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When Touch is Required: From the practice of the psychologist using the body-oriented method[1]

Els Plooij[2]

Abstract

In addition to interventions directed towards the cognition and behaviour of the client, the body-oriented psychologist uses body-focused interventions to help the client experience who he is and how he relates to others and the world. The client is guided in his/her development from there on, on an experiential basis. These interventions span a wide spectrum, including focusing verbal attention to the 'felt body', meditation exercises, movement-oriented exercises, working through past experiences in guided structures and different ways of therapeutic touching. In 'When Touch is Required' the author gives a literature review of touching as a psychological intervention. Indications and contra-indications as well as guidelines are given. The case study illustrates how and when touch is required in addition to verbal therapy.

Key words: haptonomy, haptotherapy, touch, body-oriented method

Introduction

Why would a psychologist touch a client? Is talking not enough? Els Plooij researches these questions based on the literature on touch in psychotherapy and her experience working as a body-oriented psychologist. Various categories of touch, indications, contraindications and guidelines are discussed. A case study illustrates in her opinion the requirement of touch.

Casus Marianne (part 1)

Marianne (47) has a congenital disease. This disease has caused her to be exceptionally small, have extremely limited eyesight and she wears glasses with a very strong prescription. She underwent jaw and chin reconstruction surgery because of a serious sleep apnoea. Her hair is very thin and so she wears a wig. She was bullied regularly as a child. Her parents gave her a great deal of concrete attention and stimulated her to persevere, but there was no room for emotions. She compensated for her insecurity by studying hard, which resulted in her many accomplishments. She works as a lawyer, has her own house, but still spends a great deal of time with her parents.

When Marianne had her life in order with regard to work and living arrangements, she decided to work on herself, motivated by her desire for a relationship. In the past six years she has worked on many issues with a cognitive behavioural therapist: her extreme adaptation to others' expectations, her low self-confidence, always being busy with what has to be done, her severity for herself and others, her lack of affective communication with others and her sexuality.

This psychologist-sexologist referred her to me. Through her therapy, Marianne now knew cognitively and behaviourally how to make contact with others but it was primarily a question of 'doing' and she experienced little emotion in the process. She suffered from loneliness. She needed to get acquainted with affectivity, with feeling, in order to add quality to her life and relationships. This could not be achieved solely by talking. Here, touch was required.

In psychology, it is a well known fact that mind and body are interconnected and mutually influential. In the Netherlands, psychologists whose work centres on this fact have primarily used methods from non-academic education since the nineteen-seventies, methods such as bioenergetics, gestalt therapy, haptotherapy, Pesso Boyden therapy, drama therapy and integrative movement therapy. Following a major congress on *The Body in Psychology*, (Dijkhuis,1999) and a great deal of persuasion, these psychologists earned their place within the Dutch Association of Psychologists (NIP) in 2003 as the Department of Body-oriented Psychologists

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[2] Els Plooij (MSc) is a psychologist registered in the Department of Body Oriented Psychologists of the Dutch Association of Psychologists and a Haptotherapist registered with the Dutch Association of Haptotherapists. She has her practice in Utrecht, The Netherlands. Email:elsplooij@gmail.com.

(lwp). What formerly was considered to be 'alternative' and placed outside the realm of psychology was now included within the academic world of the professional association of psychologists. This brought recognition to the field along with the need to bring scientific substance to the body-oriented methods.

This group formulated its Professional Standard, including a part on touch as intervention, mentioning among other things: '(...) this touch is different from 'normal' touch, in the sense that it is touch within a therapeutic relationship. This causes an unequal balance of power between client and therapist, whereby the latter can be held responsible for this touch. (...) Touch as intervention, then, must fit into the client's therapeutic process and the skills that he has...' (Source: www.psynip.nl,january 2014)

A registration system for healthcare psychologists who practise body-oriented therapy was initiated. Educational training programmes were accredited and admission requirements were formulated. The registration system became a fact in 2010 and has 90 members, of whom the details of their practice can be found on www.psynip.nl. Since its inception the Department of Body-oriented Psychologists is very active and is steadily growing, from 349 members in 2003 to 729 members in 2014. The department believes it is important to increase the body of knowledge on body-oriented therapy through publications and research. Neuroscientists and trauma experts are paying increasing attention to the central role the body plays in psychological processes. Seminars organized by the Department of Body Oriented Psychologists attract hundreds of psychologists from all disciplines.

The psychologist who works from the body-oriented perspective has in addition to verbal therapy, interventions at his disposal, which help the client to experience through his body, who he is, his place in the world and how he relates to others. This experience helps to work towards change. These interventions have a broad spectrum, from verbally focusing attention on how the body feels, meditation exercises, movement-oriented exercises, and working on the impact of earlier experiences in training situations, to touching the client.

Within this spectrum, this article will examine touch as a psychological intervention. Touch is an intervention that can help the client to feel himself and his boundaries better, but can also cross over boundaries at times. It is an intervention with great potential, but can also create dependence. Should the psychologist then not use touch to avoid any problems? Does he not then deprive his client of something valuable? If touch is required, the psychologist had better know what he is doing.

Since 1993, haptotherapists in the Netherlands have their own specialised professional organization called the Association of Haptotherapists. The association has over 550 registered members upon publication of this article. There are three educational haptotherapy programmes in the Netherlands that are officially recognized by this association, the Academy for Haptonomy, the Institute for Applied Haptonomy and Synergos. The majority of healthcare insurance companies cover, at least partially, the costs of haptotherapy under supplementary insurance packages.

In France, professionals who work using haptonomy also receive specialised educational training. For information about these educational programmes, see www.haptonomie.org/en/.

Categories of touch

Leijssen (2006) indicates three categories of intervention through touch, listed in increasing intensity:

- *Attentional-affectional touch*; for encouragement and support during a difficult period. A handshake, an arm around the shoulder and inviting the client to self-touch fall under this category
- *Emotional-expressive touch*; as support when expressing feelings and for protection against decompensation or disintegration.
- *Cathartic touch*; this entails the touching of a specific part of the body to loosen emotions, while still maintaining containment. Because the therapist does not stop touching as the emotions are freed, the client can remain connected and in contact with the therapist, with his emotions, with his body, with himself and with the here and now.

Leijssen views touch as an intervention that can be used to help take a client through and beyond a layer of fear, so that he can benefit more from other interventions. This layer of fear could be the *muscular armour* as the Austrian-American psychiatrist and psychoanalyst Wilhelm Reich (1897-1957) once called it: the armoured body, tension that blocks the body through stiff, painful muscles, through fearful experiences in the character-formative years. As the physical tension diminishes, so does the fear.

In general, the hands, shoulders and back are the most acceptable places for people to be touched. A therapist can also touch a client elsewhere based on the theoretical framework. Touching the genitals is obviously never acceptable. For each instance of touch it is important to ask the client for permission, to clearly define the purpose of the touch and to allow the client the freedom to refuse (see further in this article, 'informed consent').

Goodman and Teicher (1988) name two categories of touch and provide both the positive sides of this intervention as well as important cautions:

1) *Holding*: as a safety net, to relax and to prevent being flooded by emotions.

Holding fits within a supportive therapy. In this way the therapist provides support and protection and also offers a corrective emotional experience for the absence of good-enough mothering during the client's youth. The positive effects include affirmation of the client's value, strengthening their sense of reality, increasing sensitivity to the feelings of others and personal growth.

Holding also carries a risk. Touching can give rise to deep childlike needs and thus lead to a serious regression. Therefore, it is important to be careful that touch is not used for the fulfilment of these needs. The corrective experience should be focused on personal growth.

In Smith, Clance & Imes (1997), Imes asserts in this context, that if the need for dependence is not fulfilled during childhood years, the therapist should not use touch. The client could otherwise become dependent on the therapists' touch and/or the therapist himself, especially if the client has few sources of support outside of therapy or if he does not explore these. Durana, in Zur (2009), warns about clients who implicitly or explicitly ask for touch.

2) *Provoking touch or evocative touch*: to reach new content that cannot be reached by the client or therapist in another way.

Evocative touch carries the risk that the therapist's intentions may not correspond with the perception and sensitivity of the client. *Provoking touch* closely resembles Leijssen's cathartic touch (2006), where she cautions that client resistance has an important protective function and that therapists must not push through because it can be retraumatising. It is notable that Leijssen emphasises *containment*, also in the process of releasing feelings.

Touch is regularly applied in multiple disciplines within the context of body-oriented psychotherapy. In the Netherlands, haptotherapy has made contact and touch the core of its work and study (Plooij, 2005). In recent years, an increasing number of psychologists and pedagogues are finding their way to this professional education. In haptotherapy, there is room for affirmative, supportive touch (*holding*), as well as touch that opens up (*evocative*) or confronts (*provoking*).

Within the framework of holding as defined under 1), it also offers an opportunity for personal development. The maxim 'to love oneself', is experienced by the client in both a mental and physical sense. Through affirmative touch, the client learns to experience himself as good, and from that point learns to take care of himself when he doesn't feel so good. *Lust* (for life) is a key concept in haptonomy (Veldman, 2007). In the vision of haptonomy, this quality is appealed to through the affective touch of a meaningful person. The client will then begin to experience what it means to take up space, to stand on one's own feet, to carry oneself, to be oneself in contact with others, to set boundaries. The therapist makes all of these psychological aspects tangible through the experiences of touch and feeling. A statement such as 'I know it, but it doesn't change' becomes 'I felt it'.

Casus Marianne (part 2)

Except for the contact with her parents, Marianne was on her own a lot. As a child she could never play with other children, she was always anxious about negative attention in public life and so she often sat alone in her little room. She has trouble dealing with friendliness. Recently, when a woman on the bus was kind to her, she was so uncomfortable that her head and shoulders began to shake.

We bring the issue of closeness and friendliness into the therapy. I sit beside her and we talk about what feelings arise in her in that situation. As she lies on her stomach on the treatment table, I touch her quietly and attentively. She experiences this as enjoyable; to her surprise, she even likes having her feet touched. No one has ever been allowed to touch her there. If the attention is given, she appears to be able to feel and articulate reasonably well.

Despite being almost middle-aged, Marianne has to free herself more from her mother's protective attention. She always buys her clothing together with her mother and so has developed little of her own taste in clothes. In the course of therapy, she begins to set more of her own boundaries with her mother and starts dressing more youthfully, appropriately for her own age. She also learns to ward off other interference from her mother, well meaning as it is. She now feels how much it bothers her that her mother is always 'rushing, steering and pushing' her during walks on vacation. She articulates to her parents how she feels. Father is the first to react positively to this, later her mother does, too.

As she lies on her back on the treatment table and I touch her belly, the story comes out that her mother thinks she is too fat and sometimes teasingly pokes her in her belly. And how horrible that makes her feel. The experience of her belly being touched without judgment, but with tender attention is completely new and it feels good to her. In this way, we work step-by-step in the direction of feeling her own softness, first physically, and then emotionally.

Goals, guidelines and warnings

Torraco (1998) defines the goal of touch in psychotherapy to be the realisation of a safe attachment. The client also learns to 'mother' himself, and intimate contact in his own life becomes possible without having to clasp on or withdraw. She provides guidelines for touch in psychotherapy, of which the most important are:

- be aware that changing physiological memories is a lengthy process that should not be interrupted;
- a mature therapeutic relationship is necessary;
- weigh up other psychological interventions against touch;
- clarification and permission are required, each and every time;
- touch is an intervention to help the client through a layer of fear. Other interventions can be used afterwards;
- never touch to gratify infantile wishes or 'because it feels good';
- be on your guard for hugging. A client would prefer to hide in a hug rather than consciously experiencing his own feelings and boundaries;
- use a firm touch with a clear objective;
- talking during and after touching is important. This allows the observing ego to put the touch experience into perspective.

Zur (2007) views touching as a psychological intervention that, as with all interventions, must be carefully considered, appropriate, effective and ethically responsible. With this intervention, however, it is crucial to have received informed consent, that is, consent to the treatment based on information, to have this signed by the client and to document this method extra carefully in the client file. He further provides the following information:

- Women react more positively to touch than men (Hunter and Struve, 1998);
- If there has been a childhood trauma, the therapist must be more careful with touch and deploy it later in the therapy. Touch as an intervention should not be avoided as research showed that 71% experiences benefit from it. Improvement is found in the following areas: confidence in oneself and trust in others, a feeling of empowerment, setting limits and asking for help when necessary (Smith et al., 1998);
- The therapist should not deploy touch if the client is actively paranoid, hostile or aggressive, or if he implicitly or explicitly demands touch (Durana, 1998).

In addition, Kertay and Reviere (1993) explicitly state that the therapist must never use a client sexually or otherwise. Their guideline for this is that the therapist may not deploy touch if it's clear this would lead to sexual arousal, by either the therapist or the client, or if the client is upset and touch would stagnate the therapeutic process. The latter could be the case if a comforting touch would halt processing emotions when in fact progress should continue.

The warning about fulfilling the client's needs is seen in the writing of virtually all of the authors. It's important in therapy that needs and desires become perceptible and discussable; any possible fulfilment must take place in one's own life. Goodman and Teicher (1988) thereby assert that touch is indicated for people with a *stagnated development of their emotional life*, who have difficulty in being themselves apart from others and to be able to remain themselves in connection to another person. These clients need to be touched in order to be addressed at a pre-verbal level, to grow from there toward verbal communication about feelings. Goodman and Teicher mention *clients in regression* as a contraindication, because the client then wants to fall back on something that he knows from before. That is the kind of need fulfilment or gratification that leads to dependence on the therapist.

Kertay and Reviere (1993) nuance this assertion somewhat. They state that the distinction between non-developed and regressed clients is not easily made, and call for further investigation. Often, there are mixed characteristics in a profile. Furthermore, some clients in regression seem to benefit from touch and some non-developed clients don't. In their opinion, the most important thing is that the therapist has theoretical grounds, whatever they may be, and acts upon them. Conversely, Imes (in: Smith et al., 1997) asserts that the client himself is the most important source in finding the answer to the question whether touch helps to further the therapeutic process.

The difference in response to touch intervention between non-developed and regressed clients and all the nuances in between definitely deserves further study. All of the literature is unambiguous about one point, however: that the therapeutic process must lead *toward development and independence* and not towards the fulfilment of needs, not the client's needs, and certainly not the therapist's!

I, too, have abandoned further touch with some clients. These clients exhibited insecure attachment patterns with both a deep yearning for touch and a strong reaction to it, such as trembling or shaking. This did not stop until I actively brought warmth and peace, so that they could leave my office calmly. Dependence formed, which is fine as a temporary part of the process, but it

must not persist. They got stuck in their wish to fulfil a need and I in my wish to stop their misery. I needed intervision or supervision to be able to reset the course. Afterwards, I could proceed with these clients with body-oriented exercises without touching, attention for self-touch (Leijssen, 2006), or with verbal therapy and mindfulness exercises.

Where the closeness of a body-oriented therapist can often facilitate development, it can also sometimes cause stagnation. Regular evaluation of a therapy and treatment plan, as well as intervision, is even more necessary with touch therapy than with other psychological interventions (Kertay & Reviere, 1993).

Casus Marianne (part 3)

During the first evaluation Marianne tells me she feels quite a bit more relaxed, with herself and in her contact with others. Being touched non-functionally and without disapproval is doing her a world of good. We decide to continue, and to now take the step to touch her head, first with her wig on, and the next time without the wig. It affects her profoundly when I touch her face. She becomes very quiet when I touch her head on top of the wig. Afterwards, she is very content with this experience.

The next time, the moment she takes off her wig in the treatment room is very moving. At home she never takes her wig off until she goes to bed, so she shows her profound vulnerability. It feels good to be touched on her head, she says, but very different from being touched on her face or body. Her scalp appears to be somewhat insensitive. I ask her to regularly touch her head at home, with her hands and with a scalp massager.

From that moment on, I always include her head when touching her whole body. She takes her wig off of her own accord every time and, after dressing, carefully puts it back on.

Attachment

When the trust in the therapeutic relationship has grown and the client has experienced that he doesn't need to do anything, and he has, through touch, begun to experience himself as good, attention is given to the relationships in his own life, in order to shape and experience these relationships based on a secure attachment. This happens to a certain extent without the need for much cognitive work. The client experiences himself as good and thus is less apprehensive of the other. Nevertheless, often in that second part of the therapy, verbal interventions and interventions focused on insight are very important, in addition to touch. More explanation is possible and the client learns to explore his own emotional and inner life.

Casus Marianne (part 4)

Marianne tells me that she was blind the first three months of her life, and how it was to have to lay in hospital much of the time as a child. In retrospect, she recognizes the deprivation of stimulation and affectivity she has experienced. She asks herself what the consequences of that are for her life today. We conclude together that there are consequences in the areas of self-confidence and attachment. This results in her being able to feel appreciation in her contact with others, but not love. She doesn't feel the love that others have for her, but above all, she is not able to feel love for others.

We decide to work on this further and I send her on her way with a couple of questions: 'Who do I find sweet?' and 'Who makes me glad?'. These questions will keep her busy for a few months because these words mean little to her. In the first instance, she is beginning to feel that what someone else dóes makes her glad; to feel that someone ís lovable is still difficult. We talk about a good friend whom she missed at her brother's cremation. 'People think I don't need anything,' and 'they don't see me as a human being'. On the treatment table I then let her feel that she is human. I touch her whole body, from head to toe, with loving attention. I lay one hand on her stomach and one on her back, so that she can experience her middle in between my hands. She feels 'slim and tall'. I have to repeat this a few times, when she starts feeling empty in her abdomen again. She is radiant when she leaves the room and I tell her that. When she looks in the mirror, she sees it herself. It is important that she starts to experience her body more at home, in order to feel even more. She was already familiar with the method of mindfulness, and at home she starts to do the body-scan regularly: to attentively go through her whole body under the guidance of a recorded voice.

Later, she is going to call her girlfriend to make an appointment and I ask her to pay close attention to what she feels and maybe even to express that verbally. At work her colleagues notice that she has changed, she is more relaxed. People physically touch her more often, a pat on the back, a hand on her arm, and she likes it. When her girlfriend came over, Marianne saw that she had a smiling face and she could feel the happiness in her own face, too.

This very precise physical feeling and naming it emotionally does her a world of good; she is curious about it and learns a lot. Now she can feel when she is relaxed. However, she sometimes needs to look in the mirror to know if she is happy.

Affective contact with oneself and with others

A securely attached person is connected to his own emotional life and to that of others. He is autonomous and on his own, as well as being connected. He is not dependent on another person for his self-confidence. He is capable

of giving and receiving love. Being able to experience our inner feelings is a condition for this.

Casus Marianne (part 5)

In her contacts with others Marianne tends to be the interested listener. She will need to start showing herself more, and voluntarily tell more about herself in order to be seen, which is what she really wants.

When a colleague has passed away, Marianne goes to the cremation ceremony, as she always would have done. This time, however, she also feels: heaviness and grief. We talk about which colleagues she feels close to, about friends and best friends. She starts to make a distinction between these. I also let her experience this differentiation in feelings physically; not every place feels the same when touched. She is increasingly able to think, feel and communicate about feelings more precisely. This helps her when making choices.

In addition to her job, Marianne has always done a lot of administrative work for her Owners' Association. This was her way of being around people, to work and be valued for that work. And to value others for their work. Now, she starts to make other choices. She says farewell to the administrative work and begins to look for sociable companionship in outings with girlfriends, in an eating club. She derives a great deal of pleasure from these contacts. She is now ready to start thinking about a possible relationship with a man. She starts to define her own appearance. She buys new glasses, a new dress, starts dressing her own age. She goes for beauty treatments. She has met a man, and although he is not necessarily 'the one', she is playing with the idea of a relationship and feels like she's much more a person and a woman.

Bringing to a close

Terminating treatment at the right time is particularly important in therapy where touch and attachment play a major role. It helps if the objectives are clearly outlined and regular evaluations are done with the client. This helps to clarify that therapy is a developmental and learning process focused on independence and thus, by definition, temporary. After such an attachment process, a period of detachment is often needed. Although it's a farewell, it is then also a joy for both therapist and client, if the client is experiencing enough contact in his own life to be able to stop going to therapy.

Casus Marianne (part 6)

Marianne is doing very well. She has a good social life, she says. She takes time for this by not reading her professional literature quite so thoroughly. She continues to pay attention to experiencing the feelings in her own body. She sees a taller woman when she looks in the mirror and she comes across that way, too. She has grown considerably, both psychologically and in her physical perception, has become more of a person and more of a woman. She has more self-confidence and no longer feels small when she hears others talk. As far as finding a man goes, she says she's moving at a snail's pace; she's thinking of joining a walking group. This next phase of development she says she can do on her own, and I agree.

She's happy with the tenderness she has found in herself and the affirmation of being touched affectively. After eighteen sessions over a period of a year, we end the therapy feeling satisfied. She also gives me her permission for this publication.

Conclusion

Touch in psychotherapy should always be weighed against other psychological interventions and only be used if and how it is necessary in the therapeutic process of the clients. The body-oriented psychologists should be aware of the guidelines and warnings that are given in the literature. Examples are: the importance of clarification of the interventions, talking during and after touching, obtaining permission for each intervention. The therapeutic process must lead towards development and independence and not towards the fulfillment of needs. Touch is a strong intervention, in particular for people that suffer from a stagnated development of their emotional life, as it addresses the clients at a preverbal level. Verbalizations of feelings become possible and the clients can develop in the direction of independency and safe attachments in their own life. It seems contra-indicated for people in regression, although some state that this should be assessed at an individual basis. Further research on this subject is recommended.

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