rated as better quality overall, with appropriate use of both descriptive and inferential statistics. It was noted that Strozier, Krizek and Sale (2003) provided only descriptive statistics in their research and did not make use of further analysis. This limited the usefulness of the data that may have been extracted from their study with regard to generalising beyond that sample.

Denzin (2012) highlights the importance of triangulation – particularly in qualitative research – which refers to the consideration of other data to assess the credibility of findings. In all of the papers reviewed, due attention was paid to how the findings aligned with other research into touch in a therapeutic setting. However, triangulation could have been improved through the use of additional data sources. For example, the studies utilising survey methodology may have found an additional qualitative element beneficial. Alternatively, the presentation of the themes generated from the qualitative research back to the participants or a similar sample to check would have bolstered the credibility of the researchers' conclusions.

1.1.4.3.3.2.1. Ethical Issues

It has been stated by the Committee on Publication Ethics (COPE, 2011) that details of ethical approval and informed consent should be provided for all human studies. The quality of all of the included studies was reduced by a lack of focus on ethical considerations. This included a lack of reporting of any ethical approval gained to conduct the study, and very limited information provided regarding confidentiality and consent information given or gained from participants.

1.1.4.3.3.2.2. Reflexivity

Richardson (2000) identifies self-reflexivity and transparency as key criteria when assessing the quality of research studies. This refers to both honesty about the research process and reflection on any potential biases that may have affected the research outcomes. Seale (1999, p. 468) suggests that all researchers should provide "a methodologically self-critical account of how the research was done". Several of the research papers reviewed introduced the emotional context of the work and the researcher's position well, allowing the reader to consider the impact that this may have had on their interpretations or conclusions.

Tune (2001) helpfully discussed the origins of his interest in exploring the issue of touch, as well as his own approach to touch in his clinical practice. This allowed the reader to consider any potential bias in either his approach to methodology or the conclusions drawn. Indeed, it does appear to have affected the approach to the research through seeking out only experienced psychotherapists viewed to be more self-aware. In addition, his conclusions appear to emphasise the importance and potential clinical benefits of touch. Conversely, Pinson (2002) did not reference the researcher's position at all. Harrison, Jones and Huws (2012) referenced the use of reflexivity methods such as memos and discussion with supervisors in attempts to manage researcher bias, but did not outline their perspective within the paper to allow the reader to assess its possible impact.

Whilst reflexivity is generally less emphasised in quantitative research methodology, in the case of survey design – and similarly the development of interview schedules – consideration of potential bias or influence on respondents is equally important. Few of the studies reviewed adequately described ways in which the surveys or interviews were developed, or adapted methods of delivery to minimise bias or leading questions. This is particularly relevant with regard to this topic, where the existing literature has demonstrated that clinicians view touch with clients as generally 'taboo' and express anxiety about being judged for their behaviour. All of the reviewed papers were conducted by peers of participants from the same discipline, perhaps leading to inhibition of some responses. As such, the assessed quality of the studies is reduced due to inability to account for possible misinterpretation of questions, biases of questions or influence of the researcher on respondents. Harrison, Jones and Huws (2012) did note that the censoring of accounts is likely to be a limitation in discussion of all controversial issues, but urged that this should not mean they are left unaddressed but that instead they should be explored further to challenge the taboo status.

1.1.4.3.3.3. *Implications and Recommendations*

Richardson (2000) suggested that the significance of a study's contribution should be judged on whether it extends knowledge, improves practice, generates ongoing research or liberates / empowers individuals.

A strength of the reviewed studies was the consideration of ways the research question could expand upon existing knowledge, and the consideration of both theoretical and clinical implications of the conclusions drawn. Examples of this include recommendations for further research focusing on touch within particular facets of the psycho-therapeutic profession (Tune, 2001), increased focus on discussion of touch instances and client consent to touch (Stenzel & Rupert, 2004)

and including the topic of touch within training programs (Strozier, Krizek & Sale, 2003).

1.1.4.3.3.4. *Summary*

All of the studies in this review have provided data of value to the topic, and have shown particular strengths in the development of strong and meaningful research questions, selection of appropriate design and generation of meaningful theoretical and clinical implications. However, only two of the studies achieved a quality rating of over 75% on their respective scoring scales (Harrison, Jones & Huws, 2012; Stenzel & Rupert, 2004) and two scored below 50% (Tune, 2001; Pinson, 2002). The main weaknesses in the quality of studies were the lack of clear methodology, lack of inclusion of ethical considerations and a lack of reflexivity regarding the impact of the researcher on the development of the survey or the results of the analysis. All of the studies recommend further ongoing research into the topic of touch in therapeutic settings. In particular, there were calls for more in-depth qualitative exploration and a focus on therapists' decision-making about whether to touch or not touch. This would not only serve the purpose of increasing our understanding, but could also open a dialogue about the topic of touch in therapy that appears to still be a controversial and in many cases taboo topic.

1.1.5. RESEARCH RATIONALE AND AIMS

1.1.5.1. Rationale

Despite the longstanding interest in the topic of touch in therapy - as evidenced in the initial literature review showing that debate and research into this area dates back to the 19th century - there remains little training, understanding or open dialogue between clinicians concerning this issue. At present, there is very little research looking specifically at the attitudes and experiences of clinical psychologists regarding touch in a therapeutic setting. Much of the research that has taken place has relied on quantitative assessment of the frequency and purpose underlying touch behaviour. The sole recent qualitative research into this topic utilised IPA methodology (Harrison, Huws & Stephens, 2012), and highlighted the value of further in-depth exploration regarding clinical psychologists' experiences of touch within an adult psychotherapeutic setting. Previous research into the topic has suggested that touch is a controversial and anxiety provoking issue for clinicians across disciplines, and one that is rarely discussed or addressed in training or supervision. Indeed, given the proposed potential benefits of appropriate touch and the potential risks of inappropriate touch outlined in the reviewed studies, it can be strongly argued that this is an interesting topic worthy of more attention.

1.1.5.2. Research Aims

This research aims to expand on the existing evidence base by exploring the views and experiences of clinical psychologists of touch in a therapeutic setting. A grounded theory methodology will be used to develop a coherent theory of touch behaviour in the context of a current lack of shared understanding. It is hoped that this research will provide a greater understanding about how clinical psychologists experience touch with clients, and the processes that underlie decision-making about touch. This will be extremely relevant clinically in considering the perceived efficacy of touch in therapy, as well as opening up a dialogue to consider how this topic is approached in training and supervision.

2. Chapter Two: Methodology

2.1. METHODOLOGY

2.1.1. Overview of chapter

In line with the research aim to explore the views of Clinical Psychologists regarding touch in therapeutic settings, a qualitative methodology was employed utilising the classic grounded theory approach as laid out by Glaser (1992). This involved analysis of data from semi-structured interviews undertaken with eleven clinical psychologists currently working in the field of adult mental health.

This chapter will provide an overview of the research methods used and will explore the rationale in adopting the classic grounded theory approach. A detailed description of the study design will be presented; including governance procedures, participant recruitment, data collection and the process of analysis. Finally, ethical considerations and methods of ensuring rigour and quality in relation to both the methodological approach and the researcher's position will be discussed.

2.1.2. Qualitative Methodology

"Qualitative research" is a broad term which incorporates a wide range of approaches within and across disciplines. Briefly, qualitative methodologies are characterised by a non-statistical approach to analysis of data. In contrast to quantitative approaches, qualitative methods are focused on gaining an understanding of the experiences of an individual or group rather than generating probabilistic observations or identifying cause and effect (Smith, 2003; Willig, 2008). Commonalities across qualitative approaches include a naturalistic interpretive approach, a concern with deep understanding phenomena and the valuing of perspectives of participants as a starting point (Flick, 2009). Researchers have highlighted various processes involved in qualitative research as an identifying marker of the methodology. These include a focus on inductive process, flexible

research design and an aim of generating meaning, explanation and rich description of human experience (Parahoo, 2006; Ormston *et al.*, 2013).

Qualitative approaches are particularly appropriate when the aim of research is to consider personal, experiential and phenomenological concepts (Smith, 2003). Fossey *et al.*, (2002) also note that a qualitative approach lends itself very well to research where there is a small evidence and theory base. Based on these factors, a qualitative approach was felt to be the most appropriate to explore the issue of touch in a therapeutic setting given the exploratory rather than objective aim. The limited nature of previous research, lack of theoretical understanding and interest in the in-depth understanding of the human experience of touch in therapeutic settings make qualitative investigation particularly relevant for this topic.

2.1.3. Grounded Theory

2.1.3.1. Philosophy and Method

2.1.3.1.1. History / development

Grounded theory is a method of qualitative research developed in the 1960's by sociologists Anselm Strauss and Barney Glaser, in opposition to the dominant positivist quantitative methods that characterised academic research at this time (Stern, 2009). The phrase "grounded theory" refers to a theory that is developed inductively from a corpus of data, allowing for development of ideas originating in the data as opposed to being restricted by concepts inherent in pre-existing hypotheses (Creswell, 2008). Glaser described the process as "a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser, 1992, p. 16).

Despite sharing the umbrella label of a "qualitative approach", there are significant differences in the philosophical position and aims of grounded theory as opposed to

approaches focusing on rich description such as Interpretative Phenomenological Analysis (IPA). In grounded theory, participants' perspectives are examined at a conceptual rather than a descriptive or an interpretative level (Glaser, 2002). This reflects the sociological tradition underlying grounded theory, with the focus of investigation being social process rather than internal psychological structures (Baker, Wuest & Stern, 1992). Glaser (2002) emphasises that the purpose of grounded theory is not to tell participants' stories, but rather to identify and explain conceptually patterns of behaviour that are used in response to particular experiences. Key methodological principles also separate grounded theory from descriptive approaches; whilst IPA researchers attempt to 'bracket' their prior knowledge and view the participant as the only true data source, in grounded theory everything is considered data and the researcher uses their own ideas and assumptions to better understand what is being observed (Baker, Wuest & Stern, 1992).

Whilst the overall tenets of the grounded theory approach as an inductive method leading to specific conceptual theory are well accepted, the approach and rigour with regard to data collection, handling and analysis gradually led to divergence between the originators of the method (Higginbottom & Lauridsen, 2014). As Strauss developed a more linear approach to the research methodology two separate schools of thought became established; often referred to as 'classic' or 'Glaserian' grounded theory versus the 'Straussian' grounded theory co-developed with Juliet Corbin in the early 1990's (Strauss & Corbin, 1990). More recently, various followers of more traditional grounded theory have approached the methodology through alternative ontological and epistemological lenses leading to 'second generation' schools of grounded theory such as constructivist grounded theory and situational analysis (Richards & Morse, 2007). Taking into account the various evolved or modified versions of the approach, grounded theory is now reported to be the most common and widely recognised technique in qualitative analysis (Gibbs, 2007).

2.1.3.1.2.   Aims and Method

Glaser argues that grounded theory allows us to 'discover what is going on' (Glaser, 1978), and suggests that the aim of researchers' who adopt this approach is to inductively generate theoretical explanations of social and psychosocial process (Baker, Wuest & Stern, 1992). To this end, grounded theorists begin with an assumption that participants share a social meaning that forms the basis of their behaviour and experience. This may emerge as a shared social problem – for example a dilemma about how to respond in a given situation – which may or may not be explicitly articulated. Grounded theorists set out to understand this shared social problem, and for their resultant theory to reflect what participants do to resolve it (Schreiber & Stern, 2001). A grounded theory should identify a pattern of behaviour that transcends empirical difference between participants to provide a conceptual, rather than descriptive or interpretive, rendering of participant behaviour. By developing a theory truly grounded in the data, as much variation in the data as possible should be accounted for so that whilst participant perspectives may vary on an empirical level the concepts themselves do not change (Breckenridge *et al*., 2012).

Grounded theory is sometimes referred to as a constant comparative method because coded data is constantly compared with other data and concepts at each level of theory development (Schreiber & Stern, 2001). The researcher moves back and forth during data collection, gradually advancing from coding to conceptual categories to theory. Glaser and Strauss (1967) highlight that the unit of analysis is not the person themselves, but incidents in the data. The resultant theory is not an authoritative truth claim intended to be proven, but a theory intended to be used and modified (Glaser, 1992). Grounded theory is therefore a helpful approach when a broad theory of explanation or process is required, and is particularly helpful when current theories about a phenomenon are either inadequate or non-existent (Creswell, 2008).

Whilst the above descriptions of aims and method are relevant across the different applications of grounded theory, the previously mentioned divergence in schools of the approach has led to some key differences in epistemology and methodology. Some of the key disparities across the different approaches are discussed, though it should be noted that more detailed description of the methodology used in this research – classic grounded theory – is included in section 2.61.

2.1.3.1.3.   Subsets of Grounded Theory Method

2.1.3.1.3.1.   *Classic Grounded Theory*

The classic grounded theory approach as advocated by Glaser was founded in critical realism, post-positivism and objectivity (Devadas *et al*., 2011). One key element of the classic grounded theory approach involves avoidance of pre-existing literature and theory within the field of study. Instead, it is advocated that researchers limit preliminary reading and literature reviews to familiarisation with grounded theory methodology and application of theoretical codes. This reflects an inherent trust that theory will emerge from the data, and the opportunity for the researcher to maintain a degree of objectivity with respect to the topic at hand (Breckenridge *et al*., 2012). Classic grounded theory also advocates an open and flexible approach to data analysis; the phrase 'everything is data' recognises value in information acquired inconsequentially throughout the data collection process as well as positioning the researcher's own viewpoints as simply another source of information to be analysed (Glaser, 1978).

2.1.3.1.3.2.   *Straussian Grounded Theory*

In moving away from the classic grounded theory approach, Barney Strauss and his later ally Juliet Corbin became more influenced by the symbolic interactionism lens and incorporated constructivist ideas through acknowledging the existence of multiple socially constructed realities (Birks & Mills, 2011). This divergence is perhaps most noticeable when scrutinising their recommendations regarding

methods of analysing data. Whilst both approaches rely heavily on the constant comparative method, Straussian grounded theory incorporates significantly more structure and guidance with regard to the analysis process. The addition of the intermediary step of 'axial coding' requires the researcher to 'connect initial categories through using open coding by considering the conditions that give rise to a category (phenomenon), the context (specific set of properties in which it is embedded), the interactional strategies by which processes are carried out, and the consequences of these categories' (Kendall, 1999). This approach has been criticised by Glaser, who proposes that the Straussian model is too forceful and limits the development of true grounded theory by pushing the data into preconceived categories (Charmaz, 2006).

2.1.3.1.3.3. *Constructivist Grounded Theory*

A common criticism of both classic and Straussian grounded theory approaches is that researchers hold an 'objectivist' or 'positivist' position purporting to discover 'truth', felt to be unrealistic by those following other qualitative research traditions. Charmaz (2003, 2006) has been vocally opposed to this stance, instead choosing to approach the method through a constructivist lens which advocates that an entwined relationship between the perspectives of the researcher and the participants results in the creation of a shared reality (Breckenridge *et al*., 2012). The constructivist approach challenges the belief that there is an objective truth that can be measured or captured through research (Crotty, 1998), and therefore places less emphasis on reducing theoretical bias through avoiding pre-emptive literature searching and more emphasis on separating out the researchers' position. Charmaz (2006) has encouraged grounded theorists to be open about the philosophical positioning of the method and to incorporate the multiple views and visions of participants in rendering their lived experiences.

2.1.3.1.3.4. *Response to criticism of Classic Grounded Theory*

Glaser argues that constructivist grounded theory has deviated from the original intent of the classic methodology in that the purpose of grounded theory is not to tell participants stories but instead to conceptualise the shared social problem – often referred to as a "core concern" - abstracted from the data (Glaser, 1998). In response to constructivist criticisms, Glaser has argued that the objective position of the researcher in classic grounded theory is a way of privileging the participants' core concern rather than seeking objectivist accuracy. Indeed, Glaser (2002, p.4) warns that under the guise of constructivism some approaches may make "the researcher's interactive impact on the data more important than the participants'". He emphasises that his approach claims only to produce useful theoretical hypotheses to be used and modified, rather than an authoritative truth to be proven (Breckenridge *et al*., 2012). Classic grounded theory has also been criticised for a lack of transparency regarding the theoretical epistemology of the approach. Holton (2007) proposes that classic grounded theory is not free from any pre-existing theoretical lens, but rather remains open to the epistemological perspective reflected in the data and ontological stance of the researcher. Rather than assuming an epistemological or theoretical perspective in advance, the researcher remains open to codes from multiple perspectives in which to organise the emergent theory (Glaser, 2005). The ongoing debate regarding the relative benefits and limitations of the respective approaches to grounded theory serve to delineate the methodology further, or possibly reflect emerging differing methodologies. However, Hernandez and Andrews (2012) helpfully separate the conflicting schools of thought more concisely by stating that ultimately a constructivist approach creates a descriptive grounded theory, whereas a classic approach generates an explanatory grounded theory.

2.1.3.1.4. Rationale for use of Classic Grounded Theory

In selecting a qualitative approach to this research, a grounded theory methodology was chosen based on its applicability to a substantive area where there is a dearth of

research or theoretical understanding (Creswell, 2008). As the aim of the research was to develop a deeper understanding of a social process regarding a shared social problem, grounded theory was preferred over a more descriptive approach such as IPA.

The researcher found the task of selecting the appropriate application of grounded theory more difficult, a common problem noted for novice researchers (Howell, 2013; Heath & Cowley, 2004). Taking into account the historical context of the various approaches as outlined above, the researcher identified the importance of clarity with regard to the methodology applied. A number of researchers have expressed disapproval of the ongoing 'method slurring' within the grounded theory field, suggesting that the vast majority of instructional texts make "non-systematic switching between references to Strauss/Corbin, Glaser and Charmaz a rather diffuse method of skip and dip when collecting data" (Gynnild, 2011, p.64). Indeed, Cutliffe (2004) criticises that many researchers opt for an ambiguous medley of aspects from each version without regard for their inherent incompatibilities, and Glaser expressed concern that the mixing of methodologies has the effect of downgrading and eroding the goal of conceptual theory (Evans, 2013).

Fendt and Sachs (2008) proposed that the most effective selection of a grounded theory method is one that best fits the goals, philosophy and cognitive style of the researcher. Upon detailed review of the methodology, classic grounded theory had immediate appeal to this researcher. Of particular importance was the emphasis placed on allowing theory to emerge from the data rather than guided by pre-conceptions; with literature review subsequent to analysis representing just another variable to be analysed (Glaser, 2007). The freedom and autonomy of the coding and memo-ing process also resonated with the researcher, in particular the opportunity to incorporate casual and serendipitous observations within the analysis (Deady, 2011). From a philosophical perspective, the aim of classical grounded theory in providing a conceptual explanation of the whole in a substantive area fitted with the stance of the researcher (Glaser, 2014).

2.2. ETHICAL ISSUES

2.2.1. Cardiff University Ethical Approval

The research proposal was reviewed and approved by the School of Psychology Research Ethics Committee at Cardiff University (see Appendix B). Ethical approval via the NHS was not required, as participants were not recruited via the NHS.

2.2.2. Informed Consent

In line with British Psychological Society (2009) and Health and Care Professions Council (HCPC) Guidance (2012), verbal and written consent was sought from each participant at various stages throughout the study as outlined in the ethics proposal. At the point of recruitment, potential participants received an email with the research information sheet attached (see Appendix C) along with contact details where they could source further information. Participants again received this information when attending for interview and were given time to ask any additional questions. Once the researcher was satisfied that participants were able to make an informed choice as to whether they wished to take part in the interview, a consent form was signed and dated (see Appendix D). The procedures adopted ensured that participants were regularly reminded of their right to withdraw their participation without explanation at any time until the transcriptions were anonymised.

2.2.3. Confidentiality and anonymity

The confidentiality and anonymity of participants was prioritised in accordance with the Data Protection Act (1998) and the HCPC code of conduct (2012). This was managed by assigning the personal demographic data collected an identifying number and storing this separately from the corresponding consent form including the participants' name (see Appendix E). Audio recordings were stored on an encrypted USB stick and deleted immediately following transcription. Participants

were all assigned a pseudonym at the point of transcription and any other identifying information within the interview was changed to ensure that quotes presented in the analysis were anonymous.

As set out in the British Psychological Society (BPS) Code of Ethics and Conduct (2009), the researcher retained the right to break confidentiality should issues pertaining to risk arise during the course of the interviews. It was noted in the ethics proposal that there was a particular risk in this research that a participant might disclose unethical practice as defined by the HCPC code of conduct (2012). The limitations of confidentiality were detailed within the informed consent forms and explained verbally to participants before commencing each interview. Time for debriefing was allowed at the end of the interview, and all participants were provided with a debriefing information sheet (see Appendix F).

2.3. PARTICIPANTS

2.3.1. Sampling

Grounded theory studies are characterised by theoretical sampling which involves the seeking out of participants in response to themes developing through coding. However, this first requires some data to be collected and analysed, therefore sampling must initially begin purposively, as in any qualitative study (Sbaraini *et al*., 2011).

Through consultation with research supervisors, it was decided that the inclusion criteria for this study would be limited to recruitment of participants who are qualified Clinical Psychologists with current HCPC registration who are working within an adult setting. The choice of limiting the target group to Clinical Psychologists related to validity. The pathway of clinical psychology training is explicit and incorporates key commonalities across all DClinPsy programmes – for example training across different theoretical models and specialities – which it was hoped would allow for

more variety in perspectives as well as ensuring that the resultant theory is relevant to this particular training pathway. It was considered at length whether the research should consider participants working within different specialities such as child, learning disability or older adult services. However, it was ultimately felt that within this study this may become a comparison of experience and lead to less in-depth theory generation. Therefore, the researcher chose to focus on adult settings with the suggestion that research with those working within different client groups would be potentially very interesting future research. This decision was reinforced by the preliminary review of research that demonstrated the presence of a number of quantitative and phenomenological studies in adult mental health settings on which this research could build.

2.3.2. Recruitment

Potential research participants were identified on the basis of the inclusion criteria through the psychology email distribution lists held by the South Wales DClinPsy programme. Details of the study were attached to the email via the Information Sheet along with an invitation to participate (see Appendix G). It was requested that interested participants reply to the researcher via email or telephone for further information and to arrange a meeting for the one- off interview.

An excellent response to the recruitment email was received, and the researcher initially thanked all respondees via email and explained that due to using the grounded theory approach the interviews would be arranged in a stepped process. Several interviews were arranged initially on an arbitrary basis of the first participants to get in contact via email, however as the interviews progressed respondees were contacted using theoretical sampling. Breckenridge and Jones (2009, p. 113) describe theoretical sampling as "a central tenet of classic grounded theory and is essential to the development and refinement of a theory that is 'grounded' in data". As themes developed through analysis, this included seeking out participants with differing numbers of years' experience, working in varying contexts or settings and with particular therapeutic alignments. It was possible to identify those who

worked in relevant contexts via information included in their response email such as email signatures. The distribution list held by the South Wales DClinPsy programme from which participants were recruited also details the service context of each psychologist, allowing more targeted follow up emails. Follow up emails were also sent to the initial respondents requesting more information about years of experience or particular therapeutic alignments as the study progressed, with explanation of the rationale underlying theoretical sampling. Due to the geographical and cultural context in which this research was conducted, the researcher did also know of some of the respondents by name or in some cases in person as a result of receiving teaching from them or encountering them in clinical meetings. The researcher endeavoured to ensure this did not affect recruitment by sending the same emails out to all potential participants meeting the gradually increasing stringent criteria, and interviewing on a first come first serve basis. The researcher also did not recruit any respondents with whom she has a more established relationship such as current or previous supervisors and colleagues. However, it is recognised that the decision to seek out certain characteristics may have been influenced through knowledge of the participants. Additionally, the initial process of interviewing could have favoured those known to the researcher as holding relevant views, leading to potential bias. The use of clear recruitment procedures, reflective diary and regular consultation with the research supervisor were used in order to control for this potential variable.

2.3.3. Participants

Along with indicating their consent, participants were asked to confirm or provide some basic demographic information prior to interview (Appendix E). This information is detailed in Table 2.1. All of the participants were qualified clinical psychologists, accredited by the BPS and regulated by the HCPC. The mean age of participants was 43.8 years; with a range of between 31 to 70 years. The mean length of time since qualification was 13.5 years; with a range between 1 year and 43 years. Most participants were working in community mental health teams, however theoretical sampling did seek out those working in other areas including inpatient mental health, inpatient health and private practice. The sample consisted

of 91% females; this is not dissimilar to the statistics reported by the BPS demonstrating a predominance of females in the profession at around 85%. Theoretical sampling identified the need to seek out a male perspective, as well as someone who recently qualified. Riley (1996) stated that most studies achieve saturation with between eight and 24 interviews, depending on the topic focus. In this research, there was no set number of interviews planned as it is noted that there is no definitive criteria for ensuring credibility or directing theoretical sampling across different topics of study (Breckenridge & Jones, 2009). However, through extensive analysis it appeared that the theory had reached the point of saturation after conducting 11 interviews, therefore it was chosen to end recruitment at this point.

Table 2-1. Participant Demographics

Pseudonym	Age	Gender	Years Qualified	Speciality
Sue	53	Female	23	NHS ADULT MENTAL HEALTH (community)
Bryony	38	Female	3	NHS ADULT MENTAL HEALTH (community)
Heather	47	Female	9	NHS ADULT MENTAL HEALTH (community)
Fran	34	Female	6	NHS ADULT MENTAL HEALTH (community)
Beth	37	Female	11	NHS ADULT MENTAL HEALTH (community)
Lucy	42	Female	6	NHS ADULT MENTAL HEALTH (community)
Helen	42	Female	15	NHS ADULT MENTAL HEALTH (community)
Caroline	45	Female	17	NHS ADULT MENTAL HEALTH (community)
Eve	43	Female	14	NHS ADULT HEALTH (inpatient)
Peter	31	Male	1	NHS ADULT MENTAL HEALTH (inpatient)
Maggie	70	Female	43	Private ADULT MENTAL HEALTH (Community)

2.4. INTERVIEW PROCEDURE

2.4.1. Individual Interviews

Face to face individual interviews took place at a time and place convenient to the participant, and varied in duration from 33 to 67 minutes. These interviews were recorded using a digital Dictaphone. At the meeting, the researcher reiterated the purpose of the interview and the role of the participant, and answered any questions. Issues of confidentiality and consent were discussed in detail before participants signed to indicate their consent to being interviewed.

Glaser (2003) suggested that in grounded theory the word "interview" is used tentatively; defining the interview as a conversation between equals led by the participant. This emphasises that the interview should focus on what matters to the participant rather than on the interests of the researcher. Field and Morse (1985) suggest that individual semi-structured interviews enable a flexible approach to data collection in line with grounded theory methodology. As such, the interview schedule was developed with the research supervisor and began with general, open questions about the topic of touch which allow the researcher to follow the participants' story rather than imposing a rigid structure. This initial interview structure was piloted by interviewing a trainee clinical psychologist, after which edits were made to finalising the initial interview schedule (see Appendix H). Schreiber and Stern (2001) note that, as theory begins to emerge, theoretical sampling engenders more specificity in data collection and the researcher draws key questions from the analysis to promote the development of theory. Thus, there was continuous change in the style and structure of the interview. However, it is important to recognise that the schedules were used as a guide only and were followed very flexibly throughout, emphasising listening to the participant and following the conversational direction as led by the participant (Scott, 2011).

2.4.2. Focus Group

Following the individual interviews and data analysis procedure described subsequently in section 2.5, an online focus group was facilitated in order to triangulate the study findings. Focus groups are recommended in order to gain feedback from participants to optimise the validity and reliability of the developed grounded theory (Martin & Gynnild, 2011). The focus group was facilitated by the researcher online using web host software ParaChat, which allowed invited users to occupy a private chat room at an arranged mutually convenient time to discuss the study results. It is noted that there are significant benefits inherent in using an online forum for the focus group; namely the opportunity to contribute anonymously and maximising attendance in a sample recruited over a large geographical area. However, there may also have been some disadvantages, such as the lack of group interaction and non-verbal input which can help build positive group dynamics and increased opportunity for debate. A summary of the results was provided to users in advance of the focus group by email in both narrative and diagrammatic format. Four participants attended the on-line focus group, which ran for approximately 45 minutes. The focus group was unstructured an involved the researcher asking open questions regarding participants' view on the results summary and allowing natural conversation to develop. An example of the focus group transcript can be found in Appendix I. An additional two participants responded by email with their comments. The focus group and email responses were not analysed using grounded theory methodology but were instead used to modify relevant aspects of the results, establish good reliability of the grounded theory and to help situate the results in relation to implications and recommendations for future research.

2.5. DATA ANALYSIS

2.5.1. Grounded Theory Procedure

2.5.1.1.   Preparation

Unlike other qualitative methodologies, classic grounded theory advocates delaying any literature review about the topic of the research until after emergent theory is sufficiently developed to allow literature to be used as additional data (Heath & Cowley, 2004). Hickey (1997) suggested that carrying out a pre-study literature review damages research by creating early closure to the direction of the analysis. The researcher therefore conducted only a very minimal preliminary literature review in order to identify the appropriateness and relevance of the research topic while minimising pre-conceptions. Existing classic grounded theory studies outside of the field of touch were reviewed in order to familiarise the researcher with the methodology.

2.5.1.2.   Data Collection and Analysis

As advocated by the grounded theory methodology, data collection and analysis occurred concurrently rather than sequentially using the constant comparative method (Baker, Wuest & Stern, 1992). This allowed emerging concepts to determine what information would be sought next, allowing interview questions to change as on-going analysis sharpened the focus of the study (Hutchison, 1986). Many different terminologies are used to explain the different levels of coding. However, those used in this research are defined below and the iterative process of data collection is demonstrated using the Hood (2007) conceptualisation of Glaser and Strauss' original model in Figure 2.1.
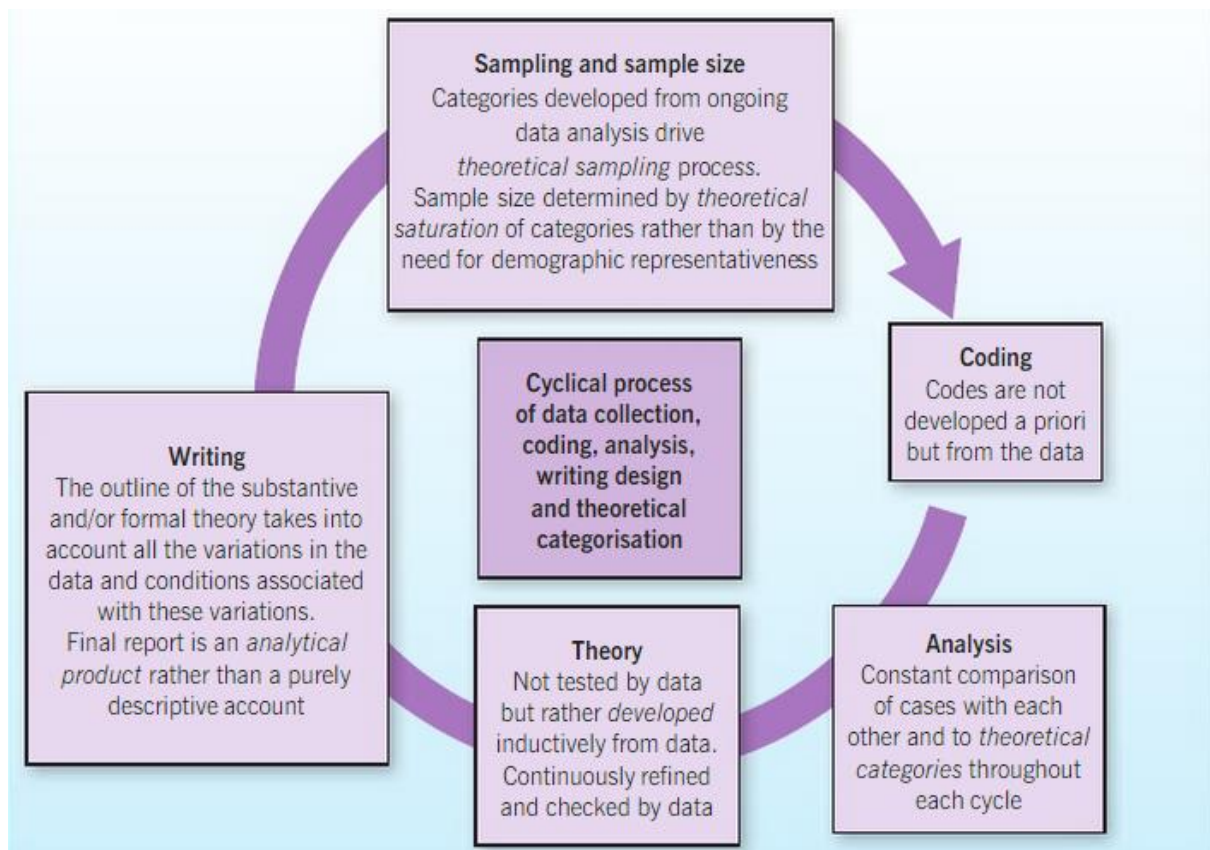
Figure 2-1. Hood (2007) conceptualisation of the grounded theory process

2.5.1.3. Coding

2.5.1.3.1. Codes

Interview transcripts were initially analysed through open coding, using qualitative analysis software NVivo10. This involves analysing interviews line by line noting specific words, phrases and sentences; fracturing the data by focusing on small aspects of responses using the participants' language where possible (Holton 2007). These codes were initially fairly descriptive, generating numerous codes from which it was possible to compare incident to incident in order to begin to generate concepts (Evans, 2013). An example of this open coding stage is provided in Appendix J.

2.5.1.3.2.   Concepts

Constant comparison of open coding allowed the researcher to develop second level 'concepts'. This involves noticing similarities between codes, allowing the collapsing of these codes into less descriptive and higher level concepts. These concepts can then be analysed against further incidents of data to elaborate and saturate the concepts (Evans, 2013). An example of concept generation can be seen in Appendix K.

2.5.1.3.3.   Categories

Categories were generated through abstracting and hypothesising about the relationship between and among concepts; as demonstrated in Appendix L. These categories allowed the researcher to begin selective coding, which involves coding further incidents of data and concepts relating to existing categories.

2.5.1.3.4.   Core Variable

The purpose of classic grounded theory research is to uncover the shared social problem or concern in a substantive area, as well as the resolution to this problem or concern (Hernandez, 2009). The core variable is the variable that accounts for the most variation in the data and therefore represents the main concern that participants are processing (Breckenridge *et al*., 2010) and is an indisputable requirement of classic grounded theory research (Holton, 2007, p.280). The final theoretical code is a parsimonious one that emerges through the coding process and serves to integrate all the substantive categories within the core variable (Simmons, 2010). Glaser (1998) notes that grounded theory but does not assert that this is participants' only concern, but that the core variable focuses on the main concern which accounts for a particular behaviour highly relevant in the substantive area. Whilst there has been controversy over methods of discovering a core variable, the researcher followed the suggestion by May (1994) who advocated that the researcher must fully immerse themselves in the process of constant comparison,

whilst using memoing and reflection to recognise the core category before again returning to constant comparison to verify ideas within the data. Once a core variable was identified, coding was limited to data relating to this concept and focused on linking concepts together abstractly.

2.5.1.4.   Memo writing

Glaser (1998, 2012) suggests that keeping memos is a key part of the grounded theory methodology, and is essential for capturing the meaning and ideas for one's growing theory as they occur. It is proposed that writing memos should be a free flowing process, which can range from a key word to several pages or even consist of diagrams or sketches (Schreiber & Stern, 2001) and free from rules of writing, grammar or style (Glaser, 1998). As research progresses, these memos tend to become less descriptive and more conceptual to help demonstrate relationships as well as gaps in emerging theories or categories (Evans, 2013). The importance of memos was recognised by the researcher, who maintained extensive field notes during the process of interviewing and analysis (see Appendix M) as well as more general memos that occurred outside of time spent directly researching (see Appendix N). This relates to the idea of preconscious processing, with the grounded theory methodology acknowledging that ideas regarding the research often arise spontaneously. It also reflects the well-known Glaser dictum "all is data", which refers to the importance of considering data on as many dimensions as possible. This may include taking into account casual interactions, media information, societal observations or historical documents as well as the interview transcripts themselves (Glaser, 2007). The sorting of the memos generated throughout data collection and analysis forces the researcher to theoretically code by hypothesising about connections between categories and later integrating these connections to help generate theory (Glaser, 1978)

2.5.1.5. Theory

2.5.1.5.1. Theory Generation

The final stage of the analytic process involved generating a theory that related the substantive categories together in order to explain the core concern of the participants. Baker, Wuest and Stern (1992) emphasise the importance of presenting an abstract theory rather than merely a detailed description in order that the theory holds up this explanatory and inherently predictive aim. Much of this was achieved through relating memos to the substantive codes identified through analysis, thereby ensuring that the conceptual ideas were fully grounded within the data (Glaser, 2005). The focus here was not on producing verifiable facts, but rather that the process of constant comparison and theoretical saturation of categories allows the final theory to be conceptual and therefore to account for much generation in the data (Glaser, 2004). The theory is described in detail in Chapter Three, Results.

2.5.1.5.2. Theoretical Sensitivity

Theoretical sensitivity refers to the manner in which the researcher is able to effectively engage with their data based on their previous knowledge, experience and awareness of the phenomena being examined (Birks & Mills, 2011; Hernandez, 2009). In this case, theoretical sensitivity was enhanced through the researcher having professional experience of working therapeutically in the contexts that were the focus of the research. This provided an existing knowledge base and insight into the topic to draw upon. Touch being a very common form of interaction also allowed significant personal experience, which provided a solid basis for understanding of processes involved in giving or receiving touch. However, it was important to recognise that the existence of these previous experiences – as well as being beneficial in promoting theoretical sensitivity - could be detrimental through preventing the researcher recognising issues that have become 'routine', or assuming that others' experiences mirrors her own. As recommended by Schreiber and Stern (2001), the researcher utilised memos and a reflective diary (see

Appendix O) to notice 'pet theories' in order to then recognise or challenge personal biases within the data. Unlike other methods, classic grounded theory does not assume that it is possible for the researchers' experiences to be removed from the process, for example through bracketing. The researcher used a technique proposed by Glaser (1998) of initially interviewing oneself prior to interviewing participants in order to identify pre-existing assumptions. These insights informed the reflective diary and the account of the researcher's perspective. Continued use of a reflective diary also allowed regular review to assess whether pre-conceived ideas were borne out in the data, and to ensure that the analysis was not diverted by these assumptions.

2.6. ENSURING QUALITY

2.6.1. Validity of Theory

Various processes were employed during the course of this research to ensure that the aim of exploring Clinical Psychologists' experiences of touch within a therapeutic setting was fulfilled. In grounded theory, the validity of research refers to the usefulness of the theory that has been generated. This can be defined by three characteristics; fit, grab and workability. 'Fit' refers to the closeness of the categories to the data (Stern & Pyles, 1986), which was ensured in this case through thorough constant comparison at each level of analysis from coding incidents to concept generation. 'Grab' relates to the extent which the theory resonates with the real concerns of participants (Baker, Wuest & Stern, 1992). This was prioritised through conducting a focus group to triangulate the data and to consider ways of presenting the theory that capture the attention of the target group. 'Workability' refers to the predictive and explanatory nature of the theory generated (Glaser, 1978). Utilising the classic grounded theory approach inherently directed the analysis to take place at a conceptual rather than descriptive level, which promotes the workability of the theory.

2.6.2. Reliability of Theory

2.6.2.1. Quality

In response to criticisms of qualitative research as lacking scientific rigour, researchers have attempted to develop guidelines and quality frameworks with which to evaluative qualitative approaches. This research utilises guidelines developed by Elliot *et al*. (1999) to ensure methodological rigour.

2.6.2.1.1. Elliot criteria

2.6.2.1.1.1. *Owning one's own perspective*

Elliot *et al*. (1999) proposed that researchers must specify their own theoretical orientations and assumptions explicitly, in order that the reader is able to consider how these may have influenced the analysis. This was achieved through producing a statement of the researcher's position (see section 2.6.2.2.1), which was assisted through use of a reflective diary and the process of completing a self-interview as described above.

2.6.2.1.1.2. *Situating the sample*

It is proposed that participants be sufficiently described to allow the reader to assess the range of individuals and situations to which the theory may be applicable. Full details of the participant sample are laid out in Table 21.

2.6.2.1.1.3. *Grounding in examples*

This principle states that the reader should be able to appraise the fit between the data and the concepts and theory generated by the researcher. A detailed summary

of the methodology used, alongside visual and verbal representations of the theory have been presented. There is also reference to examples of the raw data, coded interview transcripts and the conceptual process in the appendices to demonstrate the theory as grounded within the data.

2.6.2.1.1.4. *Providing credibility checks*

It is recommended that researchers should use multiple analysts and triangulate data gathered with various sources in order to check the credibility of the theory. The researcher addressed this by discussing the analysed transcripts and resulting categories and theory with both the academic supervisor and peer trainee clinical psychologists with an interest in grounded theory. This helped modify the description and organisation of the results to optimise coherent understanding. This was again then later checked by the academic supervisor for quality assurance. Triangulation was also sought via presentation of the results to a focus group of participants to gather feedback and check the validity of the presented theory as outlined in section 2.4.2.

2.6.2.1.1.5. *Coherence*

The quality criterion of coherence proposes that presentation and analysis of data should take place in a consistent, integrated way. This was achieved in the current research by clearly defining the language used in the analysis process, providing both a visual and narrative account of the interpretation and taking on board feedback from others regarding the presentation of the research findings.

2.6.2.1.1.6. *Accomplishing general vs. specific research tasks*

Qualitative researchers should provide clarity over the purpose of the research and limitations of applicability of the generated theory should be addressed. As outlined

in the aim, this research considered the experiences of clinical psychologists working within adult settings in Wales. Whilst it was not intended that the findings be considered generalisable outside of this group, it is suggested that the theory may be adaptable to or might inform research within other settings or participant groups. Details of participants are clearly laid out in Table 2.1 in order for the reader to consider the degree to which these results may be applied to other research settings. Chapter Four also discusses further limitations of the methodology.

2.6.2.1.1.7. *Resonating with readers*

It is aimed that the research and resulting theory should build an understanding of the research topic and make clear sense to readers. To promote this, both the academic supervisor and various research participants were presented with the analysis at different points during the process in order to gain feedback. An overview of related theoretical and clinical issues was also included within Chapter One, in order to orientate the reader to the background and rationale underlying this research.

2.6.3. Reflexivity

Reflexivity refers to the ability for the researcher to acknowledge, disclose and consider their own perspective in relation to the research topic. Classic grounded theory does not assume the naive objectivity of the researcher but rather proposes that the rigorous application of the methodology allows biases to be discovered and accounted for (Glaser, 1998). Dey (1993, p. 63) emphasises that it is not feasible to conduct research in a *tabula rasa* fashion, proposing that "there is a difference between an open mind and an empty head – the issue is not whether to use existing knowledge but how". This was considered carefully within this research. Through preliminary self-interview, the noting of initial pre-conceptions, the presentation of position and the keeping of a reflective diary the researcher considered her own perspective and the ways in which this may influence the interpretation of the data. It

was also noted that within qualitative traditions there is often an expectation that the researcher explicitly state the philosophical position of their research question. However, Holton (2009) pointed out that classic grounded theory is not defined by one particular philosophical perspective and that the theoretical perspective will be implicit based on the theoretical codes that emerge from the data.

2.6.3.1.   Researcher's Position

The researcher is writing from the perspective of a 29 year old female living with her partner in an urban area of South Wales. Prior to clinical training, the researcher worked predominantly in the fields of adult mental health within a community setting and neuropsychology in an older adult setting. At the time of conducting this research, the researcher was undertaking clinical training and was working clinically within a low secure forensic mental health setting with adult males. The researcher has discovered a particular passion for working in the field of adult mental health, particularly with individuals with longstanding complex difficulties such as trauma or personality issues. In particular, the researcher enjoys conducting psychological therapy and providing consultation informed by relational and attachment models. This led to professional development through personal therapy within a Cognitive Analytic Therapy (CAT) model and an elective placement with a specialist CAT component. It is recognised that the researcher subscribes to models which promote the importance and reciprocal nature of relationships, which perhaps impacts on her views regarding touch.

Personally, the researcher experiences and values very positive and close relationships with family members and close friends. The researcher recognises her own personal style as being that of a tactile person who often greets those close to her with a hug and uses touch to convey both positive and negative emotions. When raising the topic of touch in informal conversation during the course of this research, it was noted that many people commented on the researcher's tactile nature in personal relationships, for example noting that within the family she is recognised as the most open person to both initiating and reciprocating touch. The researcher also

became more consciously aware of her own personal boundaries regarding touch behaviour during the research process and tried to capture some of these ideas within a reflective diary.

Professionally, the researcher recognises a particular interest in how the function of touch impacts on human development and communication. As such, it is recognised that the researcher does view touch as important and of special interest. The researcher was able to reflect on her motivation for undertaking this research as linked to clinical experience of touch phenomena as an assistant and trainee clinical psychologist. This became a particularly relevant issue during the researcher's first year core adult mental health placement, where there were several instances of clients requesting or initiating touch in the context of long term therapy. The researcher reflected on these experiences in supervision and more informally with peers and colleagues. From this, the researcher noted with interest that there seemed to be eagerness to discuss the issue and a sense of a vast range of different perspectives. On reflection, there was perhaps a motivation to discover others' practice and how they had come to occupy their position on the issue, as the researcher was not yet clear on her own views and opinions on the topic.

During the process, the researcher did not align herself explicitly aligned with any particular epistemological position. However, it was acknowledged that bio-psychosocial, systemic and relational ideas underpin her clinical stance. It was also recognised that the researcher places high importance on the therapeutic relationship and 'soft skills' used in therapy, which it was felt can be neglected in favour of a focus on learning about different models and diagnostic categories during training. Self-interview also highlighted some underlying assumptions, which allowed these to be accounted for and to minimise any bias to the analysis. This included the views that:

- Touch is an important issue
- Touch is something that is not often talked about in supervision or with peers

- There is a lack of consensus among psychologists about when touch is appropriate or helpful

- Individual psychologists tend to have their own specific rules regarding touch

- Touch in therapy has the potential to be both very effective and very harmful

- Age and gender of the client will have a significant effect on whether touch will be initiated or accepted

- Touch will happen more in inpatient settings than in community

- The reason a client is seeing the psychologist will significantly affect the decision to initiate or accept touch

- The therapeutic orientation of the psychologist will impacts on the use of touch

3. Chapter Three: Results

3.1. RESULTS

3.1.1. Overview of chapter

This chapter presents the grounded theory that emerged from the analysis of interviews with the eleven participants as outlined in Chapter Two. Using classic grounded theory methodology, initial analysis first identified many codes. Through sorting of memos and constant comparative analysis, grouping of *concepts* identified a total of fifteen **sub-categories** which went on to be condensed into three key superordinate **CATEGORIES**. Ongoing analysis went on to identify the presence of one *CORE VARIABLE*, which aided the development of the resultant **GROUNDED THEORY**.

A diagrammatic and brief narrative summary will be presented first to orientate the reader to the grounded theory and results as a whole. Each categories will then be discussed in more depth and illustrated with interview quotes identified by pseudonyms. Finally, a presentation of the core variable and theory are included alongside quotes to illustrate the development and grounding of these conceptualisations within the data. Words that have been added to quotes to enhance meaning or to remove identifiers are shown in [brackets], and omitted words or phrases in order to condense quotes are demonstrated by '…'.

3.1.2. Diagrammatic Summary

GROUNDED THEORY: MOVEMENT TOWARDS A POSITION OF CONSOLIDATION – PSYCHOLOGISTS' CONFIDENCE IN AND TOLERANCE OF AMIBGUITY IN DECISION-MAKING REGARDING TOUCH BEHAVIOUR

CORE VARIABLE: COST-BENEFIT ANALYSIS IN THE 'GREY AREA' - WEIGHING UP OF THE VARIABLES TO ASSESS RISK VS. REWARD OF TOUCHING OR NOT TOUCHING

[CORE CONCERN: PROCESS OF DECISION-MAKING REGARDING THE EFFICACY OR APPROPRIATENESS OF TOUCH IN AN AMBIGOUS SITUATION]

Individual characteristics	Meaning of touch	Influence of Context
Client characteristics / Psychologist personal identity / Psychologist professional identity / Interaction within relationship / Negotiating boundaries	Touch function / Touch motivation / Types of touch / Predicting Outcomes / Consideration of Alternatives	Situational Factors / Model / Theory Influence / Identity of Clinical Psychology / Social and Cultural Context / Situating Self in Context

Figure 3-1. Visual Illustration of grounded theory, core variable, categories and sub-categories

3.1.3. Narrative Summary

The grounded theory that emerged from the analysis of these interviews centred on the developmental process of clinical psychologists moving through a process of consolidation, ultimately occupying a position where they are able to tolerate ambiguity in relation to decisions regarding use of touch with clients.

This grounded theory relates particularly to the core variable identified of cost-benefit analysis of the use of touch within the unclear 'grey area'. This grey area represents situations where the efficacy and appropriateness of touch is regarded by the participant as unclear, as opposed to occasions where touch is fairly unambiguously felt to be either acceptable or unacceptable. The core variable of cost-benefit analysis emerged as the process psychologists used to resolve their core concern of when to facilitate and when to withhold touch in the therapeutic setting.

The core variable of cost-benefit analysis was demonstrate to involve the consideration of a number of key variables. Numerous concepts considered to be relevant variables were identified through analysis, though ultimately these were reflected within three key categories. Firstly, the consideration of individual characteristics of those involved in the therapeutic relationship – the psychologist and client - and the interaction between these two individuals. Secondly, deliberation regarding the possible purpose underlying touch and the effect this might have on the client or on the therapeutic relationship. Finally, factors related to the influence of context from the situational to the societal level were considered.

The development of the theory from identification of key categories through to the conceptualisation of a core concern and core variable will be outlined in much greater depth below, with supporting quotes to ground the theory within the data.

3.1.4. Category Overview

3.1.4.1. Category 1: Individual Characteristic

3.1.4.1.1. Summary

Characteristics of the individuals involved in the therapy relationship and the nuances inherent in this unusual social relationship were shown to be a significant consideration in Clinical Psychologists' experiences of touch. In particular, evaluation of these individual differences was key in the identified core concern of when and how to use touch. Within the category of 'INDIVIDUAL CHARACTERISTICS', five sub-categories were identified and are outlined below.

See Figure 3.2.
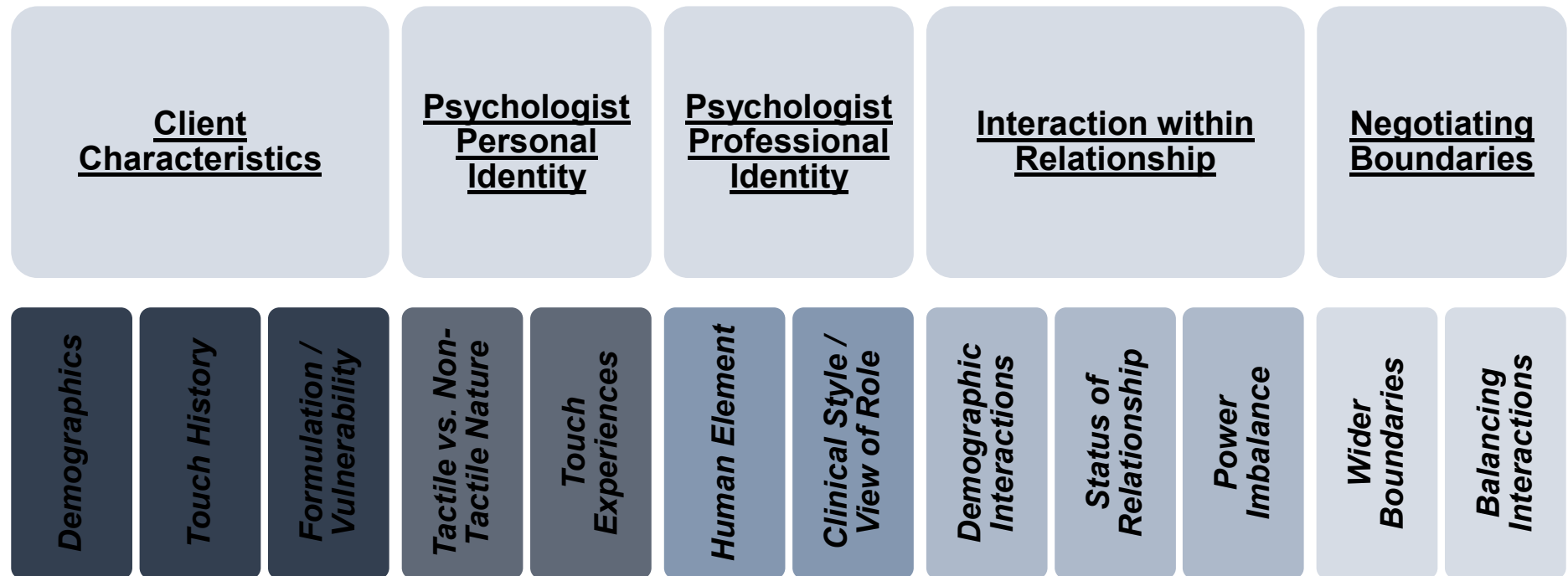
Figure 3-2. Diagrammatic Summary of Category One - Individual Characteristics

3.1.4.1.1.1. *Client Characteristics*

Participants discussed how, when working with individuals, certain demographics of the client were key factors affecting their comfort in allowing touch to take place. In particular, age and gender featured significantly in many interviews; and in some cases these appeared to be the dominant factor in motivating differing approaches towards touch with different clients. The influence of demographics was evident in both the psychologists' comfort or ease in using touch as well as their views on the appropriateness of touch.

> *"I can imagine working with older adults I would be less concerned about touch"* - Helen
>
> *"I feel more comfortable comforting an older woman than a younger one"* – Peter
>
> *"I would be much more aware about touch with a male client, it would be easier with a female client"* – Maggie
>
> *"I would possibly be more inclined – rightly or wrongly – to do it if it is a woman rather than a man"* – Sue

When discussed in more depth, it appeared that differences in approaches based on age and gender revolved around concern for potential harm through misinterpretation. This appeared to relate to both misinterpretation by the client as well as others who may become aware of the use of touch.

> *"If I thought it was going to be mis-communicated I wouldn't do it. So possibly young males, perhaps males the same sort of age as me"* – Eve

Importance of demographic factors remained dominant throughout the interviews, although it was notable that initial strong and concrete reactions often began to become less rigid upon further exploration. Many participants went on to reflect that what initially felt like the clearest boundary between touching or not – gender or age of the client – did not hold up as expected upon further deconstructing. Instead, they

suggested that demographics played just a small part in a much more intensive consideration of the individual client.

> *"One of the things it makes me reflect on is why it is different for different people? Because although you can start out with what you think is a blanket rule it doesn't quite work out like that in reality…. Why is that ok with this client and it might not be ok with another client"* – Heather

> *"It's so individual because with certain people that perhaps would feel ok and I don't know if I would even need to say anything at all. With her, something about it just made me feel quite uncomfortable"* – Lucy.

An awareness of the individual formulation of the client was suggested as important in decision-making about the use of touch. This helped psychologists identify and consider additional variables, such as the meaning and possible responses to provision or rejection of touch for that individual. A perceptive understanding of that person that considered instinctual responses became apparent, perhaps hinting at the complexity of the decision-making process. In particular, participants were concerned that the potential vulnerability of clients should be at the forefront of attention. It appeared that the perceived imbalance of vulnerability within the relationship could be an inhibitor to using touch, with the worry that the potential harm may outweigh the potential good.

> *"If someone was very dependent it would probably make me more conscious about what kind of touch was allowed ... because it has some sense of meaning in their formulation"* – Heather

> *"with some people it really wouldn't have been an issue ... With her, something around her boundaries generally with people felt like it wouldn't have been particularly helpful to give her a hug ... Formulation of the person, and perhaps also gut feeling as well"* - Lucy

> *"you are potentially working with someone who is quite vulnerable ... so it's probably best not to do or if you do at a minor level, and that it certainly has to come from them I think"* - Sue

Much of the concern raised regarding client vulnerability in respect of touch was related to potential negative early experiences of touch. The current context of clinical psychologists working in adult mental health focuses on therapeutic work with clients who have complex presentations, often as a result of a traumatic or abusive history. Participants demonstrated an understanding of the potential for touch behaviour within therapy to be re-traumatising in the context of previous physical or sexual abuse, or extremely unnerving for those who have experienced emotional abuse or a lack of touch throughout development. The refraining from use of touch with individuals with a history of abuse appeared to be a strong message that was picked up during training and had endured for most participants.

> *"if I knew someone was a survivor of child sexual abuse of any kind of inappropriate physical touch then that might be something I just consider" – Lucy*

> *"I certainly wouldn't touch if I know someone has been sexually abused" – Maggie*

However, it was also suggested that these clients or therapeutic relationships may be missing out on a potentially enriching experience or even experiencing further harm due to this apparent taboo regarding touch. This again highlights the dilemma facing psychologists of assessing cost and benefit with regard to their touch decisions.

> *"I remember doing some training once ... it always stuck in my mind that someone had said not only have we been abused in our lives but now nobody is even allowed to touch us in case they scare us, and that felt like a double abuse" – Bryony*

3.1.4.1.1.2. *Sub-category 2: Psychologist Personal Identity*

As well as the individuality of the client, these interviews highlighted the importance of considering the individuality of the psychologist from a personal perspective outside their professional role. A key variable that emerged from the analysis was

that of the personal touch style of the psychologist, and how this might affect their choices within the therapeutic relationship. A strong theme was of self-identification within definitive 'camps' of tactile versus non tactile individuals. This clear distinction appeared to come much easier when discussing personal approach compared to when discussing touch style or use professionally.

"I am a tactile person" – Lucy

"I am a huge hugger! I think probably due to upbringing, it was something we did at home" – Sue

The participants made a clear distinction between their personal touch choices and the way they approach touch in a therapeutic capacity. It appeared possible for individuals, regardless of their personal choices, to adopt a different stance with clients fairly naturally and without significant difficulty.

"It's not something I am naturally against but I think it is one of the different hats I wear in work. It's been really interesting going through this to recognise how little you do it in work, compared with anywhere else" – Eve

Although personal touch style was not considered a key influence on touch behaviour in a therapeutic setting, there was an emphasis on the personal touch experiences of psychologists in their interpretation of the efficacy of touch. Several participants cited personal touch events as having a significant impact on their approach to touch with clients; particularly in relation to how they want to present themselves interpersonally. For example, positive experiences of receiving touch when in distress makes it more likely that the psychologist will be inclined to offer that to others in distress.

"in the context of having therapy myself ... my therapist did that to me [hugged] which also I think might have been a point where I think that it was ok" – Bryony

"I think what psychologist would I have wanted to be for my Nan. You want somebody who is warm, so that has always influenced me" – Eve

3.1.4.1.1.3. *Sub-category 3: Psychologist Professional Identity*

It appears that the professional identity of the clinical psychologist and the 'clinical style' with which they approach their work impacts significantly on their propensity to allow or encourage touch with clients. In contrast to the fairly direct way in which participants described their personal touch style, their approach to touch in the therapeutic setting and understanding of how it fits with respect to their professional remit appeared to be more nuanced. This included the rationalisation of how problems leading to distress or the need for touch have manifested, as well as how the role of the psychologist in providing therapeutic intervention is viewed. Some participants described an understanding of the psychologist role as a source of healing for the traumatised 'inner child', and therefore viewed touch as an appropriate response to distress. Conversely, others felt the role of the psychologist to be one of containment and listening and advised that touch may threaten the ability to sustain this role. Regardless of their positioning along this continuum, many participants highlighted the influence of human nature and the urge to respond empathically to another individual in distress or need within their expressed or inhibited responses.

"I think that when somebody comes to therapy and they're working on child trauma, it is often that child that is the person in distress, their inner child that is being comforted. And if a child was distressed the natural human response would be to try and soothe" – Bryony

"when people might grab your arm or might be upset ... it might cross your mind that you want to tap somebody on the shoulder but you hold back because perhaps you recognise that boundary and you're thinking my role here is to sit, contain and to listen not necessarily to have somebody sobbing their heart out on your shoulder" - Heather

Within the discussion of professional identity, a clear link to the influence of dominant models drawn upon in clinical practice was apparent and this will be discussed in further detail in section 3.1.4.3.2.2. However participants acknowledged the likelihood that one is likely to be drawn to or seek out models or environments that fit with pre-existing preferences and beliefs.

"for me what changed dramatically was finding a model that embraced it and advocated it and DBT did that for me … I rejected those theoretical models and looked for models that fitted with the way I was brought up" - Cara

"possibly that is why I have gone into health settings because it suits me to be like that" - Eve

3.1.4.1.1.4. *Sub-category 4: Interaction within the Therapeutic Relationship*

Whilst characteristics of both the psychologist and client appeared to be important, the intricacies of the relationships between both individuals emerged as a key factor in decision-making about touch. In particular, it seemed that the interaction between the demographics of the client and psychologist exerted more influence than those demographics separately. Specifically, similarity of age and difference of gender were viewed as particularly inhibitory to touch in the therapeutic capacity, as a response to social norms and dominant models of sexual attraction. Almost all psychologists expressed caution in using touch with someone of the opposite sex and of a similar age, and many suggested that such situations felt the most 'risky' in terms of potential for misinterpretation.

"I don't hug men ... sometimes I have when there aren't any other factors that come into play like we could be the same age to have a relationship. That seems like a real inhibitor" – Cara

"Being a young man ... I feel like I'm most aware of touch and issues around touch when working with younger females. I feel more comfortable with touch with older women because it doesn't feel like there is any sexual element to it, I suppose" – Peter

Much of this concern seemed to focus around potential for sexual motivation or mis-interpretation. However this was also a dynamic variable, allowing touch behaviour with individuals of particular demographic characteristics to change over time as the societal roles imposed on the relationship change. This can allow touch to become

111

either freer or more inhibited depending on how this behaviour could be viewed within that particular type of relationship. This again demonstrates the thoughtfulness surrounding touch choices, particularly in interpreting the emotional status of both individuals in relation to each other and possible consequences of touching. It is also recognised that the potential risk of touching whilst holding a non-sexualised role – for example one of a parental figure - could be equally inappropriate or harmful when considered within the formulation of that particular therapeutic relationship.

"I think becoming older it is easier to keep the erotic side away ... so it is easier almost like a grandmother touching you and that makes it easier. And grandma can touch a man as well it is not such a big thing" – Maggie

"when it taps into a maternal side, and I've got an 18 year old sitting there and I just want to say "oh it's alright and it will be fine" but that's not what I am there for" – Heather

"I have a client ... one of the things we reflect on is that he is similar to my Dad ... similar kind of military history and it would feel inappropriate ... like he was being paternalistic and feel wrong for the therapeutic dynamic" - Cara

The status and quality of the particular relationship appears to impact significantly on psychologists' comfort with touch. The duration of the relationship and the content of discussions during therapy often reflect the psychologist's sense of closeness to that individual and intimacy already present, which may allow the gap towards accepting or providing touch to feel smaller. Whilst a longer and more in-depth relationship may often foster higher propensity for touch, most psychologists noted exceptions to this rule. Instead, there seems to be benefit in more in-depth knowledge of the client with regard to their possible responses to touch.

"I think most of the times it has happened it's been with somebody I have spent a longer time with. Probably also heard about a wider section of their life" – Caroline

"The one I know longer is still awkward about touch ... whereas the other gives me a hug! So it's not the length as such. Hmm what is it. It is the more

you tune into how that person feels about touch, if it is something positive or negative ... reassuring or threatening" - Maggie

In spite of acknowledging these dynamic interactional influences, there remains a cautiousness on behalf of the psychologist who recognises the ever present effect of power imbalances within a therapeutic relationship. The imbalance between the seeker and provider of support provides the psychologist with heightened power along with heightened responsibility for ensuring a non-harmful approach. Consequently, even when the acceptance or provision of touch feels right in the circumstance, the psychologist remains mindful of imposing their own values or making the wrong decision. This sense of overall responsibility is felt to be lying almost completely with the psychologist, which can be further inhibitory to stepping into less familiar or ambiguous territory.

"There is an element of power the transcends our work and there is a hierarchy issue in that respect, so I try to be as mindful as I can about how that might affect whether they or I were to initiate touch and what that might mean in relation to that power" – Peter

"I could go away and still be quite happy that the boundaries were all skippety-boo but I don't know that the client can hold those boundaries as neatly so it's my job to kind of make those assumptions that I am holding these boundaries for the client" - Heather

3.1.4.1.1.5.   *Sub-category 5: Negotiating Boundaries*

The interviews highlighted the fact that psychologists find it difficult to separate the issue of touch from other therapeutic boundaries, with approach to other boundaries often aligned to the approach to touch. Flexibility or openness regarding self-disclosure, methods of communicating and dress mirror a similar flexibility or openness towards touch. It was a dominant narrative that psychologists had worked out their own boundary limits with regard to each of these areas through experience and sifting of information from outside influences.

"That's interesting you raise that, because as I was just saying that I was thinking about the blurring of the boundaries ... how much we disclose and give of ourselves. So if I thought that it would be beneficial for our relationship and for the clients' ... then, like touch, self-disclosure is something I am prepared to do and can be very valuable for the client" – Peter

"Not touch, but more around self-disclosure, I think DBT has certainly influenced me to self-disclose much more than I would have done" – Lucy

Whilst the above quotes represents a decision-making process inherent within the psychologist, a key concept also emerged demonstrating the ongoing balancing act between individuals in maintain boundaries comfortable to both parties. This could be envisaged as changes in typical approach or behaviour made in order to maintain an equilibrium when boundaries are shifted significantly by the other party. An example of this might be touch overfamiliarity by a client due to disinhibition as a result cognitive impairment, in response to which the clinical psychologist may employ more rigid boundaries including less touch than they might do ordinarily, in an attempt to maintain the appropriate balance within the relationship. What was emphasised by participants was the two-way nature of the relationship and the importance of ensuring that both individuals feel comfortable with the presence or absence of touch within the therapeutic relationship.

"Sometimes the clients can be quite disinhibited ... their judgement is not always great. So in some respects I feel a need to be more aware of that judgement myself I suppose" – Sue

"in learning disabilities touch was about keeping appropriate boundaries with people who wouldn't necessarily have a strong awareness of social boundaries and personal space" – Bryony

"You might have a therapist that doesn't want touch and isn't tactile and isn't an ethical relationship reciprocal? So it isn't just what is right for the client" – Cara

3.1.4.2. *Category 2: Meaning of Touch*

3.1.4.2.1. Summary

Ascertaining the meaning ascribed to any touch in the therapeutic setting along with the motivation underlying the urge to touch was considered to be an essential part of the decision-making process. Indeed, the mediating effect of perception of meaning within the process of cost benefit analysis appeared to be perhaps the most prominent of all the influences on the core variable. Five subcategories were identified within the category of MEANING OF TOUCH and are discussed below.

See Figure 3.3 below.
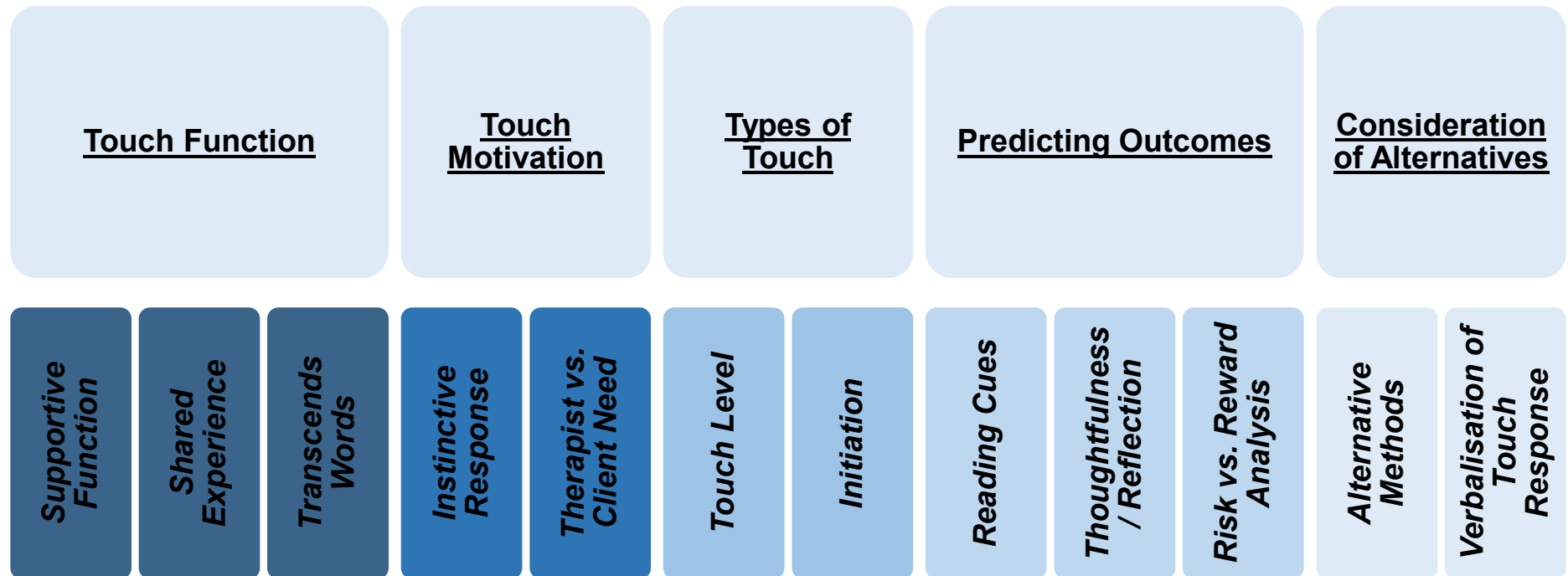
Figure 3-3. Diagrammatic Summary of Category Two - Meaning of Touch

116

3.1.4.2.1.1. *Sub-category 1: Touch Function*

A crucial consideration for psychologists in their decision-making about touch involved sense-making about what the function or meaning of that touch might be. The urge to use or accept touch often related to a desire to provide something beneficial or additional for the client. Commonly, this was a supportive function in times of need, for example providing comfort or reassurance to a client experiencing distress. Touch was considered as a way of reminding a client of the psychologist's physical presence, acknowledging the individual's distress or encouraging them in the moment. Additionally, touch was sometimes considered as a way of modelling or reinforcing healthy expression of emotion for those who may not have experienced this during their development.

> *"In the height of distress when somebody is actually sobbing I have put my hand on them and rubbed their arm and just said 'its ok, it's ok'" – Bryony*

> *"I guess at the time it felt more instinctive to just kind of hold her hand or something, just to kind of reassure more than anything" – Sue*

> *"I would use it as a kind of behavioural contingency, so if I was trying to show warmth and positively reinforce skilful behaviour in DBT I would move and sit closer as opposed to if they talked about self-harm I would try and move further away and kind of withdraw warmth" - Cara*

As well as providing additional support or benefit to clients, it was evident that there is potentially great benefit to the therapeutic relationship through the incorporation of touch. It was suggested that touch can help deepen the sense of shared experience between a psychologist and client, representing empathy and understanding between two individuals. This was often described as developing a more robust connection through helping the client to feel they have been heard and understood.

> *"lots of different functions, mostly about strengthening the relationship, that's the theme I guess, and trying to show the people who believe nobody gets them that I really do get them and like them ... it has the kind of effect of*

deepening their affect ... of being with them in the moment of their greatest pain" – Cara

"You do give them a hug goodbye, because you want to let them know how you feel really ... you want them to know you're sad to say goodbye too" – Eve

Whilst the potential benefits of touch in certain circumstances were emphasised by all participants, the specific mechanism through which touch transcends other methods for communicating warmth or shared understanding was harder to articulate. Ultimately it was felt that touch allowed a deeper level of communication, and an innate way of connecting with another human being. Participants stated that touch offered an expression of warmth in situations when words did not feel adequate, for example when a client has shared something which the psychologist feels they are unable to acknowledge adequately with words. It was also felt to be a method of communicating understanding when a conversation is not possible due to circumstance. Certainly it seemed that participants understood a brief touch to be able to powerfully express what would be a much more complex message to convey verbally.

"I just gave her a little squeeze on the arm as if to say, you know, are you alright. I know this thing that we haven't been able to talk but I get it. I was trying to give her the message that I could see things really weren't ok for her" – Bryony

"I guess it's another dimension of communication and a more embodied expression ... sometimes words cannot describe and capture what feelings are about ... touch can be a channel of communication, a way of containment ... a way of empathy or warmth, love, hope ... lots of different extensions of the language" – Peter

3.1.4.2.1.2.   *Sub-category 2: Touch Motivation*

Identifying where the motivation for touching arises is an important element of identifying the appropriateness of touch in that situation. At initial appraisal, much

touch behaviour is felt to be an instinctive human response to another's need. This can be linked to the potential reward found in use of touch, through the deepening of a connection between the psychologist and the client when there is a perceived genuine and appropriate level of responsiveness to distress.

> *"Sometimes it's been an intuitive or instinctive thing and it has felt like the right thing to do" – Bryony*

> *"The instinct is natural to kind of reach out and I guess demonstrate a level of warmth" – Sue*

However, it was also recognised by participants that this instinctive response may be driven by other needs aside from the clients'. Psychologists are trained to reflect on the two-way relationship within therapy and to acknowledge the impossibility of their own needs being completely detached from their clinic work. As such, some participants reflected on the identification of where the need to touch arises – evoked in the psychologist or needed by the client – as the main dilemma affecting their decision of whether to offer or accept touch. This was expressed as a complicated process and an inexact science, due to the difficulty in extricating transference and countertransference experiences from personal motivation.

> *"I was always aware 'Is it my need or is it the client's need?' ... because certain clients will evoke certain things in you ... but is that our stuff or their stuff? Have they invited or given us permission to engage at that level? – Maggie*

> *"I just have a massive urge to hug this [client] ... she is very distressed and I just want to hug her. I took that to supervision and talked about the urge ... I still haven't as I think that is more my need than hers, which I think is where the boundary is" – Bryony*

> *"To sit and watch somebody distressed in a room and not to go and offer them comfort in a way that comforted you feels incredibly uncomfortable, so I am probably indulging my own needs by going to offer it" – Cara*

"I put my hand on top of her hand, but she didn't respond at all and that really sticks in my mind as I think I was doing it more for my sake than for her because I couldn't bear how upset she was" - Caroline

3.1.4.2.1.3.   *Sub-category 3: Types of Touch*

Much discussion during the interviews centred on the different types of touch used by clinical psychologists, the meaning these types of touch are felt to represent, and comfort in using these levels clinically. There was a clear sense that certain types of touch were felt to be predominantly 'safe', for example handshakes. This mirrored the social acceptability of shaking hands with most individuals feeling like the norm and the potential for misinterpretation or harm being low. At the other end of the spectrum, any sexualised touch was felt to be very clearly off limits with clients, again mirroring social acceptability where this type of contact is reserved for intimate relationships. The 'grey area' where comfort with and meaning of other types of touch - such as hugs and a reassuring touch on the arm, hand or shoulder - was more ambiguous. Certainly all psychologists interviewed seemed to have some sense of where their comfort boundary lay, but this varied significantly between individuals and was also not a static position, varying in relation to other variables described in this section.

"Shaking hands, social norms would be ok ... I wouldn't touch somebody's leg for example ... thinking about touch it would be an arm or a shoulder" – Bryony

"I think, depending on the situation, then a handshake is fine, kind of a tap on the arm or shoulder or whatever that is fine, and if somebody asked me for a hug and if it was appropriate and that person was female then I would be ok with that if I felt comfortable with it and had worked with that person for a long time" - Fran

"I think it is all or nothing. So apart from handshakes I have very little contact with people apart from those ending hugs. I suppose that makes is different to normal life where it is quite usual for people to pat your arm or shoulder ... that really low grade touch" - Caroline

To follow on from that caveat regarding the impact of the multiple variables, linked very closely with the type or level of touch was the factor of who initiates the touch. Whilst other factors remained important – particularly individual characteristics and any existing formulation of that client's difficulties – comfort with touch was significantly enhanced when it was initiated by the client. Several of the psychologists interviewed said that they would be very unlikely to initiate touch themselves. This appeared to reflect the difficulty often experienced in pinpointing the motivation for the touch and anxiety about possible misinterpretations of touch initiated by the psychologist.

"I think it's initiating it definitely. I would never lean in to hug someone unless they were leaning in to hug me" – Eve

I think it has only ever been initiated by other people. I wouldn't ever refuse or step away from somebody but it wouldn't be initiated by me" – Caroline

3.1.4.2.1.4.   *Sub-category 4: Predicting Outcomes*

A striking theme within the interviews was that of the thoughtfulness that underlies the process of decision-making about touch behaviour. In particular, assessment of possible outcomes if touch were to be either used or withheld. An element of this thoughtfulness, perhaps mirroring of touch behaviour in everyday life, is the monitoring of many subtle and cues presented by the other person to gauge their comfort and need with regard to touch. Much of this was described at an implicit rather than overly conscious level within the decision-making process.

"I don't know if it's through training you sort of micro analyse people's reactions, intentions, tone of voice, perception, intuition. I think we are taking a lot in and reading a lot to know when something is ok. Being aware of your stuff, their stuff, transference, countertransference. You know all those other influences they must be all at play in that moment to help you make that decision or not" – Bryony

I can't explain it. I am almost tempted to say it is on an energy level so it is the emotional intelligence, you could say, that you sense that the person is comfortable with and would like to have some physical contact ... So that is why it is difficult to teach what is safe touch and what is not" – Maggie

Several participants seemed surprised that, when asked to consider their thought processes underlying touch, there was such a multitude of variables considered both with regard individual situations and to their stance as a whole. Much of the predictive element of considering possible consequences of either touching or not touching seemed reliant on careful reflection – either personally or aided through supervision – of numerous individual and systemic variables.

"I guess whenever we do anything there is a consequence of whatever we do, be that positive or negative. So we can hold assumptions of "if I do this will that change something for good or bad" ... what are the consequences for that person?" - Peter

"It feels like it hasn't become automatic, it is still something I would think carefully about every time I think" – Cara

The key inhibitor to the use of touch appeared to be prediction of potential negative consequences. Where participants felt particularly unsure of whether provision of touch would be beneficial or regarded as intended, they were more likely to abstain. This seemed to reflect a calculation or risk vs. reward. Whilst psychologists recognised the potential reward of enhancement of the therapeutic relationship through touch, the risk of misinterpretation or damage to the relationship outweighed this reward. Equally, psychologists also weigh up the risk vs. reward of declining touch initiated by the client particularly, centred on the perception of facilitating a sense of warmth or rejection.

"When in doubt I wouldn't do it" – Eve

"that would affect it if I thought it could be taken the wrong way or perhaps they would read more into it than was meant, then that would definitely affect whether I would hug them or not and I would be more likely to offer a handshake" – Lucy

"She was really distressed and crying and she just sort of gripped me ... that would have felt wrong I feel, withholding that would have felt un-therapeutic and unhelpful" - Bryony

3.1.4.2.1.5.   Sub-category 5: Consideration of Alternatives

In weighing up the decision regarding touch, it was clear that psychologists often considered whether alternative methods of communicating might meet the same ends with reduced potential for negative consequences. Whilst it was recognised that touch is often inimitable in terms of the emotional connection it can foster, other methods of responding to need or distress had proven helpful through acknowledgement and recognition.

"I think there is a lot of offering of tissues! I think that is a strategy we all use when it feels like touch wouldn't be appropriate or isn't comfortable for one party or another. It's sort of a here's a bridge, I get it, I get the connection" – Cara

"I offer some verbal comfort and suggest they take a minute, it's ok, say something vaguely reassuring or calming. Rather than actually physically touching them" – Helen

Many participants also emphasised the benefit of verbalising their urge to touch in circumstances where they were unsure of whether to act on this instinct. This appeared to serve the purpose of communicating their emotional connection to the client, as well as potentially placing the decision of whether touch is pursued into the client's hands.

"I might say 'Oh gosh I can see you're really upset right now and one of the thoughts I might be having is I wish I could give you a big hug, however perhaps it is not the best thing in this relationship', so I might implicitly imply or say I would have liked to have given a hug but not" – Heather

"I think when I notice that urge and it doesn't feel appropriate I would ask for guidance from the clients. So I might say 'I'm not sure what would help right now, I feel that I would like to offer you a hug but I don't know if that feels right for you" - Cara

3.1.4.3. Category 3: Influence of Context

3.1.4.3.1.   Summary

It was evident that participants experienced strong influence at a systemic level as well as an individual one with regard to their touch behaviour. In particular, the identity of clinical psychology and society as a whole seem to factor significantly in how touch was used and viewed within a therapeutic setting. A dominant narrative of touch being used sparingly and with caution portrays the subject as fairly taboo and one that clinical psychologists are often left to deliberate in isolation. Five subcategories were identified within the category INFLUENCE OF CONTEXT and are discussed below.

See Figure 3.4.

INFLUENCE OF CONTEXT

| Situational Factors | Model / Theory Influence | Identity of Clinical Psychology | Social and Cultural Context | Situating Self in Context |

- Level of Distress
- Environment
- Timing
- Model Perspective
- Allegiance to model
- Should's / Shouldn'ts
- Training Messages
- Professional and Policy Guidance
- British Culture
- Social Norms
- Dominant Narratives of Therapy
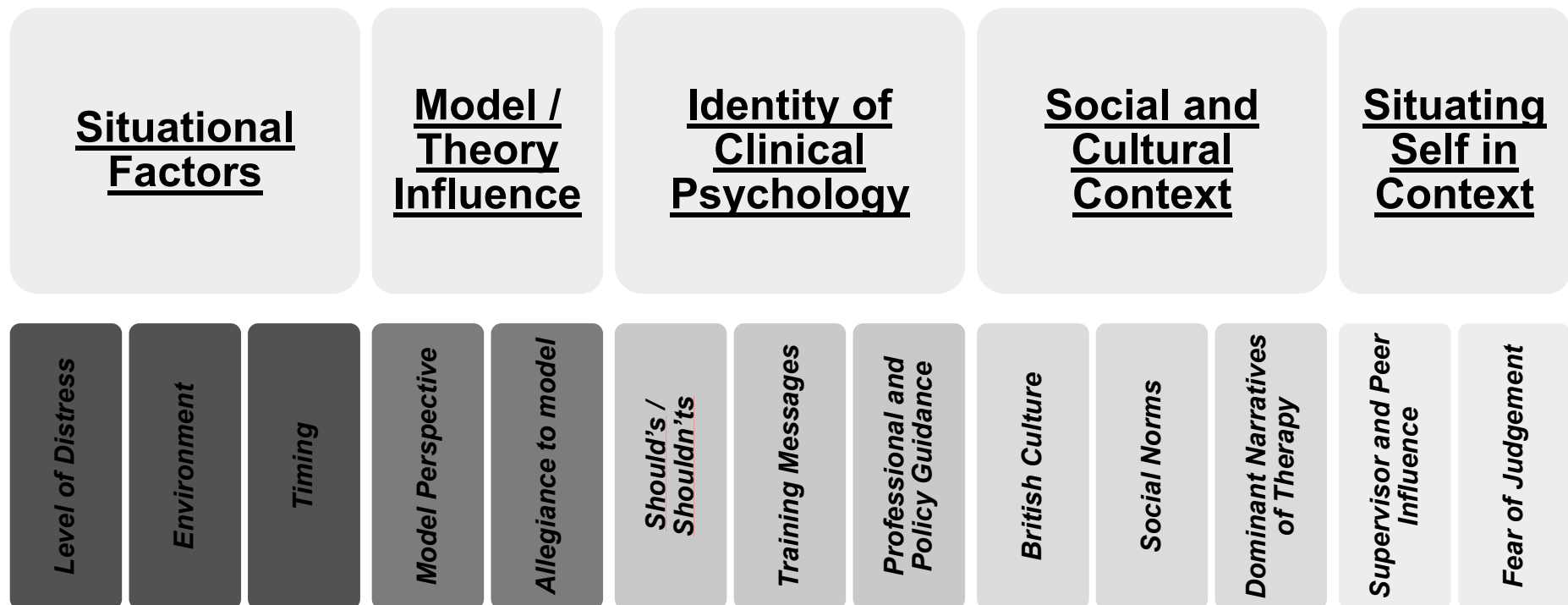- Supervisor and Peer Influence
- Fear of Judgement

Figure 3-4. Diagrammatic Summary of the Category 3– Influence of Context

3.1.4.3.1.1.   *Sub-category 1: Situational Factors*

A situational variable commonly linked to the urge to touch was heightened levels of client distress. The potential positive effects of touch as described previously were felt to be particularly relevant on occasions where the client was particularly distressed. However the dilemma of identifying whether the underlying motivation is client or psychologist need is also very apparent. Nevertheless, many of the participants were clear in their belief that they were most likely to initiate touch at times of particular distress with the aim of providing comfort, reassurance or grounding.

> *"In the height of distress when somebody is actually sobbing I have put my hand on them and rubbed their arm and just said 'its ok it's ok"* – Bryony

> *"It feels quite unnatural sometimes to not touch somebody when they are really distressed"* - Cara

Physical and contextual variables related to the setting that psychologists may be working in clinically also appeared to affect their openness toward touch. Environmental factors such as physical proximity to the client and the setup of the room often seemed to be a barrier to touch. Interestingly, several participants spoke about their tendency to use touch increasing when working within an EMDR model and reflected that whilst this may be related to the likelihood of clients experiencing distress the less traditional set up of having chairs very close and alongside each other may also make touch feel more accessible and natural. More widely, the environment in which psychologists work can vary greatly. It was stated that touch boundaries can vary depending on the context in which someone is seen. Settings such as forensic units can lead to a reduction in touch behaviour whilst the boundaries in health settings can be dramatically shifted – for example through requiring physical help or needing to conduct sessions at bedside – which may make touch feel more appropriate. Whilst all participants interviewed currently work in adult settings, all had previous experience in other fields as a minimum during their

training placements. The contrast between behaviour with other client groups was evident throughout the interviews, with touch in a child or learning disability context often being perceived as being much more educative and developmentally appropriate. Similarly, in older adult settings it was suggested that the meaning and potential for misinterpretation of touch is likely to be different.

"There's a way we place out chairs, a setup of the room that doesn't really invite physical contact" – Cara

"I worked in a forensic secure unit and I wouldn't have ever used touch in those instances I think" – Bryony

"I guess going back to training and thinking about working in child services ... or even learning disabilities ... touch is far more acceptable in some respects. So, again, why does it become not acceptable for adults, it sort of challenges your thinking I suppose" – Heather

As well as content and environmental factors, the timing of touch within the process of therapy was a common theme that occurred throughout the interviews. There was a strong sense that touch at the end of therapy was the norm and considered generally more acceptable, even for psychologists who generally did not facilitate touch often with clients. This appeared to reflect the process of social norms, where touch often happens at significant moments such as times of saying goodbye. There also appeared to be an element of slight release from the professional role at the end point of a session or therapy allowing the boundaries of the therapeutic relationship to change somewhat now the individuals are no longer occupying the roles of 'therapist' and 'therapee'.

"I think endings are important and it is the chance to 'do' saying goodbye and feeling often quite strong emotions ... that often seems to be the place where touch occurs. It doesn't happen much otherwise, if someone is going to go for something other than a handshake it is usually then" – Caroline

There is something about the beginning and end of a session, I guess, because when you have finished the session and someone is leaving, then

the session is finished. Therefore I am now [touching] someone who is not in therapy, if that makes any sense" - Heather

3.1.4.3.1.2.   *Sub-category 2: Model Influence*

The influence of theoretical models was evident particularly when focusing on more extreme perspectives. Much of the influence was focused on where that model located the meaning of touch with clients, and whether it was explicitly supported or unsupported. Regardless of their own theoretical orientation, the majority of participants displayed the most familiarity with the psychodynamic perspective on touch and related interpersonal boundaries. This was understood as touch between psychologist and client to be strongly discouraged due to it being unhelpful through complicating the relationship or placating the client's inner emotion. Whilst the psychodynamic perspective appeared to be the most clear-cut, participants did acknowledge that Gestalt, re-parenting and attachment based therapeutic approaches support the use of touch and view the function of it as modelling healthy interpersonal behaviour and taking a holistic view of the individual. Between these two schools of thought, there was much less clarity regarding how psychological models position touch. It was felt that many models often had no clear stance on this issue, and participants appeared to be inferring possible standpoints based on related boundaries.

"I know that in some therapeutic approaches there would be a higher emphasis placed on what does it mean ... in psychodynamic psychotherapy there would be a lot more to be said about this ... so that would be a DON'T touch people or DO touch people narrative in my head" – Caroline

"I'm not actually sure what different schools of thought there are. I would think probably less so in CBT, and I'm not sure whether I know which therapies would be more likely actually" – Lucy

"I suppose those of us more interested in re-parenting type therapeutic interventions would be more inclined to want to touch and use physical connection" – Cara

Whilst there was recognition of different model perspectives, it was apparent that the majority of participants identified their own approach as eclectic and that this raised particular challenges in taking guidance on touch behaviour from models. Without the clear direction from a given model, it appeared that the waters are often muddied in terms of seeking out an evidence base to support a clinical position. This could leave psychologists susceptible to being most influenced by the strongest opinions such as that of the psychodynamic approach, with a lack of available forum to consider touch more broadly. This may lead to clinical psychologists feeling particularly unsure about whether their own adopted approach is appropriate as they move between different ways of working.

"I will draw on different things and then be a bit more targeted approach. Whether it's CBT or the more third wave CBT or schema, or even if it's more systemic work looking at people's attachment issues ... there's lots of different approaches. And I would say it perhaps lessens my observation of touch, I suppose" - Heather

3.1.4.3.1.3. *Sub-category 3: Identity of Clinical Psychology*

The perceived identity and stance of the Clinical Psychology profession appeared to exert significant influence over participants' understanding of the appropriateness of touch in a therapeutic capacity. Throughout the interviews, there was a clear dominant narrative that psychologists are generally viewed as people who don't use touch, in quite clear contrast to others in the helping profession. The source of this understanding varied from it feeling being delivered as a direct instruction to a far more subtle and general perception that this was likely the overarching position. It was hypothesised that the nature of the work that clinical psychologists undertake can require a degree of separateness and a very professional persona in order to contain the distress that is often expressed within therapy. The influence of the psychodynamic tradition, which formed a significant basis of the profession, was also considered to have shaped this approach. Regardless, the sense that touch is generally not advocated within clinical psychology appeared to be a key inhibitor to the use of touch with clients.

"A CPN will have no problem comforting somebody when they are upset ... whereas psychologists, I have always been taught that we have a very different relationship which doesn't have that touch" – Fran

"I'm not sure we were ever formally taught about it, other than that it was largely, unacceptable ... I'm not sure if that is something we were explicitly told or something that was more absorbed" – Cara

This sense of unspoken rules regarding how a clinical psychologist 'should' act was a strong theme throughout. Many participants referred back to their training and a lack of formal teaching or discussion which persisted into their qualified career. It was reflected that generally touch was a topic not discussed in supervision or with peers, and that this led to a confusion about how other psychologists actually do behave with regard to touch and a feeling that the ways to proceed should be obvious and simple enough to manage independently. Interestingly, many participants were keen to know how their own views had compared to others who had been interviewed, and appeared concerned that they may be unusual in their approach. A potential risk of this lack of formal discussion is that only the more extreme standpoints are heard – either advocating strongly for touch as in Gestalt therapies or against touch as in some Psychodynamic approaches – leaving the majority of psychologists who appear to have more flexible views feeling unsure of the efficacy and acceptability of their approach.

"So you know self-disclosure wasn't a good thing, and touch wasn't a good thing. So coming away from training feeling like I had these strong ideas of what you are not meant to do" – Bryony

"I can't recall ever discussing it in supervision really. It felt like there was a rule around it and you didn't really break it" – Cara

"It's just how interesting it is really and how little time we spend talking about it. Because this is the first time in, well I don't think I ever have in 14 years of qualifying" – Eve

It was considered that this tendency of the profession to lean towards abstaining from touch with clients or evading consideration of the topic is reflected in the professional guidance on the matter. All participants acknowledged that they did not know of any policy or guidance around the issue, but that they could hypothesise that any documentation is likely to be unclear or to err on the side of risk aversion by recommending touch with clients be minimal or non-existent. Whilst this contributed to a further lack of clarity regarding appropriate ways to use or accept touch, it was also recognised that trying to apply blanket guidance for such an individual and nuanced issue would be likely unhelpful.

"I'm not sure if there's any BPS documentation or guidelines for touch and stuff like that" – Fran

"I know there wouldn't be any documentation saying 'yeh touch your clients'! – Bryony

"it's probably indicative of the fact that it's not in the BPS guidelines as far as I can think about or professional practice guidelines ... They are woolly on confidentiality, let alone whether you shake somebody's hand or not. Nobody is ever going to have the audacity ... to put that into concrete language, that's always going to be a personal judgement within a certain boundary" – Heather

3.1.4.3.1.4.   *Sub-category 4: Social and Cultural Context*

The social and cultural context in which therapy is practiced was cited frequently as an influence on the use of touch with clients. In particular, the British and Welsh culture overall appeared to be perceived as rather touch adverse and reluctant for touch to be discussed openly. Whilst there was recognition that perhaps touch has become more common in Britain, there remained a sense that compared to other cultures even within Europe that touch occupied an awkward and uncomfortable subject for many. For example, whether to hug or kiss or otherwise touch someone on greeting remains a very nuanced and unclear scenario which can vary greatly between individuals. This has implications for the therapeutic context. If individuals

are uncomfortable with touch in everyday life then this is likely to be further enhanced within a far less familiar scenario.

"But it feels awkward with lots of people. I still think here that people are not at ease with a hug. Therefore if they come into my consulting room a hug is still something they didn't grow up with, parents didn't hug them very often and especially if they went to public schools" - Maggie

"I think Britain has become a more touchy culture over the years" – Caroline

The view of the therapeutic relationship as a microcosm of general interpersonal relationships is helpful in considering why certain factors appear particularly significant. As previously described, gender variables appear to play a significant role in decision-making about touch in therapy. Some participants hypothesised that the sexualisation of touch between genders as well as the stereotyping of females being positively represented as tactile and masculine identity being represented as non-tactile had strong impact. Similarly, many of the choices regarding timing of touch in therapy mirror that which occurs outside that setting, for example increasing the use of touch at times of heightened emotion or when saying goodbye. It was noted, however, that - whilst these kind of emotional moments can be amplified in therapy potentially suggesting touch could be used significantly more - the relationship is also much more temporary and one-sided, perhaps recommending more caution in its use.

"I wonder if it is a societal thing in that it keeps a disconnection and in particular keeps men in those roles of being slightly more stoic and kind of keeps those myths around men that cry or need a hug as effeminate" – Cara

"The coal mine background working class felt much more at ease with touch – except the men again, they don't do that. It is immediately sexual" – Maggie

"where it may seem to be very intense and with that intensity comes that level of contact because that is what happens outside of this relationship, maybe here it may not be so normal or appropriate" - Peter

133

The context of the therapeutic setting and its relation to touch behaviour is further complicated by societal understanding of psychological therapy. Unlike nations such as the USA, therapy is not considered commonplace within society and in the main tends to be reserved for individuals experiencing significant mental health problems. As such, there does not appear to be a clear and realistic presentation of what happens in a therapy setting presented to the public as a whole. Instead, as noted by several of the participants, many people attending therapy are either wholly unsure about the social 'rules' of therapy or reliant on narratives often communicated through the media which can depict the psychologist as very distant and unlikely to touch. Participants suggested that this could lead to clients being unlikely to initiate touch, instead relying on the psychologist who is in turn often attempting to take the lead and pick up subtle cues from the client. This perhaps perpetuates the narrative of touch being rare in therapeutic settings.

"I think most clients come to therapy and there's no social script. It's not like other countries where this is a norm and freely available. I think people don't know the script of what is permitted here. So I find that clients are generally very reluctant ... people are very apologetic when they know they want contact and ask for it ... I wonder how many more would like it but don't feel empowered or believe that they could ask" - Cara

3.1.4.3.1.5. *Sub-category 5: Situating Self in Context*

Whilst the theme of situating oneself within the context of others has arisen within several other sub-categories explored above, the idea of psychologists trying to identify where they position themselves in relation to others was very strong and felt worthy of deconstructing separately. In particular, there appears to be a strong influence of the behaviour of colleagues and supervisors in shaping how clinical psychologists choose to align themselves in relation to touch. This was particularly true when the participants had experienced either a strong positive or negative reaction to a supervisor's approach in the past, though the extent to which a current supervisor's approach would modify their own varied across the sample. Certainly though, supervisors and learned peers appeared to have exerted some influence with regard to the acceptability of touch. This was recognised as perhaps being even

more influential given the lack of well-known research on the issue and the aforementioned dearth in the topic during training leading to a reliance on other avenues of guidance.

"if I had a supervisor who thought it was a terrible thing, I think I would feel bad doing it because I would, yeh it would make me feel as though I was doing something wrong" – Sue

"I just think it would be nice to know ... I think it would be nice if there were research on it. And I'm hoping what this means is that you're addressing a sensitive subject which perhaps people feel like they are doing something they shouldn't be doing if they touch people and to normalise it. Yeh, rather than it be a taboo subject" – Bryony

Despite peers having a helpful influence in some aspects towards developing a touch identity, the behaviour of others appears to be a significant source of anxiety for many and a potential barrier to the topic being discussed more openly. Interestingly, as well as citing this during the interviews many of the participants also expressed to the researcher some worry about how their approach may be perceived and were keen to understand the researcher's standpoint on touch. This highlights a fear of judgement of touch behaviour that may perhaps lead to a tendency to err on the side of caution and withhold touch. This process also leads to a lack of open discussion which can further fuel anxieties through the need to infer other's touch behaviour. Indeed, several participants remarked on how surprisingly little they knew about how other psychologists use touch and the sense that touch dilemmas are for the psychologist to deal with individually. Furthermore, in addition to fear of negative judgement from peers or supervisors, it was also remarked upon that the more overarching potential for judgement at a higher level was always in peripheral awareness. With a 'blame culture' increasingly emerging in society and more transparency around professional action through avenues such as malpractice claims, psychologists' approach to touch is influenced by a fear of potential misinterpretation which could lead to them needing to defend their approach at a higher level.

"I wonder if someone talks about their view, say for example they thought touch was really important and did a lot of touching, could that be misinterpreted or misconstrued from the other person's position and what would happen with that information, does it feel safe to talk about that ... Which is interesting because it's not like I have anything to hide but I feel like I am made to feel guilty or overly-concerned about something which perhaps should be talked more about" – Peter

"It's interesting, isn't it, how come I don't know if people struggle with that or not. I would ... have a good idea to represent other psychologists' views on giving out personal information ... or where you are going on your holidays. But I wouldn't know what other psychologists would say about whether I hug more or less, am I finding it easier or harder to resist. Which is very telling, isn't it, in terms of how much it is spoken about?" – Caroline

"My first thought was nobody is witnessing this so I was then very kind of thinking 'PC' ok that's lovely and stuff but I can't prolong it, I can't hug him back" – Fran

"You hear about the HCPC naming and shaming psychologists publicly if complaints are made ... even if an accusation is made it still gets put up on the register before it is proved or disproved. I think you have got to be quite careful" - Peter

3.1.5. Core Variable

The aim at the outset of this study was to explore the experiences and views of clinical psychologists regarding touch in a therapeutic setting. As can be gathered from the deconstruction of the categories above, the core concern of participants was shown to be the decision-making process surrounding when touch was or was not helpful or appropriate. This appeared to be a concern regarding making the best decision possible in that particular situation. There were clear cut areas where this decision did not seem ambiguous; for example, the extremes such as sexual touch with clients being a boundary not to be crossed and generally accepted appropriate touch such as handshakes or assisting someone who needed physical help. However, the participants' key dilemma focused on the 'grey area' in between these two ends of the spectrum, where there is far more room for debate and the boundaries of touch can shift with minimal changes or a shift in focus within the categories outlined above. As such, the core concern for psychologists appears to be how they approach touch within this grey area.

> *"There's ones where everyone would agree would be totally inappropriate, but it is as you get down into the greyer areas ..."* – Heather

> *"It's bloody hard to try and tease out all of what is going on then and there and we do make mistakes. Hopefully we have the time or can create the time to have the space to think about this or to reflect so that we can learn from our experiences"* - Peter

The core variable relates to the process undertaken by psychologists to resolve this core concern. In this case, the process of decision-making regarding touch behaviour within this grey area revolves around cost benefit analysis. Specifically, it involves weighing up of all of the variables making up each of the key categories to determine whether the potential risks of facilitating or withholding touch outweigh the potential reward. Through interviewing and analysis, this has been shown to be an extremely thoughtful process at both a moment by moment and more longitudinal time frame. Whilst extremely thoughtful, much of this process is unspoken and some

137

occurs even at a preconscious level reminiscent of a duck paddling beneath the calm surface water. Ultimately, this scrutinising and computing of the multiple variables outlined above provides an equation for cost benefit analysis allowing the psychologist to provide a best guess – but certainly not certain – answer to the question of how they should approach touch in that particular situation.

"It's case by case, isn't it? It's very dependent on the type of work you're doing, the type of issues you're dealing with, the type of person it is, the context in which it occurs, what else is going on" – Eve

"It's about the balance between engaging somebody and what is the harm, what does this do ... yeh in the brain. That's why you go home and think 'I didn't do much today just spoke to four people', but I'm absolutely knackered, that's why" – Heather

3.1.6. Grounded Theory

Through abstraction of the data and sorting of memos, a grounded theory emerged from the analysis. This incorporated the core variable of cost-benefit analysis regarding touch in the grey area, but was situated more widely within the concept of psychologists' own comfort and confidence in decision-making. Specifically, psychologists' tolerance of the ambiguity inherent within the cost-benefit analysis process appears to be a prominent factor within their approach to touch. A visual summary of the developed grounded theory is shown in Figure 3.5.
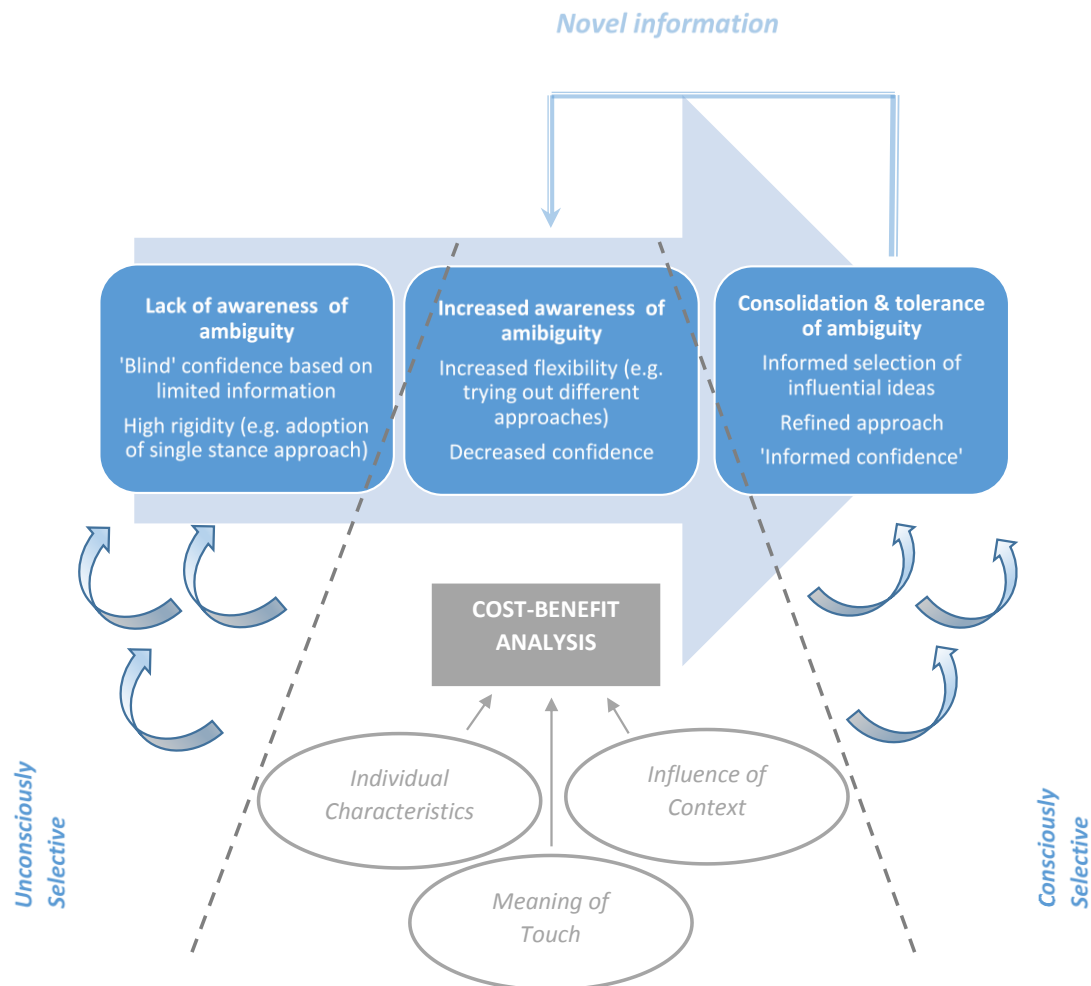
Figure 3-5: Grounded theory model of developmental process of reaching point of consolidation and confidence in tolerating ambiguity

Inexperienced or aspiring psychologists initially have less information to 'flesh out' the key categories related to decision-making regarding touch, and are therefore likely to be heavily reliant on unbalanced information within a particular category they feel comfortable with. This may, for example, lead to an overreliance on instinctual response leading to touching more freely. Conversely, it may result in relying on rigid contextual information that is felt to prohibit the use of touch entirely. This could be

visualised within the initial part of the framework, where psychologists are unaware of the multiple other options with regard to touch.

As more information is obtained - for example through training and increased exposure to clinical scenarios - psychologists can feel overwhelmed by the conflicting variables surrounding touch leading to heightened anxiety about their own approach. Within a predominantly risk and touch adverse culture, psychologists are likely to lean towards more rigid rules and be less likely to use or facilitate touch in a therapeutic setting. This could be considered within the second aspect of the framework, whereby psychologists become aware of the ambiguity inherent with touch and do not feel confident in their ability to manage this ambiguity.

Over time and through exposure to more varied perspectives and practice based evidence, psychologists are likely to develop more confidence in integrating variables to better understand the meaning and efficacy of touch within their own practice. Becoming more comfortable in delineating their own boundaries and understanding their comfort zone allows psychologists to develop increased confidence not in making the 'correct' decision but in justifying their own approach whilst accepting the possibility of getting it wrong on some occasions. As it does not appear possible to reach a place of absolute certainty in the context of touch given that the variables are so dynamic, this could be considered as reflecting the third part of the framework. This highlights the increased comfort in tolerating the ambiguity within decision-making rather than seeking definitive clear right and wrong behaviour with regard to touch. Of course, this is not a purely linear process and significant experiences or gaining of new knowledge may lead people to move differently along this framework in both directions. However the developmental nature of the process emerged as a key concept during analysis and thus is reflected in the grounded theory.

"I think definitely pre and post training. Pre-qualification I felt way more uncomfortable from the perspective that I would be doing something wrong if I

ever touched a client. Whereas now I am completely comfortable and feel ok with it" – Bryony

"I think it has come with confidence and a belief about what works. Of being less rear guarded, believing I am a good practitioner and I stick to a clear code of conduct" – Cara

"I think I would be a lot more mellow about it now. And I suppose that mellowness comes from trust in my judgement ... so yeh a sort of mellowness about it through I suppose an accumulation and experience of seeing many people" – Caroline

"whenever you go into things on a continuum everyone is going to have their different cut offs so it's a bit of a minefield I suppose and maybe when I was less experienced it was easier for me to just draw a very clear 'let's not go there at all' because the vagueness is harder. Whereas I am more comfortable with thinking I can actually justify this" – Heather

3.1.7. Conclusion

In conclusion, grounded theory analysis of the interviews undertaken with eleven clinical psychologists has demonstrated that the decision-making process underlying touch behaviour in therapy involves a complex process of cost-benefit analysis evaluating a multitude of variables. These include the individual characteristics of the psychologist and client, the intended and perceived meaning of either touching or not touching and how the chosen behaviour fits within a wider professional and societal context. With experience and exposure to a variety of perspectives, clinical psychologists appear to develop increased confidence in managing this difficult and ambiguous task. This mirrors a developmental process, which appears to begin with an initial stage of limited awareness, which could be irreverently regarded as a point of 'blissful ignorance'. Subsequently, clinical psychologists deal with an overload of information, whereby a crisis of confidence could ensue due to dealing with awareness of the multiple conflicting perspectives regarding touch in therapy and they very real potential for error in decision making. Finally, clinical psychologists are

able to reach a state of consolidation, where they are able to recognise the limitations of their cost-benefit analysis process but are able to comfortably justify their approach to individual situations through appraisal of the various influences and increased understanding of their own clinical style. It is felt that in this context, the dynamic nature of the variables involved mean that reaching a stage of absolute certainty with regard to decision making is not possible therefore the process is seen as continual and open to change.

4. Chapter Four: Discussion

4.1. DISCUSSION

4.1.1. Overview of chapter

This chapter presents an overview of the results of this study, and considers these results in relation to existing literature and psychological theory. The strengths and limitations of the study will be discussed, along with the theoretical and clinical implications of the results. Finally, recommendations for ongoing research into the topic of touch in therapy will be presented.

4.1.2. Research Findings

4.1.2.1. Summary of Findings

The principal aim of this study was to explore clinical psychologists' views and experiences of touch in therapy. This is the first study to utilise a grounded theory methodology to research the experiences of this particular professional group, and one of only a handful qualitative studies investigating more widely therapists' experiences of touch with clients.

Similarly to the related quantitative and qualitative research outlined in Chapter One, the results of this study suggest that whilst touch is a complex dilemma rarely spoken about, it does occur in therapy at least some of the time (Zur, 2007; Pope *et al.,* 1987). However there are a multitude of influences at an individual, service and societal level that affect touch behaviour in this context.

The exploration of experiences indicated that there are certain categories of touch where the expected behaviour is considered unambiguous or 'black and white'. This

includes touch that is almost universally considered acceptable, such as handshakes or helping a person in physical need, and touch deemed wholly unacceptable; for example sexual or aggressive touch. The core concern for psychologists is the decision of when to allow or inhibit touch outside of these clear parameters; the 'grey area'. The process that psychologists use to resolve this concern emerged as a cost benefit analysis, involving the weighing up of numerous variables in order to decide the risk versus reward of either touching or abstaining from touch in that given situation. Three key categories emerged from the data as encompassing the main variables weighed up in this equation; Individual Characteristics, Meaning of Touch and Influence of Context.

Whilst cost-benefit analysis was the key element of the decision-making process with regard to touch behaviour, there appeared to be an overarching developmental course that reflected psychologists' comfort in relation to the ambiguity inherent in this process. The grounded theory presents a developmental model, reflecting progressive changes in confidence and competence regarding complex decision-making. In short, in their early career psychologists are reliant on limited information and often align themselves with a particular viewpoint in which they feel most comfortable, thereby practising rigidly and without awareness of alternative perspectives.. As they become more informed, this can lead to feeling overwhelmed and confused by the multiple perspectives regarding the appropriateness of touch. This can lead to the decision-making process feeling arduous and characterised by a lack of confidence or certainty about own stance. Over time, psychologists appear to become more confident, not with regard to certainty of when and when not to facilitate touch but with the validity of their own decision-making process, allowing them to tolerate the ambiguity inherent in this decision. In this grounded theory, this is presented as a process of consolidation leading to increased confidence and ability to tolerate ambiguity. It is proposed that the complex and dynamic nature of the variables identified as affecting the validity of touch in therapy do not allow progression to a position of certainty, thereby presenting the position of confidence and ability to tolerate ambiguity as optimal.

The subsequent literature review provided significant support for the findings and the grounded theory, both through related quantitative and qualitative research within the field and psychological theory underlying interpersonal behaviour and decision-making processes. The relation to the existing evidence base will be outlined for each of the core categories, the core variable and the grounded theory below.

4.1.2.2.   Relation to Existing Literature

4.1.2.2.1.   Individual Characteristics

The individual characteristics of those involved in the therapy relationship were found to be a key consideration within the decision-making process regarding touch. This included particular characteristics of the client, the psychologists' personal and professional identity, and the dynamics and existing boundaries within the interpersonal relationship between psychologist and client.

The majority of previous research has focused on quantitative assessment identifying characteristics of clients whom therapists do or do not touch. It has been clearly demonstrated that touch behaviour is a very individual choice with respect to both the individuals involved and the specifics of that situation (Harrison, Jones & Huws, 2012). Clance and Petras (1998) note that considerations are made at a client level rather than following blanket rules. The evidence base related to the sub-categories of Individual Characteristics are outlined further.

4.1.2.2.1.1.   *Client Characteristics*

In this study, the demographics of individual clients were frequently reported as an important factor in decision-making about touch behaviour. In particular, the age and gender of the client had a mediating effect on whether clinical psychologists would be more or less likely to touch. With reference to age, participants suggested that they might be more likely to touch either much younger or much older clients. This

replicates findings by Strozier, Krizek and Sale (2003) who found that therapists are most prone to touching children or older adults. A broad overview of the touch literature by Phelan (2009) suggests that touch with children is seen as more normative than with adults, particularly when they are at the ages and stages of neediness. A possible explanation for proposed comfort regarding touch with older adults may be the reduced relationship to sexuality and therefore reduced risk of misinterpretation, given that professionals and society more widely separate advancing age and sexual desire (Inelmen, Sergi, Girardi, Coin, Toffanello, Cardin & Manzato, 2012). With respect to gender differences, it appeared in this study that touch with a client of the opposite sex felt most taboo. Due to the predominance of female participants in this study, this was discussed mostly in terms of reluctance to engage in touching with males. There is a wealth of research in both social and evolutionary psychology which may contribute to a discrepancy between touch behaviour with men and women. An influential theory by Nancy Henley (1977) highlighted the social discrepancy by proposing that men initiate touch with women more often than women with men due to historical asymmetry in the status difference between genders. Hertenstein *et al.,* (2006) showed that there are also differences in the purpose and level of communicative ability that touch can provide for men and women. They reported that females are more skilled at communicating and detecting compassion through touch while men are more skilled at communicating or detecting anger.

Whilst initial responses from participants stressed the relevance of client demographics, further exploration suggested that more complex aspects of individuals, such as the formulation that has been developed or their touch history, are also highly relevant to decisions made regarding touch. Of particular note was the presence of previous abuse of touch through sexual or physical abuse. This variable has been widely noted as influential through other studies (Harrison, Jones & Huws, 2012; Pinson, 2002), with some researches proposing that the risks for this client group are such that touch is controversial or would be almost entirely inappropriate (Rothschild & Staunton, 2002; Glickauf-Hughes & Chance, 1998; Hunter & Struve, 1998). Participants in this study did not appear to hold this extreme view, instead recognising this as a further variable in need of consideration and

147

noting that the potential for both increased risk and benefit for previously abused individuals heightens the importance of cost-benefit analysis further. This viewpoint is supported by Caldwell 1997) who found that 69% of sexual abuse survivors found touch to be a positive aspect of their treatment, helping to develop trust, openness and bonding. Smith, Clance and Imes (1998) also reported positive effects of touch within this client group when touch was used in an appropriate and respectful way.

4.1.2.2.1.2. *Psychologist Personal and Professional Identity*

The participants in this study acknowledged that their own style, preferences and allegiances impacted on their approach to touch in therapy. In particular, the influence of their own framework for understanding psychological wellbeing and their theoretical orientation were considered to be significant in driving their touch behaviour. The alignment of therapists to a specific therapeutic model has been shown by other studies to be a key predictor of touch behaviour (Strozier, Krizek & Sale, 2003). A well replicated finding is that psychoanalytically aligned therapists are least likely to touch whilst humanistically orientated therapists are most likely (Milakovich, 1998; Strozier, Krizek & Sale, 2003). Whilst the majority of participants in the current study did not appear to strongly align with any particular therapeutic model – most identifying themselves as eclectic – there was a clear awareness of these more clear cut perspectives on touch, which appeared to have influenced their own perspective to some degree. However, it seemed that more importance was placed on how their perspective conceptualised touch and distress, for example whether their therapeutic approach emphasised a particular meaning or significance to touch in therapy. This supports the idea presented within an online synthesis of touch literature by Zur and Nordmarken (2011), which proposes that touch behaviour varies dependent on whether it is viewed as a technique in itself, an element of re-parenting, a behavioural process of modelling or an additional method of communication. Furthermore, participants were able to recognise that their own personal style and experiences outside of their professional capacity may have shaped their theoretical standpoint or their views regarding touch. This supports the empirical research by Milakovich (1998) who identified that therapists who had

experienced abuse as a child were most likely to provide touch, as were those who had experienced positive touch in their own therapy.

4.1.2.2.1.3. *Interaction and Boundaries within Relationship*

The results of this study demonstrated the importance of the dynamics within each individual therapeutic relationship. As previously discussed, client characteristics were considered important as per existing research, but this study also built on this understanding by identifying such influences to be multi-level and dependent on interaction with the psychologists' characteristics. For example, it was demonstrated that age and gender of the client was important in relation to the age and gender of the psychologist, rather than as a stand-alone variable. In particular, participants reported increased caution in using touch with clients of a similar age and of the opposite sex, with reference to social norms dictating that a sexual connotation is most likely in such circumstances. This finding supports that from other studies which have noted that the interaction of therapeutic dyads is important (Stenzel & Rupert, 2004) and often reflective of social norms (Major, 1981). Specifically, it has been found that female therapeutic dyads are most likely to touch (Holroyd & Brodsky, 1977), which is perhaps reflective of research which shows that in social interaction female dyads interact at closer distances and engage in more casual touch (Ford & Graves, 1977).

Additionally to the interaction between therapist and client characteristics, the unusual nature of the therapeutic relationship was considered within participants' decision regarding touch. It was recognised that the power balance is unequal within such a relationship, and concern was expressed regarding whether clients are ever able to make a truly open and unbiased decision about touch regardless of how much they are consulted. Therefore, the responsibility was felt to lay particularly on the clinical psychologist to ascertain the remit of the relationship and to make the appropriate choices regarding touch and boundaries beyond that. This was considered particularly true for certain clients, such as those further disadvantaged or disinhibited through learning disability or other conditions affecting cognitive ability

as experienced during clinical training or in previous roles. Unfortunately, there is a lack of literature focusing on touch with such client groups and is a topic worthy of future research. Geller, Norcross & Orlinsky (2005) support this idea that therapy by its nature is a unique and unbalanced relationship where interpersonal nuances can be magnified or altered completely. The high level of responsibility felt by the therapist to dictate consistent and congruent boundaries within therapy may rely on the development of clear self-concept for the psychologist (Rogers, 1970) as they ascertain the comfortable boundaries for them as a clinician.

4.1.2.2.2. Meaning of Touch

Similarly to previous research, the meaning ascribed to either provision or inhibition of touch is a key contributor to decision-making for clinical psychologists. There was a particular focus on the types of touch, and the motivation underlying the urge to touch. As previously stated by Young (2005), there remains room for discrepancy no matter how thought through, as even benign intention by the therapist can be perceived differently by the client. This complexity was acknowledged by participants in this study, who emphasised the scrutiny they paid to trying to work out potential outcomes or consequences based on their actions.

4.1.2.2.2.1. *Touch Function*

Participants expressed the idea that touch does offer something additional to words alone. Knapp and Hall (2013) note that verbal communication represents only one form of human communication, and proposes that non-verbal communication through visual, tactile and intuitive methods can be employed at different levels either consciously or unconsciously. Frank (1970) even asserts that language never supersedes the more primitive forms of communication such as physical touch and voice tone. The interesting experiment by Hertenstein, *et al*., (2006) demonstrated the power of touch through showing that human strangers can convey a deep level

of communication such as complex emotion through a simple touch without any additional cues.

The potential positive benefits of touch proposed by the participants in the study such as providing the client with reassurance, calming, grounding and empathy also mirror those suggested by other reviews (Zur & Nordmarken, 2011; Downey, 2001). This could be considered in relation to various frameworks. As discussed in Chapter One, affectionate touch has been shown to trigger the release of oxytocin, a hormone that decreases stress related responses (Field, 2002) which could explain the calming effects of touch. These positive consequences may also refer back to the basic premises of attachment theory which proposes that touch conveys feelings of safety and security (Bowlby, 1975). The potential positive effects have been borne out in research exploring client experiences (Horton *et al*., 1995) showing that appropriate touch can enhance bonding, trust, safety and understanding. Additionally, the healing effects of touch with regard to trauma experienced in early life have been demonstrated (Hunter & Struve, 1997; Aquino & Lee, 2000), providing support for the idea presented by some participants that touch can form part of a re-parenting approach to traumatic experiences. Similarly to the potential positive effects of touch suggested by participants, the potential for negative consequences if used inappropriately was mirrored in existing research focusing on client experiences of touch. In particular, abuse of the power differential was highlighted in this and previous studies, with Horton *et al*. (1995) finding that touch was least helpful when used incongruently with their presenting problems, not discussed openly and used without the existing context of a positive working alliance.

4.1.2.2.2.2. *Touch Motivation*

An interesting finding from the present study was the conflict and confusion regarding whether the decision to touch relied more on instinct or on conscious thought. A key discussion point in the focus group centred around surprise at how much thought went into a topic previously felt to be fairly instinctual, whilst still maintaining emphasis on what 'feels right' in the moment as important in the

decision-making process. This idea of instinct and reliance on non-verbal cues was particularly prominent in the previous qualitative study into clinical psychologists' experiences of touch in therapy (Harrison, Jones & Huws, 2012) and has been commented on in other qualitative research (Tune, 2001). This could possibly be explained in relation to the core variable of decision-making through the idea of dual models of information processing. Various researchers have argued that there are two modes of thinking; intuitive and analytical (Hogarth, 2001; Kahnemann & Frederick, 2002). Rather than being distinct, it is proposed that these methods represent the ends of a continuum and that any serious complex thinking employs both analytical and intuitive thought.

Another key factor felt to be important but very difficult to both assess and articulate was clarification of whether the urge to touch reflected the client or the therapist need. It was emphasised that touch should be inhibited if it was driven by the therapist need, and ways of ascertaining this were identified predominantly as self-reflection and supervision. Various researchers have emphasised this importance of abstaining from touch driven by the desires of the therapist (Shaw, 2003, Carere-Comes, 2007), though few have proposed clear methods of how the needs of the client and therapist are delineated. A further complication to this is proposed by Vereshack (1993) who notes that all psychotherapy brings pleasure to therapists through the pleasure of healing and being in an intimate relationship. Additionally, Pope *et al.,* (1986) report that sexual attraction to clients is a common phenomenon, with 95% of male therapists and 76% of female therapists feeling attracted towards a client at least once in their career. Whilst the participants in this study reference their own needs predominantly in relation to difficulty tolerating the distress of a client or experiencing strong countertransference, these additional variables are important to consider. Bonitz (2008) recommends that when touch is used it should be underpinned by a clear rationale – theoretical or otherwise – that privileges the client's need.

4.1.2.2.2.3. *Types of Touch*

Types of touch and the issue of initiation were strong themes in this study. It was evident that some of the 'internal rules' developed by therapists regarding touch could be comfortably brought back to initiation, with the most common theme being that touch would be most acceptable when initiated by the client. This appeared to relate to a reduced probability of misinterpretation of intentions by the client. These results supported the previous research by Pinson (2002) and Stenzel and Rupert (2004) who also found that touch was felt to be 'safest' when initiated by the client. However, this contrasts with Tune's (2001) findings that touch was reported as most concerning and problematic when initiated by the client. This perhaps refers to the unexpected touch that is reportedly commonly in therapy, irreverently referred to as the 'ambush hug' by some researchers (Bar-Levav, 1998). This is perhaps deemed particularly difficult due to the lack of time to consider options, leading to an over-reliance on the instinctual thinking process in the moment, and allowing time only for more analytical consideration on reflection (Hogarth, 2001; Kahnemann & Frederick, 2002).

Different types of touch, their categorisation and perceived acceptability as discussed in this study strongly mirrored findings from previous research. The different levels of touch mapped on to the taxonomy of touch developed by Smith (1998) and the framework proposed by Zur (2007; see Table 1.1). Participants clearly recognised different types of touch encompassing different meanings, with much of their deemed acceptability related to social norms and the commonality of that touch within every-day settings. As found by various other researchers (Wilson, 1982; Stenzel & Rupert, 2004), brief, non-erotic touch such as handshakes or brief touches on the back or shoulder were perceived as the safest forms of touch. Much more caution was suggested regarding touch on other areas of the body, prolonged contact or hugs with clients. This reflects the opinion proposed in a literature review by Bonitz (2008), who summarised that research suggests nearly all therapists would offer or accept handshakes but that the percentage who would hug their clients was much lower and that even fewer would consider holding a client's hand.

153

4.1.2.2.2.4. *Predicting Outcomes and Considering Alternatives*

The idea of verbalising the urge to touch was raised by several participants, but to the author's best knowledge has not been included in other research into this topic. It is suggested that verbal reflection of the countertransference is perhaps used by clinical psychologists as a tool to validate the emotional experience of the client without the need to undertake the complex decision process underlying actual physical touch. This could be conceptualised as serving two different functions, either reinforcing the boundaries of the relationship through acknowledgement that the urge to touch is there but is not appropriate under the circumstances, or placing the choice regarding touch behaviour onto the client. This is likely to be dependent on the psychologist's understanding of the boundaries and remit of therapy. This is supported by Bonitz (2008) who proposes that use of touch should always be embedded in a larger therapeutic context. Interestingly, although Bonitz did not reference verbalising the urge to touch specifically, it is noted that less risky interventions bringing about the same result should be considered. Support for the role of verbalisation of touch and the holding that this can provide could also be seen as underlying the statement by Winnicott (1965, p. 240) that "Occasionally holding must take a physical form, but I think this is only because there is a delay in the analyst's understanding which he can use for verbalising what is afoot".

4.1.2.2.3.   Influence of Context

The participants in this study reported that a strong influence on their approach to touch was the context. This extends from consideration of the individual situational level of what is occurring in the room to a cultural level of the acceptability of touch. In particular, the perceived taboo of touch between therapist and client was felt to be exacerbated through touch being sexualised widely in society. This has been similarly evidenced in other research, including Harrison, Jones and Huws (2012) whose key finding on this topic was that clinical psychologists believe themselves to

occupy a profession that "does not touch". Additionally, the review of touch literature by Bonitz (2008) reflects a low level of perceived acceptability regarding casual touch in Western culture, with most touch felt to be associated with close and intimated relationships.

4.1.2.2.3.1. *Situational Factors*

The specifics of the situation in which touch might occurs appear to be important to clinical psychologists. The timing of the touch in relation to the therapeutic process was a particularly striking theme, with the vast majority of participants stating that they are most likely to touch at the end of the therapy process. This was conceptualised as a way of acknowledging the relationship, of congratulating success and of saying goodbye. The frequency of touch at the end of a session was rare, but overwhelmingly more common than spontaneous touch during a session. This tendency to save touch as a greeting or ending has been demonstrated across studies in this area (Tune, 2001; Pinson, 2002; Harrison, Jones & Huws, 2012) and is reflective of social norms regarding touch. Tune (2001) also suggests that the distinction between the therapeutic and social space that occurs at the end of a session of therapy allows a change in interpersonal dynamics where touch becomes less of an unusual phenomenon in the social rather than the therapeutic space.

Another situational factor affecting the probability of touching was that of client distress. Many of the participants felt that heightened client distress increases their urge to touch and the likelihood of them offering touch. This was explained as the time clients may be most in need of the calming, grounding, reassurance or acceptance felt to be inherent within appropriate touch. Wilson (1982) supported this idea, reporting that touch was experienced by clients as most useful at times of crisis. However, several researchers have also proposed that it is at times of heightened distress when it may be most difficult to resolve the previously discussed dilemma of identifying whether it is client or therapist need that is motivating the desire to touch. Bacorn and Dixon (1984) suggested that the therapist's anxiety is reduced by touching the patient, and that to lessen the patient's anxiety through

gratifying touch may be dismissing an important issue. Gilbert and Leahy (2007) also discuss the need for therapists to be able to tolerate the distress of clients and the reaction this provokes in themselves without feeling the need to 'rescue' in order to help clients' maturation.

4.1.2.2.3.2. *Model / Theory Influence*

Theoretical orientation has been defined as a conceptual framework used by a clinician to understand clients' therapeutic needs (Poznanski & McLennan, 1995). Whilst the majority of participants in this study identified themselves as eclectic, their understanding of the acceptability or otherwise of touch appeared to be significantly influenced by learning from theoretical models. This supports previous research showing theoretical orientation to be a key variable in relation to touch behaviour, particularly in relation to more definite viewpoints on touch such as those held by the psychoanalytic or humanistic traditions (Smith, Clance & Imes, 1998; Strozier, Krizek & Sale, 2003). Lambert (1992) notes that theoretical orientation is the most common way of defining therapists, and that 95% of therapists report that their orientation always or frequently influences their practice (Prochaska & Norcross, 1983). The professional training of clinical psychologists differs from that of other therapeutic training programmes aligned to one theoretical perspective, and perhaps results in a more varied perspective within the profession. However, the perspectives encountered appear to play a part to some degree, as the participants appeared to be influenced by ideas regarding the meaning of touch presented by different models when weighing up decisions regarding touch. Bonitz (2008) reflected this idea of being influenced rather than driven by models well, stating that clinicians are still guided by theoretical considerations although the rigid positions once held appear to have become more flexible and diverse, resulting in the establishment of a more pragmatic middle ground.

Whilst theoretical orientation was noted as influential, participants raised an interesting idea in questioning whether the model aligned to dictates one's approach

to touch, or whether personal preferences drive the attraction to a particular model. Feltham (1997) suggests that there are indeed complex reasons underlying therapists' choice of approach; generally classed as opportunity - such as training pathway or supervisor's orientation - and personal philosophy, encompassing individuals' previous experiences and values. Woolfe and Palmer (1999) suggest that a clinician needs to reach an advanced developmental stage with capacity for reflective judgement before they can make an informed choice of orientation which marries up to their epistemological position.

4.1.2.2.3.3. *Identity of Clinical Psychology*

The influence of the perceived norms regarding touch behaviour in the clinical psychology profession appeared to be extremely significant for participants. Indeed, concern about how one's own touch behaviour compares to others was a key point of discussion both within the interviews and during the focus group. The most prominent viewpoint was that touch was generally not encouraged in clinical psychology, a message that participants reported receiving both implicitly and explicitly. This was felt to lead to a lack of discussion on the topic as the position was already viewed as fixed. The only other study focusing on clinical psychologists also reported this as a strong finding (Harrison, Jones & Huws, 2012) and related studies have similarly found an ambivalence regarding both discussion and provision of touch in therapy (Tune, 2001; Strozier & Rupert, 2004). The urge to ensure integrity to the professional norms can be considered in relation to social identity theory (Tajfel & Turner, 1979) which proposes that group membership is an important source of pride, self-esteem and belonging. All groups have norms to provide cohesion and structure, therefore practising outside of the perceived parameters can lead to fear of being judged or shunned by other group members. Unfortunately, the very human nature of touch means that it is a topic that arises in therapeutic settings and, as Wilson (1982) and Pinson (2002) have shown, the taboo on touch in therapy does not necessarily lead to reduced touch behaviour but does lead to reduced open discussion of touch with clients themselves, supervisors and peers.

A key contributor to the taboo of touch in therapy appeared to be the lack of reference to the topic during training. This has also been reported in other studies. For example, Strozier, Krizek and Sale (2003) report that 83% of therapists stated that touch was not addressed during their training. The researchers hypothesise that the lack of such content in training could be reflective of educators' discomfort and lack of clarity regarding the topic of touch, therefore selecting to bypass the topic entirely. This was felt to be exacerbated further by messages from therapeutic models given that - aside from those occupying the more extreme ends of the continuum such as psychoanalytic and humanistic orientations - many therapeutic models do not make their position on touch explicit (Strozier & Rupert, 2004). Additionally, the risk averse culture in which clinical psychologists practice was noted as influential, a finding supported by previous research. Dating back over sixty years, Wolberg (1954) claimed that the biggest fear of touch in therapy is that it will lead to sexual contact, or claims of it. Joshi, Almeida and Shete (2010) propose that the increased transparency regarding malpractice claims has only heightened this anxiety further. The fear of misconduct claims is a rational one, with 44% of psychologists stating that they knew of at least one client who had reported sexual contact with a previous therapist (Stake & Oliver, 1991) and an increasing number of legal claims brought against therapists in recent years (Zur, 2007). The consequences of such claims – both true and unfounded – can have serious implications for both client and therapist (Pope & Vetter, 1991). Along with the better understanding that has developed regarding the negative effects of ill-timed or inappropriate touch experienced by clients (Bonitz, 2008), this may explain why touch could be increasingly considered as a risk management issue rather than a clinical intervention.

4.1.2.2.3.4. *Social and Cultural Context*

This research was conducted solely in Wales, and many participants referenced the part that the approach to touch in the wider culture of Britain had played on both their personal and professional touch behaviour. Britain appeared to be categorised as a fairly touch averse nation, a fact borne out by statistical evidence showing that

Britain is one of the least tactile cultures globally (Montagu, 1986; Andersen, 2008). Along with those in much of Northern Europe and the Far East, people in Britain have been shown to demonstrate very little physical contact in their everyday interactions, in contrast to the Middle East, Latin America and Southern Europe where touch represents a large part of socialising. Within the individual culture, there also develop other social norms regarding the purpose of touch and how it is expressed between individuals. The focus placed by participants on the age and gender interactions between client and psychologist reflect wider norms regarding touch. Edwards (1981) explains that in low contact cultures such as Britain the high level of contact infants receive diminishes as they grow into adulthood, where touching behaviour becomes interlinked with sexual activity. Additionally, gender differences in touch behaviour become apparent, with females becoming most likely to be touched and a reduction of between-gender physical contact (Major, 1981; Stier & Hall, 1984). In research into touch in the therapeutic relationship, Field (2002) spoke about the prevailing 'no touch' culture in response to the sexualisation of touch and its link to aggression. As per Field's research, participants in the current study spoke about such social norms as a barrier to touching for fear of being seen as behaving inappropriately by those outside the therapeutic relationship. This demonstrates the additional level of complexity faced by clinical psychologists, who must consider not only the very nuanced social norms but additionally the complexity of an interpersonal relationship in a therapeutic context.

4.1.2.2.4.   Cost-Benefit Analysis in the 'Grey Area'

The core variable in this research focused on decision-making regarding touch behaviour using cost-benefit analysis. As outlined previously, certain behaviours are considered almost entirely acceptable or unacceptable, whilst there is much less certainty regarding others. The categories outlined above represent the factors considered when making decisions about touch behaviour within this less clear area, referred to in this study as the 'grey area'. Previous studies have supported this idea of ambiguous aspects of touch, with certain behaviours categorised as either 'safe'

or 'unsafe' (Stenzel & Rupert, 2004; Strozier, Krizek and Sale, 2003). This links to the taxonomy of touch (Smith, 1998) where the five main touch types represent the ambiguous areas but where there is additional reference to two other touch behaviours – sexual and aggressive touch – which are classed as wholly unacceptable in the therapy context.

The literature review conducted following the development of this grounded theory was positive in reinforcing the concept of cost-benefit analysis identified as the crucial process in making decisions about touch (Harrison, Jones & Huws, 2012; Pinson, 2002). Smith (1998) highlighted the significance of this dilemma, noting that "touch is both powerful and risky" whilst Strozier, Krizek and Sale (2003) pointed out that clinicians must consider touch carefully, as it can be harmful or helpful depending on how it is used. Whilst it was acknowledged by participants that the complexity of this dilemma and the potential for harm could lead to a tendency to avoid touch altogether – particularly within the context of a risk and touch averse culture - they also recognised that the potential for benefit is of equal importance. This is reminiscent of the position taken by Lazarus (1994, p.260) who pointed out that "one of the worst ethical violations is permitting current risk management principles to take precedence over humane intervention". Ruderman (2000) emphasises the individuality of touch decisions, stating that for some the use of touch could mean the destruction of the therapy but for others it may be indispensable for the continuation of treatment.

Given that the supportive understanding of cost-benefit analysis regarding the choice of touch behaviour within this 'grey area' of therapy is very complex, psychological theories of decision-making can help underpin the process. Choice is regarded as the evaluation of different options in order to decide on an option   outcome of a process which involves assessment and judgement. Thus, the process involves the evaluation of different options and making an informed conscious decision about which option to choose (Hastie and Dawes, 2001). The Information Processing Approach to decision-making can be traced back to Simon (1995) and is based on the idea that decision-making is a cognitive process affected by the information we

choose to attend to. The Adaptive Decision-Maker Framework is an example of an Information Processing Approach to decision-making, based on how individuals choose between different courses of action in ambiguous situations. This framework argues that problems are solved through a process of information acquisition and evaluations regarding the available options (Beach and Mitchell, 1978). It is noted, however, that in situations where there is an element of risk involved, this process becomes less balanced. Kahnemann and Tversky (1979) proposed Prospect Theory following economic research, which demonstrated that how decisions are framed in relation to risk significantly affects decision-making behaviour. For example, findings show that the way outcomes are framed results in very different decisions being made and that loss aversion leads to people favouring the status quo over options that contain both more risk and more reward. When mapped onto the context of decision-making regarding touch in therapy, these cognitive models demonstrate that cost-benefit analysis is indeed likely to play a key part in such a complex decision involving potential for risk and reward. Furthermore, prospect theory suggests that dominant narratives focusing on negative outcomes of risk are likely to foster a tendency towards touch avoidance and ambivalence within the profession about pursuing the topic as demonstrated in the findings of this study.

4.1.2.2.5.   Grounded Theory: Consolidation - Confidence and Tolerance of Ambiguity

In line with the classical grounded theory approach, the concept of confidence in one's own decision-making and the tolerance of ambiguity was arrived at by the researcher through abstraction of the data and literature review conducted to triangulate these findings. This led to the development of a grounded theory conceptualising how clinical psychologists reach a point of consolidation, reflecting a stage at which they feel confident and competent in their ability to make informed decisions regarding touch in therapy. Throughout the study, participants displayed difficulty fully articulating both the process of decision-making within individual situations and the ways by which they had reached the point of feeling secure in their overall approach. However, this was a strong theme throughout the analysis, supported by previous qualitative research (Tune, 2001), and appeared to relate to

experience and the integration of numerous influences. This sense of a change in touch behaviour in relation to the development of therapists is reflected by Joshi, Almeida and Shete (2010) who showed that experienced female therapists touch most often and inexperienced therapists least often. The trend in the present study sample toward more experienced therapists perhaps emphasised this more given that these individuals may have self-selected to take part due to holding a clear perspective and feeling comfortable exposing their practices to others

A model identified which helps to contextualise the developmental process outlined in this grounded theory is the 'safe-uncertainty' framework developed by Mason (1993). This framework was originally developed in relation to the family therapy process, but appears to mirror the process conceptualised in this study well. Mason's theory is visualised in Figure 4.1 below.
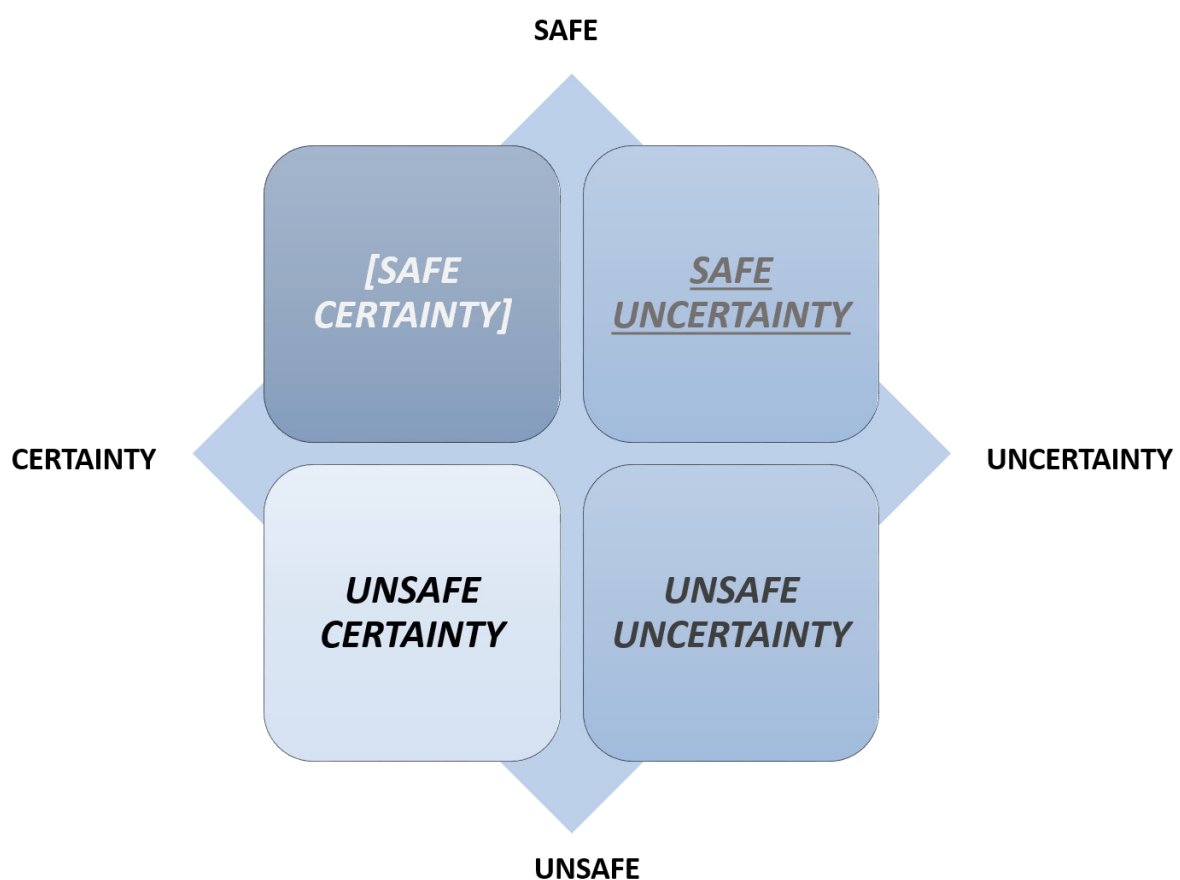

Figure 4-1: Developmental model of 'safe-uncertainty' based on Mason (1993)

The stages detailed in Mason's framework – families movement from a stage of unsafe-certainty through unsafe-uncertainty and onwards – could also represent, in the context of this study, a developmental process for the clinical psychologist. The initial part of the current model could be viewed as reflecting unsafe certainty, whereby psychologists have limited knowledge yet feel confident in their decisions. The middle part of the model could be viewed as the clinical psychologist occupying a position of unsafe uncertainty, as they become aware of the multitude of variables surrounding touch in therapy but do not yet feel able to consolidate these and making a confident decision. The latter part of the current model could reflect safe uncertainty in Mason's model, whereby the clinical psychologist is aware of the ambiguity in the decision making process regarding touch but is able to tolerate this and make appropriate decisions. Many parallels can be drawn with the model developed in this study, for example the process of moving developmentally within the model and the relative non-existence of an idea of 'safe-certainty' or, in the case of this study, absolute certainty regarding the choice of touch behaviour. Existing models such as that of Mason (1993), which map neatly onto the developed grounded theory, provide theoretical support by recognising the presence of this developmental process in other areas of interpersonal behaviour.

Various developmental supervision models also highlight the developmental process of gaining confidence and competences as a clinical psychologist. For example, Hogan (1964) outlines a four stage process which culminates in the therapist demonstrating 'mastery'. This does not represent faultless ability, but instead an insightful awareness whilst preserving an understanding of the limitations to that insightfulness. This nicely reflects the consolidation and confidence/tolerance position in relation to decision-making about touch in therapy, which is not one of complete competence but one in which the clinical psychologist is able to make an informed decision whilst accepting that a risk remains of making an error of judgement. Lingard, Hayes, Mills and Christie (2003) similarly discuss this movement from an unhelpful focus on one's own limitations to the acceptance and understanding of such limitations. They propose that inexperienced individuals or students tend to view uncertainty as something to be avoided or disguised, whereas experienced individuals or teachers accept uncertainty and find ways to deal with it.

The Skovholt and Ronnestad Model (1992) of therapist development also lends support to the developed grounded theory. The first two stages of this model reflects the experiences that the participants outlined in the study of feeling uneducated regarding touch in their early career and thus relying heavily on a limited amount of knowledge, human instinct and the imitation of mentors. This has been conceptualised within this grounded theory as the initial stage in the developmental process. In stages three and four, Skovholt and Ronnestad propose that therapists are completing the task of assimilating new information and refining their own ideas through exploration as they become more educated. This is reminiscent of the middle stage identified in the present grounded theory, where inexperienced clinical psychologists are attempting to integrate conflicting opinions on the appropriateness of touch during therapy – for example from theoretical models and training experiences – and often find themselves feeling very unsure of whether their touch behaviour is appropriate or not. 'Integration, Individuation and Integrity' form the last three stages of the model, and emphasise that therapists are likely to be able to integrate the information they have gathered and to assimilate it with their own personal style in order to develop increasing authenticity and to be able to work integratively. This helps to emphasise the more comfortable position occupied by clinical psychologists at the stage of consolidation, as well as the more natural and unconscious nature that can then become characteristic of the decision-making process. Clance and Petras (1998) reported that in spite of the wealth of evidence showing the numerous variables considered, many therapists consider touch decisions to be guided by instinct or feeling. This strongly resonates with similar ideas expressed by participants in the current study who appeared surprised by the level of thought and analysis going on at a less conscious level, perhaps reflecting their stage of development.

4.1.3. Clinical and Service Implications

Qualitative research should contribute to wider knowledge and understanding about policy, practice and theory (Spencer, Ritchie & Lewis, 2003). It is felt that the results

of this study have raised some important considerations with respect to clinical, training and service development arenas. Some suggestions for change to practice are outlined below.

4.1.3.1. Clinical Implications

Results of the study provide evidence that clinical psychologists perceive touch as important and that it is viewed as having significant effect on the client, either positively when used appropriately and sensitively or negatively otherwise. Additionally it is emphasised that touch is an important issue that arises in psychology services across adult mental health settings and as such should not be considered only as within the remit of certain therapeutic orientations. Furthermore, these results demonstrate the complexity and multitude of factors that should be taken into account by clinical psychologists when considering their approach to touch. The universal nature of this issue suggests that it may also be relevant to consider in the context of other services. Physical health settings may particularly benefit from the perspective brought to the issue by clinical psychologists who, as demonstrated through this research, take a holistic view of the risks and rewards of touch. Indeed, initiatives such as those undertaken by physiotherapists alongside psychologists to integrate the physical and psychological effects of touch in treatment of chronic pain have already provided promising results (Lyall, 2007).

Feedback from participants during the interviews and the focus group highlighted that the process of taking part in this discussion had helped participants feel more reassured about their own practices, more supported and safe in their choices and more able to openly consider when and why they use touch. This was regarded as a positive experience which has also allowed them to discuss their approach with colleagues and in turn to gain further understanding and support. This suggests that increased dialogue regarding the topic of touch in therapy would be a positive outcome of this study which may allow clinicians to practice with more awareness and conscious thought. A more open dialogue between professionals may also foster more open dialogue with the client regarding touch. Tune (2001) identified that

secrecy regarding touch is common, both in the professional arena and between the therapist and client, which has the potential to be harmful by providing mixed or unclear messages to the client. This was not raised as an issue in this research, and the omission of discussion about touch between clinical psychologists and their clients suggests that it is possibly not commonplace. As recommended by Pinson (2002), all touch behaviour - whether spontaneous or pre-planned - should be reflected on sensitively with the client as part of the therapeutic process. Given the findings in both the present and previous studies that there is potential for negative experiences of touch by the client, there should also be opportunity made at an individual service level for clients to safely report experiences of inappropriate or harmful touch.

4.1.3.2.   Training and Supervision

The neglect of touch as a topic for discussion in clinical training and supervision was identified as a key barrier to understanding the efficacy and appropriateness of touch, particularly noting that touch is often raised only when it is experienced negatively. This was mirrored in related research (Hunter & Struve, 1998; Horton *et al*., 1995), but it has also been shown that the taboo regarding touch does not necessarily preclude therapists from touching but does prevent timely consultation with supervisors (Pinson, 2002; Wilson, 1982). This is unhelpful both in reinforcing the message that touch in therapy is equated to risk and negative consequences and in potentially allowing inappropriate touch to occur given the lack of opportunity to consider it in supervision.

A positive outcome of this study would be for there to be an increased focus on the topic of touch during clinical training. As noted by Sanderson (1995, p. 256) 'therapists are better prepared to handle situations competently when they have been prepared to deal with them before they appear in clinical practice. It would not be easy for a therapist to intuit what appropriate touch with clients would be'. Increased training would help reduce the reliance on a 'blind confidence' approach of relying on limited knowledge and also reduce anxiety when individuals are

166

experiencing difficulty gaining confidence or tolerating the ambiguity of the decision making process by acknowledging the complexity of the issue. A more open dialogue regarding touch through inclusion within training would help emphasise the importance of self-awareness regarding attitudes towards physical contact, proposed by Durana (1998) as an integral part of ethical guidelines surrounding touch in therapy. Interestingly, participants noted in the focus group that they had not previously acknowledged the part their personal attitudes and preferences played in their professional decisions about touch, suggesting that opportunities to develop self-awareness in this area have been limited.

Equally important in achieving these aims would be increased opportunity to reflect on touch dilemmas within supervision. Tune (2001) notes that supervision provides an opportunity to become educated about rationales for the use of touch, awareness of the approach of others and the reviewing of guidelines related to touch in therapy. Given the strong theme of fearing judgement from peers and supervisors, inexperienced supervisees appear unlikely to bring up the issue themselves. Use of contracting and discussion of touch as a legitimate topic to bring to supervision may be helpful in reducing this reluctance (Hawkins & Shohet, 2012), and supervisors should maintain an awareness of the very individual and dynamic variables shown to influence clinical psychologists' approach to touch, both in relation to the supervisee and to themselves. Peer supervision may also provide a useful forum in which to discuss touch and similar issues such as boundaries in therapy, allowing a cross section of viewpoints to help integrate information. Given the fact that provision of supervision, consultation and reflective practice are core competencies of clinical psychologists (BPS, 2007), the profession is also well placed to provide support to other professions regarding boundary issues such as the use of touch in therapy.

4.1.3.3. Service and Policy Implications

The burden of responsibility alongside the complexity of the decision-making processes regarding touch in therapy highlight the difficult and often emotive tasks faced by clinical psychologists and others working therapeutically. In particular, those

at the middle stage of the developed model may be particularly vulnerable to burnout characterised by emotional exhaustion and feelings of reduced personal accomplishment (Anderson, 2000). As reflected by the focus group in this study, the unconscious nature of these decision-making processes mean that clinicians may often be unaware of the draining nature of their roles. These results imply a need for services to be aware of the emotional demands of the role and to provide appropriate time and support for clinicians to manage the task appropriately. This could include ensuring that appropriate time is set aside for professional support, for example through supervision or debriefing, and that the level of autonomy expected is appropriate to the clinician's stage of development.

These results emphasise the importance of a good therapeutic relationship for touch to be experienced positively. Services must ensure that an excessive focus on outcomes and time limited interventions does not disregard this and other evidence citing the importance of a good therapeutic relationship in achieving positive long term outcomes. The lack of recognition of touch in policy identified through this research must also be considered. As discussed in Chapter One, this phenomenon is either not referred to at all or is only briefly referenced within professional practice guidelines in relation to unacceptable touch. The issue of touch is a complex one to capture and prescriptive guidelines for its application are likely to be unhelpful. Thus, blanket statements linking touch only to sexual behaviour and risk perpetuates the narrative of touch in therapy as taboo. As highlighted previously, this serves only to reduce open discussion of touch rather than the occurrence of touch itself. As noted within the BPS Professional Practice Guidelines (2007) and DCP Leadership Framework (2011), clinical training provides a unique skill set enabling clinical psychologists to take a leadership role in service development and delivery. The profession is therefore in an excellent position to highlight existing research on the importance of the therapeutic relationship and soft skills such as touch in therapy, in order to influence future policy and service development.

4.1.4. Strengths and Limitations

As discussed in Chapters One and Two, it is important that the quality of qualitative research is considered systematically. The criteria defined by Elliott *et al.* (1999) were considered in relation to the design of the current study and the SURE (2012) criteria were used in the systematic review to evaluate the existing literature. Both will be employed to assess the methodological strengths and limitations of the present study.

4.1.4.1.   Design and Methodology

A clear strength of this study was the selection of a clear research question, specific population of interest and appropriate design with which to explore the chosen topic (SURE, 2012). A clear rationale for the research was identified by conducting a preliminary surface review of the existing, literature highlighting the limited amount of qualitative research in this area and the presence of only one qualitative study focusing on the population of clinical psychologists. Whilst a quantitative approach was considered, it was not felt appropriate to the aim for in-depth exploration of experience, and the limitations of a relatively small sample were outweighed by the detail demonstrated as important within this nuanced topic.

Fidelity to a clear and robust qualitative methodology of classic grounded theory (Ponterrotto, 2006) was also a strength of the study. Qualitative research, and grounded theory in particular, has long been criticised for "method slurring" (Gynnild, 2011; Evans, 2013), and Glaser (2003) notes that the various different applications of grounded theory are often contradictory to the original method. Maintaining a structured approach allows presentation of a clear and tested process to the reader, as well as facilitating replication of this study.

4.1.4.2. Recruitment and Sample

Theoretical sampling is a central tenet of classic grounded methodology (Breckenbridge & Jones, 2009), and a strength of the present study was ensuring that sampling was conducted in line with this approach. This allowed full exploration of the emerging categories, variables and theory to achieve data saturation. Unfortunately, this did ultimately rely on participant self-selection through response to recruitment emails. This is a limitation of the recruitment and sampling process as this may have allowed a bias in participants towards those who held a particularly strong opinion on the topic or a vested interest such as seeking reassurance regarding their own practice. Whilst this bias could lead to some distortion of the results, this does require counterbalancing with the value of selecting a sample able to discuss the topic in an informed and valuable way.

As recommended by Elliot *et al*., (1999), this study clearly situates the sample through the inclusion of key demographics in Table 2.1, whilst maintaining confidentiality through the use of pseudonyms and the removal of any identifying information within the quotes (Thompson & Russo, 2012). On reflection, following analysis, this could have been benefitted further by requesting participants to document how they align themselves therapeutically in order for the reader to consider this information in relation to the included quotes.

The sample size of 11 is an appropriate number for grounded theory research, which suggests that between eight and 24 participants are usually required to achieve data saturation (Evans, 2013). It is noted that data saturation is the benchmark by which appropriate sample size should be measured (Glaser, 2003) and that criterion was met within this study. Whilst the sample size was a strength of the research, a number of limitations are recognised when considering the sample further. Firstly, the sample was sourced from Wales alone and all of the participants were white and British. The transferability of results to other populations may therefore be limited (SURE, 2012). In particular, recruitment in Wales through contacts of the South Wales Doctoral Programme only may have produced a bias related to training

experiences given the high level of retention of Clinical Psychologists from this training course post-qualification. Whilst this study did report findings similar to those seen in previous research within the systematic review, the majority of these studies were also conducted in the UK and USA thus predominantly reflecting western experiences of psychological therapy settings. An under-representation of males was noted within the sample, despite attempts to recruit males through theoretical sampling. Whilst there is a gender ratio of 3:1 female to male within the population of qualified clinical psychologists, the ratio 10:1 female to male participants in this study demonstrates a significant underrepresentation of the male perspective. This is a particular weakness of this study given the importance noted of gender interactions on touch behaviour. Additionally, the mean number of years' experience of 13.5 years and the median of 11 years demonstrates that the sample is biased towards more experienced therapists. Similarly to seeking out male opinion, recently qualified clinical psychologists were sought out through theoretical sampling. As previously hypothesised, the propensity for experienced therapists to self-select for these studies may related to the occupation of the consolidation and confidence position, whereby these individuals are willing to openly discuss their practice. However, the perspective of individuals at earlier points in their qualified career would be valuable in improving the breadth of the grounded theory.

4.1.4.3.   Data Collection and Analysis

This study was conducted with clear consideration of maintaining high ethical standards, including addressing informed consent and maintaining confidentiality as demonstrated through the Cardiff University Ethical Review process. This is a marker of good quality research noted to be omitted by several of the studies examined within the systematic review (Tune, 2001; Pinson, 2002; Harrison, Jones & Huws, 2012).

The use of a clear semi-structured interview format developed through thoughtful collaboration with the research supervisor and modified following a pilot interview was a strength of the study, enhanced by the inclusion of the interview schedule

within the appendices to allow the reader to understand the content and direction of the interview (SURE, 2012). Smith *et al.,* (2009) suggests that the use of a semi-structured interview provides flexibility in the structure of the conversation whilst allowing both researcher and participant to focus on particular aspects of the topic that are of key interest. Continual modification of the interview schedule alongside theoretical sampling allowed for the collection of rich data to contribute to the emerging grounded theory.

Whilst there were many positive aspects regarding the data collection process, it is noted that the use of an interview with the researcher from the same profession as the participants may have been inhibitory with regard to participants expressing their true views and experiences of touch (SURE, 2012). This may be particularly true for this research topic, given the categories that became apparent demonstrating a sense of taboo and ambivalence about discussing touch in the therapeutic context. The depth and quality of the interviews may also have been affected because the one-off nature of the meetings may not have allowed for sufficient rapport to be built which may have enabled participants to open up regarding a predominantly private topic. Nonetheless, coherent results were produced (Elliot *et al.,* 1999) and the on-line focus group, in which participants were able to be anonymous even to the researcher, demonstrated that the results have both fit and grab (Baker, Wuest & Stern, 1992), markers of good quality qualitative research.

Another strength of the present study was the transparency regarding the data analysis process (Yardley, 2008). A detailed description of the transcription, coding, memo-ing and analysis process was provided in Chapter Two and was supplemented by various examples of each analysis stage within the appendices. This allows the reader to evaluate the methods used in the process of producing the grounded theory (SURE, 2012). Furthermore, the use of direct quotes chosen systematically in order to incorporate a selection of quotes from each participant as well as discrepant results allow the credibility and fit between the data and concepts or theory to be appraised (Elliot *et al.*, 1999) and the voices of participants to be privileged (SURE, 2012). Importantly, in contrast to various studies included in the systematic review (Harrison, Jones & Huws, 2012; Pinson, 2002; Tune, 2001), the

process of reaching data saturation was reported in line with good quality qualitative research guidelines (SURE, 2012).

4.1.4.4.   Ensuring Credibility

Credibility of the findings is a key marker of the quality of a qualitative study (Elliott *et al.,* 1999). The present study demonstrated strength in this area through use of a variety of techniques to ensure credibility. As outlined in Chapter Two, owning one's own perspective is a key procedure for enhancing credibility. The researcher attempted to explore this both in order to control for inherent bias within the analysis and to orientate the reader to their perspective (SURE, 2012). This was achieved initially through self-interview and production of a reflective statement (see section 2.6.2.2.1) and progressively throughout the process using a reflective diary and memos.

In line with quality frameworks proposed by Elliot *et al*., (1999) and SURE (2012), triangulation of the produced themes was conducted using various methods. Along with review in relation to existing literature, the emerging categories and theory were regularly discussed with the research supervisor and later with peer Trainee Clinical Psychologists in order to examine the logic and resonance of the theory with individuals who have experience working therapeutically in an adult mental health setting. Guion, Diehl and McDonald (2011) describe such processes as enhancing the validity of qualitative research. Thompson and Russo (2012) proposed that quality can be further enhanced by sharing and receiving feedback on the grounded theory with participants. In order to address this, the researcher facilitated an online focus group in which the analysis was discussed with attendees and comments were used to develop the grounded theory further. This focus group identified that the grounded theory and key categories resonated with participants, further demonstrating the reliability of the analysis. A particular strength of the on-line focus group was anonymity and the opportunity for group discussion. However it is recognised that the on-line setting removed the opportunity for face to face interaction which may have influenced the quality of conversation.

4.1.5. Recommendations for Future Research

Despite having been discussed for many years, empirical research regarding touch in therapy is limited in relation to both the amount and the quality of studies. In the first instance, the present study - along with others outlined in Chapter One - have identified the fact that touch is a complex and controversial topic that is still largely viewed as unclear and taboo within clinical psychology and the therapeutic community more widely. Thomas and Magilvy (2011) propose that the aim of qualitative research is to provide a starting point for research, by producing findings with the potential to be explored with a wider range of people in future. This study provides some interesting preliminary ideas, and as such the key recommendation is to continue exploring the phenomenon of touch in therapy with a view to dialogue regarding this issue becoming more open and commonplace.

Additional research into the decision-making process of clinical psychologists, driven with the developmental theory of progressing through to the stage of consolidation in mind, would be helpful in maximising the validity of this theory. In particular, investigation delineating experienced and inexperienced therapists or those who identify strongly with a particular therapeutic orientation would be helpful to help explore this influence further.

As noted previously, whilst there is a paucity of quality research regarding the topic of touch in adult mental health settings there is even greater neglect of this issue relating to other client groups and settings. The categories generated in the present study suggest that future research focusing on different clinical populations or settings - such as forensic or physical health care – would benefit from specific investigation.

A variable raised repeatedly in the current study was that of the initiation of touch and the importance of whether it is client or therapist initiated. This often appeared to be a confusing factor for participants when they were trying to articulate their approach, and therefore studies focusing specifically on either client or therapist initiated touch may be beneficial. Furthermore, the effects of touch are entirely

interpreted or assumed given that the present study and the majority of existing research has focused on therapists' experiences of touch. Further research is needed to consider the client perspective regarding experiences of touch in therapy, particularly in relation to the positive and negative functions that touch serves in the context of the therapeutic relationship.

The existing large scale quantitative research has taken a particularly exploratory view fixated on the frequency, rationale and barriers related to touch. In light of the results of the present study, future quantitative research could focus on the decision-making process and influential factors such as beliefs about therapeutic or social norms in order to further validate these findings. The systematic review demonstrated that the existing quantitative research also relied heavily on survey methodology. In order to reach a full understanding both of widespread patterns of touch behaviour and of related decision-making, a combination of large scale quantitative surveys and qualitative exploration is likely to be needed.

Given the universal nature of touch, it is recommended that the present study is replicated outside of Wales and the UK. This is particularly relevant with regard to this topic, as social and cultural norms, along with training experiences, appear to have a significant mediating effect on touch behaviour.

4.1.6. Conclusions

Touch has been demonstrated to have significant impact on human development (Bowlby, 1975; Montagu, 1986). However, there remains both significant opposition and advocacy regarding the use of touch within therapy settings (Phelan, 2009).

Paralleling existing literature, the findings of this study demonstrate that clinical psychologists perceive touch to be potentially very harmful or very helpful depending on the appropriateness of its use. The process used in assessing this appropriateness involves a cost-benefit analysis, taking into account several key variables including Individual Characteristics, Meaning of Touch and the Influence of Context. The dynamic nature of these variables means that - regardless of the thoughtfulness applied to the dilemma of facilitating or withholding touch - there remains a significant degree of ambiguity involved in the ultimate decision. It was evident that comfort in tolerating this ambiguity evolved over time, conceptualised as reaching a point of consolidation which reflected models of stage development previously described in arenas such as family therapy and supervision.

These findings support existing research in confirming touch as an important aspect of human behaviour that does occur in the therapeutic context. Furthermore, there remains a significant taboo regarding discussion of this topic within the therapeutic context, perhaps related to historical ideas proposed by early psychoanalytic therapists or to the modern proposal of touch as sexualised and associated with risk. This study supplements existing research by proposing a framework for the process of decision-making with regard to touch behaviour, and presenting a theoretical understanding of how therapists may reach a point of comfort in their own touch practice.

More research is needed to replicate these findings and to establish the generalisability of these results across different settings and contexts. However, these results provide a positive start in exploring the predominantly neglected issue

of touch in therapy. Ultimately, the aim of clinical psychologists and other therapists is to act in the best interest of the client and allow them to achieve the best outcomes possible. As demonstrated through the present study and related theory, touch can be extremely powerful and there is a need to approach its use with awareness and sensitivity. This can be achieved through encouraging an open dialogue and conscious decision-making by increasing transparency regarding this topic in training, supervision and research.

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Appendices

A. Breakdown of Systematic Review Process
B. Cardiff University School of Psychology Research Ethics Committee Approval
C. Participant Information Sheet
D. Informed Consent Form
E. Participant Demographic Sheet
F. Debriefing Sheet
G. Research Invitation to Participants
H. Initial Interview Schedule
I. Focus Group Transcript Extract
J. Example of Open Coding
K. Example of Concept Generation
L. Example of Category Generation
M. Example of Interview Specific Memos
N. Example of General Memos
O. Extract of Reflective Diary

Appendix A: Systematic Review Process

Literature search 31/03/15

What are clinicians views and experiences of touch in a therapeutic context?

((Therap* OR psycholog* OR psychother*)) AND (touch OR "physical contact")

Inclusion

- Published in peer reviewed journals
- Adult focus
- All study designs
- English language only
- Key words within title / abstract / key words
- Focus on touch within a psycho-therapeutic relationship

Exclusion

- Opinion / review articles
- Non-published or abstract only articles
- Physical health setting / focus
- Duplicate articles
- Not relevant to review question
- Not yet published in peer-reviewed journal (including dissertations, conference presentations, pre-publications, book chapters and 3rd sector research which has not been peer reviewed).

Databases

- COCHRANE REVIEW
  - 24
    - Minus non-peer review journals (0) = 19

- Minus irrelevant / physical health focus (19) = 5
  - Minus 'therapeutic touch' (2) = 3
    - Minus non-adult focus (3) = 0
      - Minus non-therapy settings (0) = **0**

- PUBMED
  - 322
    - Minus non-peer review journals (0) = 322
      - Minus irrelevant / duplicates (64) = 258
        - Minus 'therapeutic touch' (251) = 7
          - Minus non-adult focus (1) = 6
            - Minus non-therapy settings (2) = 4
              - Minus opinion/review (3) = 1
                - Minus group (1) = ***0***

- SCOPUS
  - 397
    - Minus non-peer review journals (12) = 385
      - Minus irrelevant / duplicates (203) = 182
        - Minus non English (12) = 170
          - Minus 'therapeutic touch' (164) = 6
            - Minus non-adult focus (1) = 5
              - Minus non-therapy settings (1) = 4
                - Minus opinion/review (4) = ***0***

- OVID (MEDLINE, PSYCINFO, AMED, PSYCHARTICLES)
  - 1463
    - Minus irrelevant / duplicates (210) = 1253
      - Minus 'therapeutic touch' (1199) = 54
        - Minus non-adult focus (20) = 34
          - Minus non-therapy settings (18) = 16
            - Minus opinion/review (14) = *2*

- WEB OF SCIENCE
  - 526

200

- Minus non-peer review journals (0) = 526
  - Minus irrelevant / duplicates (305) = 221
    - Minus 'therapeutic touch' (201) = 20
      - Minus non-adult focus (5) = 15
        - Minus non-therapy settings (4) = 11
          - Minus opinion/review (10) = 1
            - Minus patient focus (1) = *1*

- PROQUEST (ASSIA & SOCIOLOGICAL ABSTRACTS)
  - 64
    - Minus non-peer review journals (10) = 54
      - Minus irrelevant / duplicates (26) = 28
        - Minus 'therapeutic touch' (22) = 6
          - Minus non-adult focus (2) = 4
            - Minus non-therapy settings (1) =3
              - Minus opinion/review (1) = 2
                - Minus group (1) = 1
                - Minus client focus (1) = *0*

- CINAHL
  - 580
    - Minus non-peer review journals / duplicates (158) = 422
      - Minus irrelevant (155) = 267
        - Minus 'therapeutic touch' (255) = 12
          - Minus non-adult focus (2) = 10
            - Minus non-therapy settings (5) = 5
              - Minus opinion/review articles (2)= *3*

Appendix B: Cardiff University School of Psychology Research Ethics Committee Approval

Cardiff University Research Ethics Committee

RESEARCH PROPOSAL

LARGE SCALE RESEARCH - INITIAL PROPOSAL	
NAME	Laura Sheret (Trainee Clinical Psychologist)
CLINICAL SUPERVISOR	Mike Larner (Clinical Psychologist)
ACADEMIC SUPERVISOR	Professor Neil Frude (Research Director)
TITLE	'A Touchy Subject': Exploring Clinical Psychologists' Views and Experiences of Touch
BACKGROUND	This project developed from an interest based on the researcher's experiences of touch in clinical practice, and discussion of the topic between peers and colleagues. It appeared that use of touch within therapy is a debated – perhaps even controversial – issue. This sparked curiosity about what might influence such polarised views or choices regarding the experience and use of touch within therapy. A brief review of previous research identified that there is a paucity of literature exploring therapist views of touch in therapy; particularly qualitative literature looking at individual experience and employing inductive techniques. Several researchers have employed methods such as surveys and questionnaires to provide descriptive data of touch behaviour in therapists (Pope, Tabachnik & Spiegel, 1987; Stenzel & Rupert, 2004), whilst others have allowed some elaboration through broadening these methods to include rationale underlying touch behaviour (Milakovich, 1992; Clance & Petras, 1998). A recent study by Harrison, Jones & Huws (2012) undertook the first purely qualitative exploration of Clinical Psychologists view of touch in therapy using Interpretative Phenomenological Analysis. Their primary recommendation resulting from this research was that future research allows further

	exploration of therapists' views and experiences of touch in therapy. They proposed that this would allow recognition of this as an issue for therapists, communicate the ethical dilemmas involved and potentially have training implications.
AIMS AND OBJECTIVES	To develop inductive theory underlying clinical psychologists views on touch in therapy and the influences on these views. Hypotheses will not be developed at this stage, in order to follow procedure for qualitative research (Bowling, 1997).
CLINICAL RELEVANCE	Use of touch in therapy is a matter of controversy. The literature reflects both the healing potential of touch, and concern that touch can be harmful to clients (James, 2009; Strozier, Krizek & Sale, 2003). Westland (2011) highlights difficulties for therapists include confusion about the purpose of touch, its place within psychotherapy and potential negative consequences of implementing touch. Those advocating the use of touch suggest that its prohibition is as unacceptable as touch itself when this could exclude the opportunity for therapeutic progression (Sponitz, 1972). The available literature on this topic therefore demonstrates significant implications of the experience of touch for both clients and therapists. Exploring attitudes further will be beneficial in opening up a topic that in many ways has become 'taboo' (Stenzel & Rupert, 2004). This could be beneficial in validating therapist's anxieties, provide the platform for such issues to be discussed more regularly in supervision or affect future training regarding this topic.
THEORETICAL RELEVANCE	There is a lack of theory regarding touch in psychotherapy; the majority of research data has been presented descriptively only. Due to the data-driven rather than theory-driven ethos of Grounded Theory, this project will be influenced by and draw upon existing theories when interpreting the data

	rather than being led by them. However, it is important to acknowledge that there are a variety of theories and ideas that are likely to be of significance when exploring the area of touch. Physical and developmental explanations of touch are of key relevance; including the development of touch as a reciprocal sense, the bio-chemical response to touch and its use as a communicative method. Cultural ideas of touch have been explored in depth. The cultural reflexivity of touch, gender issues and sexualisation of touch are likely to be referenced within the study. Specific therapeutic orientations are inextricably linked to the idea of touch in therapy - for example the exclusion of touch within traditional psycho-analytical models – and previous studies have shown that the subscription of therapists to specific models is associated with propensity to touch (Milakovich, 1998). Transference and relational theories are particularly relevant in such cases (James, 2009). Studies on attachment present touch as a basic human need influencing factors such as the will to live (Harlow, 1958), ego development and and interpersonal skills (Glickauf-Hughs & Clance, 1998). In summary, there is a wealth of literature and relevant psychological theory surrounding touch / touch behaviour to draw on, which will aid in triangulating ideas developed through this research.
PLANS FOR LITERATURE SEARCH	A systematic review of the literature will be conducted. Key words in searches will be: touch, touch & therapy, touch + psychotherapy, therapeutic touch, physical contact, hug, erotic touch, non-erotic touch, tactile contact, psychologists + touch, therapists + touch.

	Literature sources will be: psychological, sociological, nursing and medical journals and databases.
	Traditional grounded theory approaches advocate for naivety to previous research findings prior to data collection in order to reduce bias and remain sensitive to themes emerging from the data. However, in order to be aware of the utility of this research and to provide background for an ethical proposal, it has been necessary to gain a basic understanding of existing literature as advocated by more modern approaches to grounded theory (Willig, 2001). However, the researcher has refrained from examining themes written up from qualitative data, and will include reflection on the literature review process in the write up. It is envisaged that a literature review will be conducted concurrently alongside interviewing participants, in order to use both emerging ideas from the data and existing theoretical or empirical information to shape the interviews (Strauss & Corbin, 2008).
METHODOLOGY	An interview schedule will be developed in collaboration with supervisors; who have extensive clinical experience within the relevant field.
	The ongoing methodology will take the form of one-stage semi-structured qualitative interviews following grounded theory methodology proposed by Strauss & Corbin (2008). It is expected that these interviews will take between 30 and 90 minutes.
	It is planned that a 30-60 minute focus group with clinical psychologists will be conducted following the qualitative analysis of interviews, in order to aid with triangulation of data.
SAMPLE (SIZE)	Up to 12 participants, though as per grounded theory methodology sample size will be dictated by when point of saturation appears to be reached (Strauss & Corbin, 2008).

SAMPLE – SOURCE	Grounded theory requires information to be obtained from a particular research population and this population must hold the information required. This project proposes recruitment of qualified Clinical Psychologists working within NHS Adult Mental Health settings within South Wales, recruited through email distribution lists held by the Cardiff DClinPsy programme.
INCLUSION CRITERIA	Qualified Clinical Psychologists who are have current HCPC registration and are working within an Adult Mental Health setting. No specific criteria within this population will be set initially, however theoretical sampling may take place following initially interviews as per grounded theory methodology.
EXCLUSION CRITERIA	None.
MEASURES - PSYCHOMETRIC	No psychometric measures will be employed. A semi-structured interview will be used.
MEASURES - QUESTIONNAIRE	Individual semi-structured interviews will enable a flexible approach to data collection in line with grounded theory methodology (Field & Morse 1985). An interview schedule will be developed informed by the available literature, the researcher's own experience and consultation with supervisors. The interview will be sufficiently structured, but allow deviation in order to explore and expand upon important emerging information. The structure will be amended regularly following information gained from previous interviews, though the core questions will remain constant.

EQUIPMENT / SOFTWARE	A reliable dictaphone will be required to record interviews.
	A computer and transcriber will be used to transcribe interviews.
	Qualitative data analysis software (NVivo 10) will be used to assist in analysis of the data.
	The researcher has access to all of the above.
PROCEDURE	Potential research participants will be identified on the basis of the inclusion/exclusion criteria, through the Psychology email distribution lists held by the Cardiff DClinPsy programme. Details of the study will be attached to the email as an Information Sheet along with an invitation to participate. It will be requested that interested participants reply to the researcher via email or telephone for further information and to arrange a meeting for the one- off interview.
	Interviews will take place as soon as possible after recruitment, at a time and place of convenience to the participant.
	At the meeting the researcher will reiterate the purpose of the interview and the role of the participant and will answer any questions they may have. Issues of confidentiality and consent will be discussed in detail to enable the participants to ask any questions. Individuals will be asked again whether they would like to participate and if so will be asked to indicate their consent to being interviewed and tape-recorded for the purposes of transcription. It will be explained that the recorded interview will be stored securely before being destroyed, and that no identifiable data will be transcribed to maintain confidentiality.
	Individuals will be interviewed by the researcher. Interviews will last for between 30 and 90 minutes;

	the interview will be tape recorded and then transcribed. Individuals who would like feedback from the study will be added to a list to obtain a research summary information sheet from the researcher on completion of the study. Participants can withdraw from the study of their own accord at any time.
PARTICIPANT INFORMATION SHEET	See attached sheet.
CONSENT FORM	See attached sheet.
PROPOSED METHOD OF ANALYSIS	Grounded Theory using NVivo 10 software. The aims of grounded theory are to develop inductive theory closely derived from the data, rather than deductive theory which is supported by hypothesis testing (Strauss & Corbin, 2008). This method is felt appropriate in this case to provide both an exploratory and explanatory account of therapist views of touch in therapy.
SERVICE USER INVOLVEMENT IN DESIGN	As this study is being conducted on clinical psychologists, the academic and clinical supervisors - both experienced clinical psychologists - will be consulted regarding the design of the study.
ETHICAL ISSUES	It is acknowledged that discussing experiences of touch could be emotive for some participants. Therefore care will be taken to ensure the well-being of participants by: ensuring that they are given informed consent and the option to stop at any time. If participants do become distressed during the interview, the interview can be stopped or postponed, depending on the participant's wishes. In the event of the researcher being concerned about the participant, the researcher will ensure that support is available from the clinical

| | supervisor, who will be available for advice and support.

The interviews may raise concerns about the welfare of service users or evidence of professional misconduct (as defined through HCPC standards). In the event of any such issues, the researcher would break confidentiality, according to the Public Interest Disclosure Act (1998) and would contact the relevant department. This will be clearly detailed in the information sheet and consent forms, and discussed with all participants. |
|---|---|
| **ANTICIPATED DIFFICULTIES & PITFALLS** | A lack of willing or suitable participants |
| **FALL-BACK OPTIONS** | If recruiting is becoming difficult, it would be possible to advertise the study in other geographical areas through contacts or via the internet. |
| **ADDITIONAL NOTES** | None. |

Appendix C: Participant Information Sheet

Participant Information Sheet

Title of Study: *'A Touchy Subject': Exploring Clinical Psychologists' Views and Experiences of Touch in Therapy*

Principal investigator: Laura Sheret, Trainee Clinical Psychologist.

Supervisors: Prof. Neil Frude, Consultant Clinical Psychologist / Mike Larner, Clinical Psychologist.

Contact details: Clinical Psychology Training, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT.

e-mail: laura.sheret@wales.nhs.uk / **telephone:** 029 2087 0582

We would like to invite you to take part in this research study to find out about Clinical Psychologist's view and experiences of touch in therapeutic work within adult services. This study aims to find out what factors influence such views, and how they mediate the experience of touch in therapy.

To help you decide whether you want to take part in the study there is more information below about why the research is being done and what it will involve. Please take some time to read through and discuss with others if you wish. If you have any questions, please contact us through the details above.

Thank you for reading the information and your interest in the study.

What the study is about

This project developed from an interest based on the researcher's experiences of touch in clinical practice, and discussion of the topic between peers and colleagues. It appeared that the use of touch within therapy is a much debated issue. This

sparked curiosity about what might influence choices or views regarding the use of touch within therapy.

Few studies have examined therapists' views of touch; although it is clear that an understanding of this could have significant implication for practice, training and supervision.

This study will employ a grounded theory approach, and will attempt to construct a theory of touch in therapeutic contexts based on the data collected in a number of interviews with clinical psychologists working in the adult field.

Why I have been chosen?

This research is considering the views of HCPC registered Clinical Psychologists currently working within adult settings. You have been identified within this group based on the email distribution list held by the South Wales DClinPsy course.

Do I have to take part?

No –participation is entirely voluntary, and can also be stopped at any time during the interview. You can also withdraw your participation any time prior to the transcript being typed and audio file deleted, at which point the data becomes anonymous.

What will happen?

If you decide to take part, the researcher will arrange a time and place of convenience to you to conduct the interview. If you prefer, it may be possible to arrange for the interview to be conducted by telephone, although this is not preferred. We would ask that your participation in the study takes place outside of your work time (e.g. in a lunch break or before/after work). This is because studies that use NHS resources (including professionals' time) need to be approved through NHS channels. This study has been approved through the Ethics committee of the School of Psychology within Cardiff University.

At the beginning of the interview, the researcher will take you through the information sheet and – if you are happy – will ask you to sign a consent form (in the case of arranged telephone interviews, this information will be sent to you in advance). You will also be asked for minimal demographic information, though this information will be kept securely and anonymous.

The interview will ask you to speak about your views and experience of touch in therapy, and may also consider touch in other areas of your life. The interview will take between approximately 30 and 60 minutes, and will be audio recorded.

The potential benefits and disadvantages of taking part

There are no direct benefits for you of taking part in this study although we hope that you will find it interesting to think about your own views and experiences of touch, and how this impacts on your clinical work. We hope that the study as a whole will provide information that will inform further discussion that may influence training and supervision practices.

If discussing these issues becomes distressing for you at any time, we will pause the interview and ask you whether your wish to continue or to end at that point. We will also ask whether you need any extra support.

Will what I said be kept confidential?

If you take part in the interview, all of the information that you provide will be kept confidential. The consent form containing your name will be kept in a locked filing cabinet within the offices of the South Wales D.Clin.Psy. training programme. All other information will be marked by a number identifiable only to the researcher.

Confidentiality would only be broken if you disclosed information suggesting that someone was at risk of harm, or implied professional misconduct as defined by HCPC standards. In this case, the researcher would discuss this with you further and also consult the research supervisors. In some circumstances it may also be required to consult professionals or agencies regarding any concerns.

The audio recording of your interview will be stored on an encrypted memory stick accessible only to the researcher. The interview will be typed up within a month, after

which then the recording will be deleted. All computer files will be password protected and only accessible by the lead researcher and her two supervisors listed below. You can ask for your interview to be withdrawn from the research up until the audio file has been deleted, as the typed up interview will not contain your name. No original names will be used in the typed up interviews and any quotes used will contain pseudonyms.

What will happen to the results of the study?

The results of this study will be written up as the thesis relating to Laura Sheret's D.Clin.Psy. qualification. They may also be written up and published in the future. Small quotes from some interviews might be used to illustrate points, but a pseudonym will be used to protect your identity. No information that could identify individuals will be included.

If you wish to have information about the results of the study please let Laura Sheret know and she will send you a summary of the results as soon as they are available.

Who is sponsoring the research?

Cardiff University is sponsoring the research.

Who has said that the study is OK to go ahead?

The research study has been reviewed and approved by the School of Psychology Research

Ethics Committee at Cardiff University. If you have any concerns or complaints about the

research you can contact the School of Psychology Research Ethics Committee by writing to:

Secretary to the Research Ethics Committee

School of Psychology

Tower Building

70 Park Place

Cardiff

CF10 3AT

psychethics@cardiff.ac.uk

If you have any further questions about the research please do get in touch. Thank you for taking the time to read this information sheet.

<u>Participant Consent Form</u>

Title of Study: *'A Touchy Subject': Exploring Clinical Psychologists' Views and Experiences of Touch in Therapy*

Principal investigator: Laura Sheret, Trainee Clinical Psychologist.

Supervisors: Prof. Neil Frude, Consultant Clinical Psychologist / Mike Larner, Clinical Psychologist.

1. I understand that my participation in this project will involve answering some questions about my views and experiences of touch in therapy, that will last between 30 and 60 minutes. ☐

2. I have read and understood the information sheet and have been able to ask any questions I have. ☐

3. I understand that participation in this study is entirely voluntary and that I can withdraw from the study at any time without giving a reason. ☐

4. I understand that I am free to ask any questions at any time. I can discuss any concerns with Mike Larner, Prof. Neil Frude or the University Ethics Committee. ☐

5. I understand that the information provided by me will be kept securely and confidentially. I understand that this information will be held no longer than necessary for the purposes of this research. ☐

6. I understand that the interview will be audio recorded and transcribed, and that the audio recording will be destroyed upon transcription. The transcript will be held anonymously, using pseudonyms, so that it is impossible to trace this information back to me individually.

☐

7. I understand that any quotes used from my interview included in the research will be kept anonymous with personal information changed where necessary to make sure this is achieved.

☐

8. I understand that the researcher will share information with their clinical supervisor if they are worried that there is the possibility of risk or harm to myself or someone else.

☐

9. I understand that if I feel distressed during the study that I discuss avenues for gaining extra support with the researcher.

☐

10. I also understand that at the end of the study I will be provided with additional information and feedback about the purpose of the study.

☐

11. I agree to take part in the above study.

☐

I, _____(NAME) consent to participate in the study

conducted by Laura Sheret (School of Psychology, Cardiff University) under the supervision of Prof. Neil Frude and Mike Larner.

Signed: **Date:**

Appendix E: Participant Demographic Sheet

<u>Participant Data Sheet</u>

Participant # …………………………………………….............................

Gender ……………………………………………….............................

Age…………………………………………….....................................

Number of years qualified…………………………..................................

Current speciality (e.g. AMH, forensic, health)……………….......................

Appendix F: Debriefing Information

Debriefing Information

Title of Study: *'A Touchy Subject': Exploring Clinical Psychologists' Views and Experiences of Touch in Therapy*

Thank you for taking the time to participate in this study. The information that you have provided in your interview will be put together and analysed with the other interviews collected for this research. We hope that the results from this study will help us to understand more about what influences the use of touch in therapy; which could have beneficial impacts on Clinical Psychology training, supervision and the experience of service users.

The consent form that you signed will be kept in a locked filing cabinet in the Clinical Psychology Department at Cardiff University, only accessible by the researchers. The audio recording will be transcribed and then destroyed. Your general information sheet and typed up interview will be anonymised. You can withdraw your participation until the interview is typed and anonymised.

If you wish to have information about the results of the study, please let Laura Sheret know and she will send you a summary of the results as soon as they are available. Should you have any further questions, or have experienced any distress as a result of this interview, please do contact us on the details below.

Principal investigator: Laura Sheret, Trainee Clinical Psychologist.

Supervisors: Prof. Neil Frude, Consultant Clinical Psychologist / Mike Larner, Clinical Psychologist.

Contact details: Clinical Psychology Training, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT.   **e-mail:** laura.sheret@wales.nhs.uk   **telephone:** 02920 870582

Dear Clinical Psychologist,

My name is Laura Sheret and I am a Trainee Clinical Psychologist completing my second year of the DClinPsy at Cardiff University.

I am in the process of conducting research for my doctoral thesis, and I am writing to you in the hope that you may be willing to participate.

The study focuses on Clinical Psychologists' experiences of and attitudes towards touch; particularly within the therapy context. I became interested in this idea as the topic of touch in therapy seems to regularly generate interesting debate, and I hope to explore this in more detail.

Participating in this research would involve approximately one hour of your time to be interviewed in a semi-structured format, which will then be analysed using qualitative methods. Due to restrictions on Research and Development within certain health boards, I would have to request that this be an hour of your time outside of your normal working day. However, I am happy to attend a time and place of most convenience to you to conduct the interview.

I recognise that in the current climate your time is stretched and that participating in additional work can be difficult. I would be extremely grateful if you were able to take part, as I hope that the outcomes of this study will be of interest to the profession.

If you are interested in being involved in this research or would like any further details please contact me on the details below.

Many Thanks,

Laura Sheret

Trainee Clinical Psychologist

Cardiff and Vale University Health Board

laura.sheret@wales.nhs.uk

07515 123587

Appendix H: Initial Interview Schedule

Interview Schedule Feb 2015

EXPERIENCES

- Can you tell me about whether and how the issue of touch in therapy came up during your training as a Clinical Psychologist?
- Can you tell me about some experiences that immediately come to mind about giving or receiving touch during therapy?

CLIENT / CONTEXT CHARACTERISTICS

- How much do you think the context – such as why or where you are seeing that person- affects your approach to touch?
- What client characteristics affect your decision whether to give or accept touch?
    o Why do you think this is?
- In what circumstances do you think you would be most likely to touch?
- " " least likely?
- Does the choice in reacting to a client initiated touch feel different to the choice in whether to initiate touch yourself?
- What do you think would be your main worries about giving or accepting touch in a therapy context?
    o Impact on client? (If so, what kind of impact?)
    o Being misjudged and affection professionality?

INFLUENCES

- How do you think supervisors or peers have influenced your views and approaches to touch?
- What models would you say predominantly inform your work and in what ways do you think these influence approach to touch?
    o How much do you understand about what other models might say about touch?

<u>TOUCH MEANING</u>

- How much thought goes into whether you give or accept touch with patients?
- What does touch provide that words don't? What is its function?
- If a client is quite unboundaried in their approach to touch how might that affect your response?
- Do you think there are clear 'safe' touching and clear 'unsafe' touching with a grey area in between?
- Do you think there is a strong sense of responsibility on the therapist to make the 'right' choice about touch, whereas in the real world it is more balanced?
- What do you see as the main similarities between general societal norms about touch and norms about touch in therapy?
- Is there a sense that withholding touch is the easy option?
- Have you experienced times when you have felt the urge to touch but have not done so? If so, why is this?
  - Do you think there is something important in conveying that urge to touch (even if not doing so) and if so why?
  - Have you found away to separate out what is your 'stuff' and what is the client's 'stuff'?
- How do you balance what you are comfortable with against what is in the best interest of the client?

<u>IDENTITY</u>

- What does providing touch say about the therapist?
  - What might you guess about someone's approach as a psychologist based on how they approach touch??
  - Does this link to other personal choices in therapy e.g. self disclosure? Dress code? Etc.
    - Is touch less openly discussed than these other things?
- Conversely, what does withholding touch say?
- How does your approach to touch fit in with the rest of your identity or approach as a therapist / psychologist?
- Do you think it is important to have an identity as a psychologist and a clear sense of where you stand on issues such as touch in therapy?
- Do you see your approach as something that is changeable or is it something that is more fixed?
- Has your approach to touch changed over time?

- How do you think being newly qualified affects your approach to touch?
  - Why do you think this is?
  - Do you think it is something that is likely to change with experience?

CP IDENTITY

- What is your understanding of what clinical psychology as a profession has to say about touch?
  - Where has this understanding come from? Explicit or implied?
  - Have you got an idea of why it is that clinical psychology has adopted that kind of position?
- Do you think clients already come to therapy with a sense of how a psychologist is likely to behave, and does this include touch?
- Do you think there being a lack of clear guidance means those choices are more genuine than if something was laid out more clearly??
- Do you have concerns about what others might think about your approach? Have you ever worried about this?
- How present is the idea of professional guidelines / potential for being seen as stepping outside of these?

PERSONAL

- Do you think the way you approach touch outside of work (e.g. being a 'tactile' person or not) seeps into work? Or do you prefer to have very separate personal and professional selves?
- Have you had any personal experiences that have affected your views on touch? For example some people have spoken about experiences they have had in personal therapy or those family members/friends have spoken about?

Some people have said that "if touch is withheld from clients for whom it could be healing, helpful or therapeutic then it is unethical to do so". Others have stated that all touch in the therapeutic context is unhelpful and only in the interest of the therapist (paraphrased). What are your views on these positions?

Appendix I: Focus Group Transcript Extract

olive: I wanted to know what everyone else said because I'm not sure it's something that's been discussed for a while, probably most discussed during training and the odd occasion when it's felt uncomfortable   hello: It was interesting for me to think about why I do or don't in different situations - I don't usually analyse myself so deeply. I did wonder whether my responses were similar or different to the other therapists you interviewed...   olive: I'm not sure if it's in the research....but would be interested to know what the difference is between diff theoretical backgrounds LauraS: That curiosity about what others do is really interesting and I think came out in the interviews, it is something we really don't know a lot about other psychologists' touch behaviour   hello: Yes, and level of clinical experience and gender too. I'll look forward to reading it properly and finding out more   LauraS: There was certainly some mention of theoretical backgrounds yes. Mainly the more 'extreme' ends (psychodynamic perceived as no touch, gestalt perceived as lots of touch) with more grey area for other models in between   olive: I know when I had my psychodynamic teaching on training, touch and any sort of self-disclosure was forbidden and I still remember that teaching very clearly as it was very prescriptive.   LauraS: A brief summary was that there were three key areas: individual characteristics (the client, the therapist, the relationship), function of touch (purpose, motivation, possible consequences) & influence of context   LauraS: The core variable tying those three together was the process of 'cost benefit analysis' so weighing up all those things in deciding whether the potential cost of touching or not touching was worth the potential benefit   LauraS: And the grounded theory referenced a process of becoming more comfortable with the tolerance of ambiguity in that decision making process. Experience was certainly a key part of that.   olive: And I guess that weighing up has very little time to happen in mostly...doods: back now   hello: Makes sense. No wonder we're tired at the end of a day, with all that cost benefit analysis going on!   olive: So yes...experience allows the thinking/weighing up to happen more quickly   LauraS: Absolutely. It's often on the spot decision making!   doods: I

guess with expereince you may get quicker at making those decisions?   LauraS: Haha yes, we are earning our keep even when we don't realise �   olive: ☺
LauraS: Yes I think you're right, it seems to come with a bit more ease over time and experience   doods: There was mention of a weighing up of different variable and one of those bing the client v the therapist need. I wonder if therapists would be as open about it being their need to touch, or where that is a further taboo?   LauraS: Some of you mentioned it being unusual to have that conversation about touch. Has it led to you having any other conversations about touch or noticing anything different in your practice?   LauraS: Ah yes doods that was an interesting one   LauraS: It certainly seemed to be acknowledged but the process of resolving that question not clear   doods: Following your research I did a couple of talks on boundaries in 2 different groups of psychologists. I was suprised by the varied responses   LauraS: Did that struggle resonate with you all or did considering therapist need feel a bit unusual?   LauraS: Oh that's interesting doods. What particularly surprised you?
olive: I spoke to a few others and mostly felt that others where along the same lines as me   hello: I think I'm perhaps more aware of it now, since my research interview. And I thought of it last weekend when I held my elderly uncle's hand in hospital (he was ill, not me). It just seemed like the most natural thing to do - and maybe it wa
olive: It's popped into my head from time to time....I'm not sure my practice has changed but awareness level has been greater   hello: I definitely wouldn't have considered my own need for touch before   olive: I've ended therapy with quite a few clients recently, a couple of whom have really held on in the hug at the end. The research definitely popped up then   LauraS: Those are really interesting reflections, particularly how it has been more in your awareness recently. One of my hopes is that this kind of research opens up a dialogue so that seems like a really good start
doods: The cross specialty group were far more guarded (LD/OA/AMH) and avoidant of discussing it/said they would not cross boundaries. The surpise was the trainees in the group were far more open and at ease with saying they felt okay about the di
olive: I suppose I've noticed a need to perhaps offer the client something and have said, 'I feel like giving you a hug' but generally save more touch for an ending.

Appendix J: Example of Open Coding

Bryony: As I have become more experienced I think. And I think in the first year after qualifying I was trying to make sense to myself what messages I had come away from training with, um, and particularly therapeutic wise. So you know self disclosure wasn't a good thing, and touch wasn't a good thing; so coming away from training feeling like I had these strong ideas of what you are not meant to do. But actually sometimes it's been an intuitive or instinctive thing that has felt like the right thing to do. And when I am talking about touch now I mean even just to put my hand on somebody when they're distressed and just rub their arm or something, or to put my hand on somebody's shoulder.

Actually I just thought of another example. There was a case in my elective placement where I did half CAT training half psychodynamic placement, and in my psychodynamic placement I said to my supervisor that as the client was leaving I put my hand on her shoulder because she had been really distressed. And that was a conversation actually, and from a psychodynamic perspective was how you complicate somebody. So if that person has any anger to express which is a perfectly normal thing to do as well towards me then I may have placated her by putting my hand on her shoulder. It was in the room and she was actually leaving the building, she had two sticks and I was holding the door open for her and she just looked so, like, sad... and I just squeezed her shoulder I think just to... and said see you next time just as a warm thing. But it had been a conversation about that touch.

Researcher: Ok, that's really interesting. So where you are at not, are there any particular models you subscribe to and whether that has influenced how you use touch where you are at now?

Bryony: At the moment the predominant models I work in are DBT and EMDR, and both of those models I would say DBT it's more that it's ok to self disclose and ok to be human with people, so when somebody is distressed it would be ok to put your arm on somebody to help... if somebody is distressed it would be an ok thing to do because it's a human thing to do. Um, and EMDR you are sitting exceptionally close to somebody so knee to knee with somebody but just to the side of them, and you know some people regularly have huge responses of strong distress and... I would say most people that I, I can think of three cases, when I have been doing EMDR and in the height of distress when somebody is actually sobbing I have put my hand on them and rubbed their arm and just said 'it's ok it's ok'.
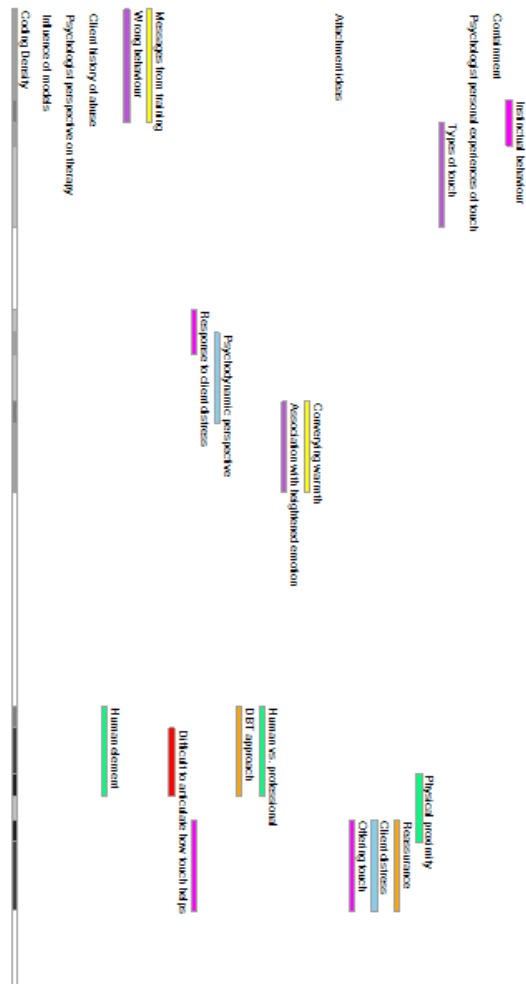
Researcher: And do you use the tapping in EMDR anyway, so there's already...

Bryony: Yeh there's already an element of touch that has happened.

Researcher: And is there anything that you think about when you do that, so the kind of function of the hand on the hand or the shoulder?
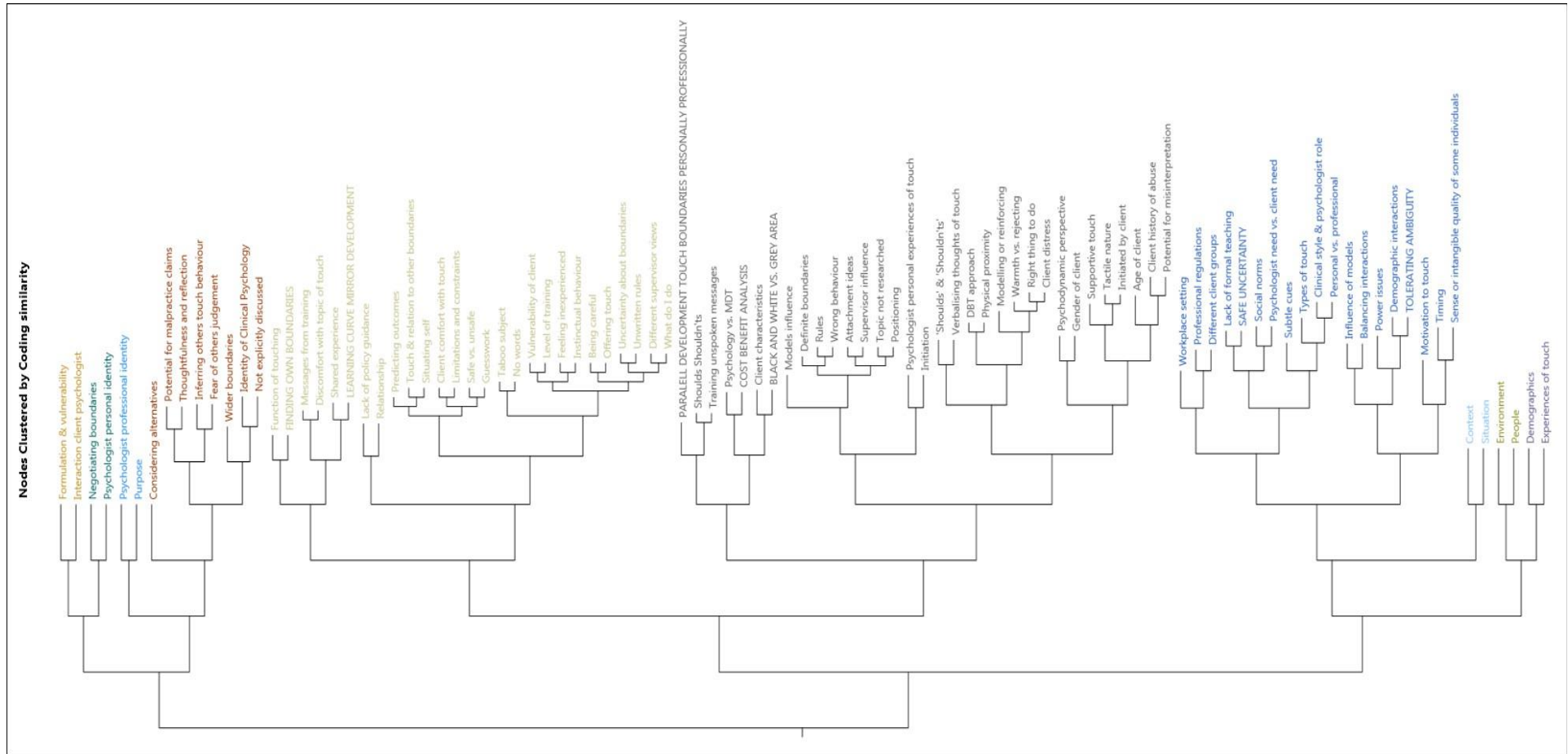
Bryony: I think that... often I think - and this is my personal perspective, well probably influence by psychological models – I think that when somebody comes to therapy and they're working on childhood trauma it is often that child that is the person in distress, their inner child, that is being comforted. And if a child was in distress the human natural response would be to try and soothe. And yeh offer some sort of containment and... I can't think of my words!

Researcher: No these are great words, so some soothing and a human reaction that's a really interesting way to put it.

Bryony: And in the context of having therapy myself as well, and my therapist did that to me as well which also I think might have been a point where I think that it was ok. So I was distressed, I actually used to go to her house for therapy and I was really distressed once and she put a little blanket over me and got me to curl up on her sofa , and she was rubbing my foot I think. She was from an attachment... she was a child psychologist previously and worked in family therapy and I think her thing behind that was about reparenting and containing the inner child and that was an ok thing to do. And it didn't feel to me in a place where I was distressed... it felt like the right thing, and we talked about it it wasn't like a feature of our every session or anything.
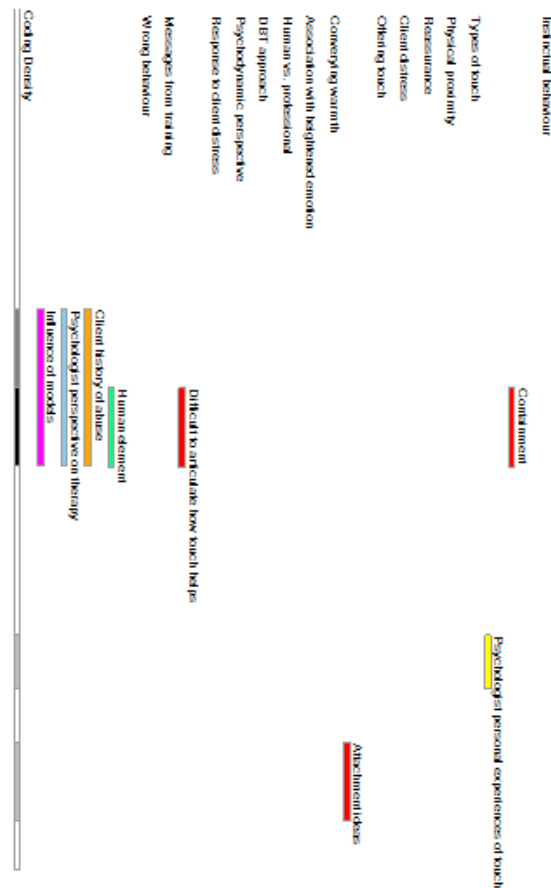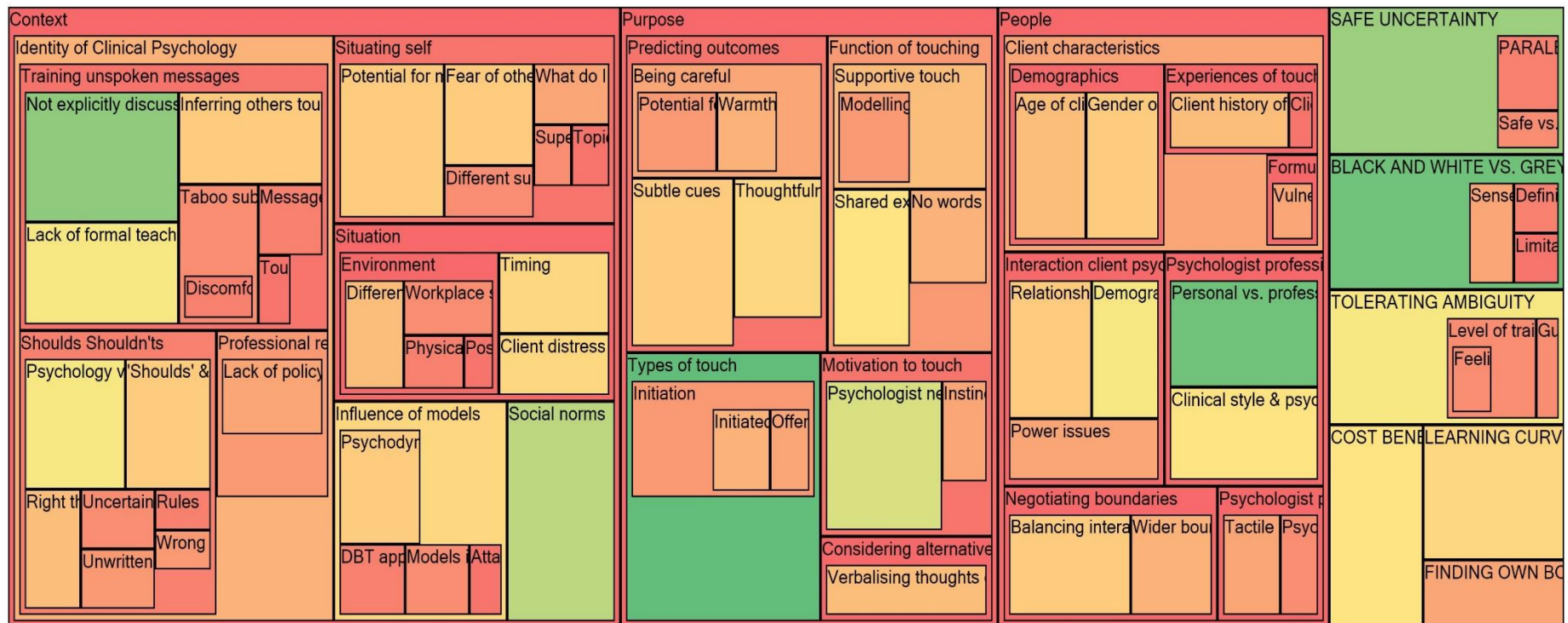
Appendix K: Example of Concept Generation

Nodes compared by number of items coded

Appendix M: Example of Interview Specific Memo

- Attitude / approach generally 'coming across' rather than being explicitly portrayed (embedded in their overall style)
- Again idea of newly qualified / less experienced = more reliant on instinct. Does this suggest that it is ultimately experience that drives conscious decisions re. touch?
  - o Perhaps more coherent understanding of who they are as psychologists?
  - o Less focus on rules (what you don't do) than what you can do
  - o Less clear definitives what is a good thing versus what is a bad thing
- **MORE CERTAINTY OF WHAT IS RIGHT? OR MORE OPEN TO THERE BEING MULTIPLE 'RIGHTS'???? (Safe uncertainty developing with experience??)**
- Different voices of instruction – us saying what we want/is ok, the model we use saying what is desired/ok, the profession saying what is desired/ok, society saying what is desired/ok.
- Embracing instinct vs. fighting instinct. Taking on board advice & other viewpoints whilst maintaining a sense of who you are – not sacrificing what you thing is important.
- **Balancing** my need versus their need…
- **PROBLEM – working out is what I am doing the right thing? Or justifying conclusions that have been arrived at? Articulating the process?** *When do I use touch and when don't I??*
- **Touch as supplementing what we can offer verbally;** sometimes even difficult to express what it is that touch does verbally?
- ??Shaming?? Fear of being disapproved of? Worries about what others will think of practice leads to lack of discussion which leads to more unknowns, more fear of shaming..?
- Some sense that being warm and not being tactile could be mutually exclusive..
- Policies always likely to err on the side of caution.. better safe than sorryConsideration of long term consequences not just immediate effect or response.
- Questioning the narratives e.g. shouldn't touch those who are abused.
- Considering societal and cultural norms – touch between men and women of a similar for example = sexual, why should this be any different for clinical practice?
- Need for authenticity > don't do something out of comfort zone.
- Duck on pond – looking calm on surface and frantically paddling underneath!
- Something about touch as being given the outlet to share distress (idea of hugging someone who looks upset > crying).
  - o Letting out emotion versus stifling it? Times touch seems to open the floodgates and times it seems to be used to placate and calm.

[Interesting observation of the interviewee keen to find out my stance and fear of my judgement – similar to previous interview]

Appendix N: Example of General Memos

20th November 2014

Discussion with family around touch. Comments around who 'is touchy' and who isn't. People keen to bracket themselves as one or the other and defend that. Seen as a trait that says something about who you are? Unchangeable?

11th Jan 2015

Professional / personal identity a core variable???

19th Jan 2015

Touch as a tool – something very clear about when we give or withhold it. When angry with someone we avoid any kind of touch, make it clear that we have withdrawn our 'warmth'. When we want to make up touch can often be the way of reaching out, making that initial gesture. Does something different / perhaps more than words? Family discussion about differences between us – seemed to be a sense that being tactile comes from 'somewhere' and also different 'camps' (touchers vs. non-touchers). More discussion with partner about touch = more touch?! Perhaps more acceptance of it having spoken about it, and also conscious awareness of its importance in different situation.

2nd February 2015

Colleagues / peers spontaneously raising issues of touch saying "I thought of you and your research.." ?not usually any other 'outlet' for this? Almost everyone saying "that's really interesting.." or having a relevant story. Most people saying it isn't something they think about a lot, but actually like to think about.

Newspaper stories re. how we "should" be giving more touch to our children. Move away from the 'let them cry' approach to parenting. Making people question whether their own practice is right?

8th February 2015

Media coverage of historical sexual abuse by people in power – lots of discussion about what is deemed acceptable at one time can change and people be held accountable for harm they have caused at a later date (claim and blame culture?)

Talking about touch makes it more ok? Reflection on interview - me & the interviewee hugged at the end. Perhaps would have felt out of context / strange had we not just been discussing it?

Appendix O: Extract of Reflective Diary

13th November 2014

Feeling enthused by a great response from recruitment email. Previously had been worrying whether this was a 'good enough' project – was it clear enough? I think stemming from the 'systematic review' day and struggling to articulate a description of the project at times when asked. Though always feeling enthusiastic about the topic myself, I often find myself thinking ahead to the viva and what might be criticised. Big worry is whether it is different enough to the other paper on this. Also finding it difficult to turn people down for interview!! Worries about what they might think having offered their time, questioning how I should select the initial participants. Feeling generally excited about doing the interviews, though a little nervous they will 'fall flat' & people won't know what to say!!

17th December 2014

Have enjoyed completing some interviews. Participants seem interested. Some worries I won't have a clear 'answer' at the end of this study – which is making me question what is driving that for me? Was that a motivator in undertaking this project, to get some certainty about what 'should' be done (& is that affecting me viewing of this theme of "shoulds" in the data)?! Also feeling as though quite a few expected themes have come up and wondering if I my analysis is biasing in such a direction. Yet equally interested in the variability of opinion in different participants. Feeling reluctant to start pinning down themes, perhaps due to not feeling as though I am effectively setting aside (or recognising) my own position..

Noticing the language I am using in my themes… e.g. informal phrases such as 'touchy-feely' rather than tactile. Perhaps a reflection of my own sense of this as an everyday / human thing and a wish to take it away from the unspoken / hidden phenomenon realm. Also representative of my own style as a therapist. Similarly language reminiscent of that used within relational therapies / attachment literature.

3rd January 2015

I am considering my own interest in touch and my interest in it both inside & outside a clinical psychology context. Conducting this research has opened up conversation with others in my personal life, & I have become more aware of how much I do touch and the value I place on this in enhancing my close relationships. I have begun to analyse my own use of touch and consider it in the context of themes arising from the research – why do I touch in this situation and not another? What am I basing this decision on? One key thing I have noticed is how much even in a personal context emphasis for me is placed on how the other will receive the touch, & how little concrete information this is based on (often relying on body language, observation of them with others or almost immediate analysis of whether they are that 'type' or not!). In often just seconds many implicit questions are asked, yet often not particularly consciously. I have enjoyed thinking about this more, and for some

reason feel that it has shifted me to employ touch more rather than less. I wonder if this suggests I am coming down on one side of the argument more than the other – taking on ideas around the potential benefit of touch rather than potential harm. I have also noticed myself more drawn and akin to participants who identify themselves as 'touchy-feely'; again perhaps highlighting both more value seen in this approach (& indicating a warm personality??) and also suggesting another possible consequence of the characteristic of 'tactile' vs. 'not tactile' – being in a group / sharing in something??

11th Jan 2015

Considering choice to take a classic GT approach. Does this truly fit with my general ontological stance? What is it about the approach that has appealed? I like the freedom, flexibility and focus on the participant experience and starting with the data. But am less comfortable with the idea of generating explanatory theory and this being perceived as 'truth'. Seeing no other LSRP's on ORCA using this approach has both made me doubt myself and feel passionate about forging my own path here!!

19th Jan 2015

Transcribing and am suddenly struck with how the content of this project has changed so much from what I initially expected. It quickly moved away from the pragmatic/concrete (e.g. how does age and gender affect touch behaviour) to more abstract ideas about identity and meaning of touch. I wonder have I lost the sense of direction, or is it that the interviews have pulled me down a path I didn't expect? Is this the usual process of grounded theory that you quickly start to become more abstract? I feel a sense of hope and relief that perhaps the unexpected direction suggests I have been true to the data and guided by it. Though there's a nagging worry that I have been seduced by certain pathways and forgotten to analyse the more practical aspects.