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Touch in the Helping Professions

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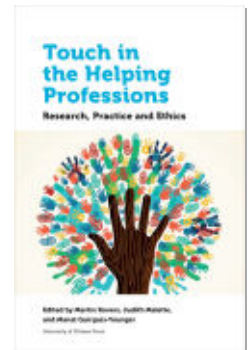
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The Intervention of Touch in Psychotherapy and Trauma Treatment

Patricia Berendsen

Introduction to Touch in Psychotherapy and Trauma Treatment

Therapists regularly deal with psychological issues that arise from developmental disruptions and trauma-related experiences. As clinicians we are brought into the lives of our clients when they are most vulnerable, fearful, desperate, feeling alone in the world, and wounded. We find ourselves in direct contact with stories that illustrate various aspects of trauma.

Touch in therapy could be an important therapeutic tool, particularly in areas of trauma, where touch was abused or withheld. However, touch in trauma and therapy is usually hinged on one word: DON'T! More often than not, we are discouraged from touching our clients for fear of crossing boundaries, transference or counter-transference, or allegations of wrongdoing. Older (1977) and Wilson (1982) echoed sentiments that continue to this day: Many therapists have used touch but do not talk about it. Clinicians tend to be intrigued by the flood of scientific data supporting the relationship between the body and psychotherapy. However, most mainstream therapists trained in talk therapy are ill-equipped to make the transition to include somatically based modalities (Berendsen, 2011, p. 32). In fact, research by Strozier, Krizek, and Sale (2003) suggests that 82% of social workers report that touch was inadequately addressed in their educational training (p. 57).

It would appear that the clinical landscape regarding touch is changing and furthermore *needs* to change. Neuroscientists have confirmed the integration of the body, mind, and emotions. Thus, somatic approaches to therapy, including touch, will become increasingly necessary within our talk therapy framework. We will need to develop body- and touch-literacy skills. The importance of a connected and empathic therapeutic presence is vital (Berendsen, 2011; Hutterer and Liss, 2006). Touch is one of the ways that a client can experience this empathic response.

Although some relationships have had the impact of wounding and hurting a human being, other relationships, including the therapeutic one, can nurture and support healing. One byproduct of trauma can be isolation. Connection and relationship, however, can become the antidote to trauma and isolation. Touch can be a necessary intervention, which in turn can help to establish a sense of self, a sense of belonging, and connection. Touch can also be highly effective in enhancing therapeutic alliance, which is the best predictor of positive therapeutic outcomes. As such, touch in therapy may be moving from an occasional occurrence to an essential and staple intervention.

Exploring Theory and Research: A Rationale for Touch in Trauma Therapy

Touch is inherent to our humanity. Our survival and ability to thrive is dependent on touch (Montagu, 1971; Feldman and Eidelman, 2007). As infants we are touched, cuddled, and rocked, yet instances of touch decline as we grow older. This reduction in touch occurs despite the fact that our “touch hunger” does not diminish over time. From this perspective, most of us could be suffering from “skin starvation.” Suffice it to say that being human and needing touch are integrally connected. An awareness of ourselves through skin contact of some sort does seem to be important for an ongoing sense of self. Touch is one of the most essential elements of human development: “The communications we transmit through touch constitute the most powerful means of establishing human relationships, the foundation of experience” (Montagu, 1986, p. xv).

Touch is important in bonding and attachment (Ainsworth and Wittig, 1969; Bowlby, 1988; Harlow 1959). Touch and sensation are our first language. According to Montagu (1971), the skin is the “self’s

organ of embrace and contact” (p. 205). We are bathed in uterine fluid before we are born. We travel the passage to our birth through a tight canal that massages our body, thus preparing us to awaken to our new form of existence. We are hugged and rocked and soothed as infants and throughout our childhood. These nurturing activities help us to formulate our attachment systems and our felt sense of the world being a safe place. Loving touch in the early years is essential to adequate neurological and emotional development (Bowlby, 1969; Harlow, 1971).

According to Montagu (1971), “any significant failure in the experiences of such contacts may lead to a profound failure or disorder to later interactional relationships . . . as well as in a variety of other behavioural disorders” (p. 205). If we were raised in homes where chaos, addiction, abuse and violence occurred, we are more likely to be negatively impacted by the absence of touch. Perry (2006) suggests that our attachment is our “. . . memory template for human-to-human bonds. This template serves as our primary ‘world view’ on human relationships” (p. 85). However, when human beings have not been satisfied by good nurturing in infancy, there remains an intense need for holding and touch (Vereshack, 1993). “Children who don’t get consistent, physical affection or the chance to build loving bonds simply don’t receive the patterned, repetitive stimulation necessary to properly build the systems in the brain that connect reward, pleasure and to human-to-human interactions” (Perry, 2006, p. 86). In fact, the lack of positive childhood touch has been linked to antisocial behaviour (Phelan, 2009, p. 98). A qualitative study by Steckley (2012) explored the role of touch and physical restraints in residential treatment settings in Scotland. The study found that the staff experienced some anxiety about touching residential clients. Physical restraints are to be utilized by staff as a last resort to control or subdue clients’ out-of-control behaviour. So it is a sanctioned form of touching. However, for anyone who has observed a child being restrained, it is anything but pleasant and is often traumatizing for both staff and clients. Yet in Steckley’s (2012) research, residential clients would use physical restraints to meet their need for touch and containment. The combination of the fears of the staff to touch and the clients’ need for touch resulted in the increased use of physical restraints. Interestingly, my experience as a team leader of a children’s residential treatment setting also confirms Steckley’s findings.

Nuszbaum, Voss and Klauer (2014) found that participants who were briefly touched on the shoulder before entering the laboratory for a product evaluation task were more confident when they were briefly touched (p. 31). Koole, Sin, and Schneider (2014), in their study on touch and self-esteem, found that interpersonal touch alleviated existential concerns among individuals with low self-esteem. In addition Debrot, Schoebi, Perrez, and Horn (2013) found that couples who engaged in regular physical contact experienced better psychological well-being even at their six-month follow-up. This study provides evidence that intimate partners benefit from touch on a psychological level, conveying a sense of strengthened bonds between them that enhances affect and well-being (p. 1373).

The Importance of the Nervous System in Emotional Regulation and Trauma Treatment

Neuroscientists are indicating that there is a reciprocal relationship between the body and mind: "But when encountering patients with emotional problems, mental health professionals seemingly ignore the importance of the body to one's emotional stability" (Wilson, 1982, p. 65). This development of the importance of the body/mind connection is shifting therapists' perspectives and necessitating the inclusion of additional knowledge in physiology (Shaw, 1996). "What is physically lived . . . is no longer separable from neurophysiological modifications of the brain and the nervous system. The body informs the brain about sensations, communicating between the mind and the brain, and it expresses a relational affectivity with its socio-cultural context" (Andrieu, Laloe and Klein, 2012, p. 157). Touch can be utilized to re-establish regulation in the nervous system and increase the capacity for self-regulation. This can occur by specific touch interventions that can interrupt stress and threat physiology. Through these repeated interruptions, new neural pathways can be forged so that nervous system regulation can occur. Pinson (2002) suggested that therapists who used touch believed that the client's longing for touch reflected a need for attachment, self-calming and regulation.

Berendsen (2014) outlines some helpful foundational strategies when incorporating the body into trauma therapy. Her acronym of S-A-F-E-T-Y formulates a foundation for integrating the body and touch into trauma treatment.

S=Stabilize and go Slowly;

A=Attunement, Awareness and Acceptance;

F= Focus on the Felt Sense of the Feeling;

E=Empathize, Educate, Explore;

T= Take Time, Titrate;

Y= Your needs matter too! (p. 124).

(For an expanded version of S-A-F-E-T-Y, see Berendsen, 2014, p.124–127. For additional guidelines on working with trauma survivors and touch, see Benamina and Sohen-Moe, 2005, p. 215–240.)

Nervous system dysregulation can be observed particularly if one has a lens from which to view it. For example, clients will have constriction patterns in their body that are the result of psychological and physiological responses to threat. It is important for therapists to be aware of these dimensions, as they can inform the direction of touch in therapy. Shoulders held high, darting or wide-open eyes, gastrointestinal issues, and breathing problems are some of the physical complaints that clients may exhibit along with their mental health issues. Physical constriction patterns may have become chronic and may be indicative of other relational or psychological difficulties. Typically, these patterns are a visible manifestation of a client's effort to survive. They are self-protective strategies that once were effective and now are getting in the way of optimal functioning. Touch can be used to reduce the symptoms of trauma.

Understanding where clients are in the five stages of the threat response cycle identified by Peter Levine (1997) is also helpful (Berendsen, 2011, p. 35–39). Clients may exhibit indications that they are stuck in (1) Startle/arrest/preparatory Orienting; and/or (2) Defensive Orienting Response; and/or (3) Specific Defense of Fight/flight/freeze/submit/immobility Response; and/or (4) Discharge (shaking and trembling, warmth, deep breath) and Completion; and/or (5) Exploratory Orienting Response. Accurately identifying the stages of the threat response cycle can enable increased precision in the application of any therapeutic intervention, especially touch. For example, a client in the stage of discharge/completion, which typically

occurs after coming out of shock and immobility, can be regulated by physical support. The proximity of the therapist and/or touch on the upper back, shoulder or arm can be stabilizing and comforting to the client. This physical contact combined with verbal assurances can reassure the client that the shaking and trembling are normal and will subside.

Potential Impact of Touch on Clients

Touch has been shown to be therapeutic. Most touch research has been conducted in relationship to touch and massage by Tiffany Field and the Touch Research Institute. However, more research is being done on touch in psychotherapeutic settings, indicating the positive effects of touch with clients (Hunter and Struve, 1998; Strozier, Krizek, and Sale 2003; Peloquin, 1989; Horton, Clance, Sterk-Elifson and Emshoff, 1995; Salzmann-Erikson and Eriksson, 2005; Rasmak, Richt, Rudebeck, 2014). In general, clients who were touched reported an overall sense of feeling better about being in therapy (Horton, Clance and Sterk-Elifson, 1995). More recently, Dunbar (2010) has suggested that touch is linked with the release of oxytocin and endorphins, neurochemicals that support bonding and reducing our experience of pain. Positive physical aspects of touch include lifting mood in the treatment of depression (including post-natal depression), reducing anxiety, pain relief, reduction in muscle tension, decreasing raised blood pressure, enhancement of immune function, improving sleep, decreasing the symptoms of sexual abuse, reducing aggression in adolescents, and improving weight gain in preterm neonates (Field, 2003; Westland, 1993, 1993a).

Touch facilitates containment and safety (Eiden, 1998; Mintz, 1969; Hunter and Struve, 1998; Courtney and Gray, 2014). Bassya (2002) found that touch provided clients with a sense of safety, and grounded them in the present. Anxiety and dissociation can often be supported with touch, allowing a client to feel his/her body (Phelan, 2009). Close proximity with the therapist—a hand on the arm, or even the therapist touching the client's foot with his/her own—can be experienced by the client as reassuring, soothing, and grounding. Touch also serves to assist the client in focusing on the here and now (Eyckmans, 2009).

Touch is culturally specific (Jourard, 1968, p. 137). Cultural sensitivity is a must when working with clients. Communication and negotiation of any touch intervention is necessary with every culture.

Eyckmans (2009) describes in detail her experiences as a therapist in different cultures, illustrating the importance of context and utilizing a culturally sensitive framework. According to Kepner (2001), “we must come to understand how we embody the cultural, as well as personal beliefs, and attitudes that make touch forbidden or frightening” (p. 74).

Touch supports connectedness with others (Courtney and Gray, 2014; Salzmänn-Eriksson and Eriksson, 2005). Horton, Clance and Sterk-Elifson (1995) found that clients indicated a deeper trust and stronger attachment with the therapist when touch was used in therapy. Clients attribute touch to creating a feeling of bond, closeness or a sense that the therapist really cares. Salzmänn-Eriksson and Eriksson (2005), in their research on the meaning of touch with patients who have been treated for psychosis, describe that through touch, clients can feel a sense of belonging and kinship. In my therapy practice, I can recall a middle-aged woman with severe eating issues. When I responded warmly to her request for a hug at the end of her session she looked up with tears in her eyes and said, “You know, I can’t believe you would hug me. I didn’t know I was deserving of being touched by anyone. I don’t feel so unlovable. Thank you!”

Touch facilitates communication and elicits comfort. Clients tend toward increased self-disclosure when touched (Pattison, 1973; Mintz, 1969; Eiden, 1998). Salzmänn-Eriksson and Eriksson (2005) reported that according to clients “feelings get communicated in the act of touching” (p. 848). In addition, touch contributes to greater openness with the therapist. As clients are able to verbalize their feelings, they increase their potential to reach developmental milestones that may have been missed (Goodman and Teicher, 1988; Tune, 2005). Montagu (1971) asserts that “taking almost anyone’s hand under conditions of stress is likely to exert a soothing effect, and by reducing anxiety and giving a feeling of greater security” (p. 216). “To give someone your hand is not just a physical action. It is a welcome into a shared world that therapists, but also clients initiate” (Rasmann, Richt, and Rudebeck, 2014, p. 5). Salzmänn-Eriksson and Eriksson (2005) indicated that “The need for touching becomes stronger when one’s mental health is in deterioration. Touch from another human being has a comforting and supportive function” (p. 847).

Touch promotes awareness and affirms the sense of the self. Touch can facilitate and support the here-and-now experience of the client. This can allow the client to be with an intense feeling or emotion and

keep their “witness” on board. In this way, touch can help a client to maintain dual awareness of both the present and the past. In addition, the client’s self-awareness tends to precede increased self-exploration (Courtney and Gray, 2014). Touch can support the acquisition of skills to enable clients to identify and experience their physiological sensations (Davis, 2001). Touch also affirms the sense of self (Peloquin, 1989; Mintz, 1969; Eiden, 1998; Courtney and Gray, 2014). Through touch, a therapist can communicate the message that “I accept you,” “I see you,” or “I am here for you.” Horton, Clane, Sterk-Elifson and Emshoff (1995) examined individuals in therapy with a non-body-oriented psychotherapist who experienced some sort of physical contact beyond accidental contact or a formal handshake with the therapist. Interestingly, 71% of patients who reported a history of abuse identified that touch enhanced self-esteem, trust, and a sense of their own power. Some patients reported that touch helped them to feel that they were worthy of respectful touch, stating, “Touch helped me learn I was lovable” (p. 451).

Touch assists in the development of intimacy. Rasmak, Richt and Rudebeck (2014) noted that professionalism involves using not only our competencies, but also our physical and emotional contact to deepen the relation. When people touch, the distance between them decreases. Touch can be a means of closeness in the therapy room. However, since touch is a form on intimacy, the timing of touch is important. Nuances of knowing when to touch and when not to touch deepen the therapeutic relationship.

Touch helps client access/process pre-verbal material (Shaw, 1996). Strozier, Krizek and Sale (2003) suggest that touch itself may facilitate clients “getting in touch” with emotions that may not be obvious in psychotherapy. “Respectful, reassuring touch seemed to help many patients feel supported and safe enough to move into threatening material on a deeper level” (Horton et al., 1995, p. 451). Furthermore, touch can be a means of processing pre-verbal material that literally has no voice, only sensations. In addition, touch can facilitate symbolic parenting when the client is incapable of verbal communication, perhaps where there has been a deficit in childhood (Bosanquet, 1970; Mintz, 1969; Toronto, 2006). In these instances, it is imperative for the therapist to meet the client at the somatic level as words can sometimes be experienced as misattunement.

Touch is needed when someone is ill. Touch can bring us out of a distressed state with considerable ease. Bowlby writes that the need

for touch increases with danger, incapacity and sickness (as quoted in LeMay, 1986, p. 28). Illness, according to Jourard (1964), occurs when “a person’s life begins to lose zest, a sense of future, meaning, and love” (p. 138). This is confirmed by several other researchers (Benjamin and Sohnen-Moe, 2005; Horton, Clance, Sterk-Elifson and Emshoff, 1995; Huss, 1977; Mintz, 1969; Strozier, Krizek and Sale, 2003).

Touch increases a sense of empowerment and aliveness. For many clients their sense of power in defining and defending boundaries has been thwarted in the wake of trauma. Touch may have been imposed upon them. Saying no to the therapist’s invitation for touch support without any negative repercussions (punishment or rejection) can be reparative and liberating for the client. Likewise, open dialogue about touch between client and therapist supports the client having a sense of control (Geib, 1998). Touch increases aliveness (Eiden, 1998; Jourard, 1968; Levine 2010, 1997), “. . . the experience of being touched enlivens our bodies, and brings us back into them” (Jourard, 1968, p. 148). Even in intimate partner relationships, touch promoted and strengthened bonds between partners. Participants who were touched more during the study reported better psychological well-being six months later (Debrot, Schoebi, Perrez, and Horn, 2013, p. 1373).

Types of Touch in Psychotherapy

Most codes of ethics do not focus on nonsexual physical contact between counsellor and client (Calmes, Piazza and Laux, 2013). Typically, the forms of touch that are most commonly used by therapists and that generally do not constitute misconduct are handshakes, touching the shoulder, arm or hand of the client, hugging, and holding hands (Stake and Oliver, 1991; Strozier, Krizek, and Sale, 2003). Hugging, holding a client in distress, stroking or patting, and a kiss on the cheek were also mentioned (Tune, 2001). Jourard and Rubin (1968) found that the most acceptable parts of the body to touch are the hand, lower and upper back, shoulder region, and middle back. Sexual or violent touch is considered unethical in every discipline.

Not touching is also an intervention. This can potentially be felt by a client as rejection and could minimize the opportunity for growth (Salzmann-Erikson and Eriksson, 2005; Wilson, 1982; Zur, 2007). On the flip side, a client’s request for physical contact declined by the therapist might be a new experience of boundaries and personal agency. This may be a new experience for a client of setting limits

and/or asking for what they need or want. Respectful touch contains within it the possibility of communicating appropriate boundaries. Another component that is paramount is that therapists who are not comfortable using touch make it explicit to their clients. In this way, therapists can inform their clients of their therapeutic stance so that clients are not “shamed by the need for physical reassurance or comforting” (Horton, Clance, Sterk-Elifson and Emshoff, 1995, p. 455).

The importance of knowing how and when to touch, as well as where to touch and for how long, are elements that a therapist needs to consider. “When physical contact was unwanted or undesired, it gave rise to feelings of inferiority, fear, and annihilation, which were experienced as suffocating and oppressive” (Salzmann-Erikson and Eriksson, 2005, p. 849). The challenge for therapists is that most do not have much training in the specifics of touch in their therapeutic work (Caldwell, 2000; Tune, 2001). Milakovich (1993) found that therapists who used touch were less concerned about risk and tended to use their own judgment about when to use touch.

Westland (2011) proposed that touching in the therapeutic relationship requires “experiential training.” This includes knowledge of how to touch contactfully, having a coherent theoretical perspective, knowing how to monitor both one’s own and the client’s responses, being able to discuss touch as an aspect of the ongoing relationship, and having adequate supervision from someone who has also had touch training (p. 27).

“Only when the therapist has learned the ins and outs of his or her own sensations and emotions and is relatively comfortable with them, can the therapist really help clients contain their own troubling sensations and emotions so that they can learn that, no matter how horrible they feel, it will not go on forever” (Levine, 2010, p. 47). Our somatic responses to our clients can tell us something about them *and* about us. When we transform our responses, we become co-regulators of the transformation of our clients’ experience, too! Becoming aware of our body sensations prior to, during, and after sessions can help monitor our own regulation or dysregulation. Vanderheyden, as quoted in Berendsen (2006), echoes this sentiment by suggesting that, “not being reflective practitioners makes us liabilities to our profession” (p. 17).

Trainings that utilize touch and the body more globally in psychotherapy are Somatic Experiencing, Sensorymotor Psychotherapy, Bodydynamic Analysis, Emotionally Focused Therapy, Psychobiological

Approach to Couples Therapy, EMDR, and Gestalt therapy, to name only a few. Given that most therapists have little or no training or exposure to touch in their therapy, it would be helpful for therapists to expand their skills by taking such courses.

Guidelines for Safe and Effective Touch in Psychotherapy

Dr. Seuss (1993) states, “so be sure when you step, step with care and great tact, and remember that life is a great balancing act.” This is especially true when integrating touch in therapy. Effectively utilizing touch means being flexibly responsive to the client who is sitting in front of us. Westland (2011) suggests that touch is informed by presence, intentionality, and congruence. “Contactful touch,” she says, “happens in the here and now, moment by moment” (p. 27). Although this is true, there are some basic elements that contribute to safe and effective touch.

Permission, permission, permission. Dialogue is critical when a therapist uses touch. It is essential for the clinician to offer touch with the caveat that the client is welcome and encouraged to say yes or no to any proposed touch intervention. Following this, it is important that each touch intervention be followed up with further permission from the client. Asking permission at several points during any touch intervention communicates clearly the therapist’s intention that the client’s needs are the priority.

Attunement. The onus is on the therapist to develop their attunement skills, which are vital to utilizing touch. Being able to accurately read verbal and non-verbal cues as well as having dialogue that is open and ongoing with clients about touch is key. As Westland (2011) states, “The client and the therapist *at this moment and with this client* should be comfortable with touch” (p. 28). Attunement is a skill that can be developed. This can be accomplished as clinicians engage in their own personal therapeutic work and deepen their understanding of developmental needs.

Intention precedes touch. “Intention is energy and may be experienced before the actual physical touch occurs. Intentionality is fundamental to relating; and the intention of the giver makes a difference to the touch, and how it is received. In therapeutic work the client and therapist co-create the field together” (Westland, 2011, p. 18). Carlsson (2003, referred to in Salzmann et al., 2005) shared the perspective that touch that is nurturing or not nurturing depends on the

underlying intention of the touch. The therapist's intention supports clarity when utilizing touch. There is less confusion for clients when the touch is congruent and there is clarity regarding boundaries. In this way, the client experiences the felt sense of the touch being for his or her benefit versus for the needs of the therapist (Geib, 1982; Horton et al., 1995).

Touching needs to be collaborative. Working together with the client is critical when using touch in therapy. Checking in with the client from moment to moment can help the client to feel involved and supported in the therapy process. "There is a sense of mystery. No helper can presume to understand fully. There is respect for what cannot be known, what cannot be understood. This profound respect, fused with an equal belief in the potential for helping, shapes a view of the person being helped as that of a vital collaborator" (Jourard, 1968, p. 25). Gelb's (1982) research indicated that many patients have difficulty requesting physical contact or sharing their negative reactions about therapy. Thus, having frank conversations and negotiating aspects of touch are essential when doing any form of touch work.

Therapist commitment to self-awareness is paramount. "If we dare to do therapy with people, we had better be aware of our own internal process, drives, needs and styles of relating to others. Unless we have dealt with our own issues, we may be tempted to focus on our own unmet needs [for power and control]" (Collins, 1987, p. 208). Kepner (2001) underscores the need for therapist self-awareness, stating, "The understanding of one's self and biases is a prerequisite for any therapeutic application, but is even more essential for such intimate and directly contactful work as touch" (p. 74). Vanderheyden (Berendsen) (2006) echoes this in her prose "I Dare You," written from the perspective of a client speaking to the therapist, saying, "I want to know if you have enough power in your own life so you don't need to have power over mine" (p. 45).

The therapist needs to be attentive to his/her own body (Rasmak, Richt, and Rudebeck, 2014). Courtney and Gray (2014) suggest that it is important for therapists to "understand their own attachment experiences of touch." Their findings also suggest that "sorting through one's own personal issues or countertransference" is pertinent (Courtney and Gray, 2014, p. 126). Ryan (1999) highlights that "a therapist who is not sensitive to, knowledgeable about, and accepting of transference and countertransference processes can fail at the therapeutic task and even retraumatize a client" (p. 472).

Therapist understanding of trauma physiology and the nervous system are essential. The therapist's knowledge of the threat response cycle can aid in identifying physiological states of the client. Understanding the autonomic nervous system assists the therapist in knowing what branch of the nervous system (sympathetic or parasympathetic) is active by observing the physical changes in the client. In addition, information about the polyvagal theory (Porges, 2011) will inform the clinician about the ventral and dorsal systems, which are deeply impacted by trauma. The therapist can then discern what forms of touch might be helpful or when touch may be beneficial. This information becomes vital in developing an overarching clinical formulation, as well as next steps for touch in particular.

The therapist needs clinical supervision. Courtney and Gray (2014) emphasize the importance of using "a structured training aimed at helping the practitioner to appropriately integrate touch into practice" (p. 126). Unfortunately, in the training and education of therapists, touch is a neglected aspect (Caldwell, 2000). In addition, Wilson (1982) discovered that clinicians were deterred from admitting using touch in their practice. Clinical supervision with supervisors who have had experience incorporating touch into their practice would be ideal. However, since this is not commonplace, engaging in supervision will support the therapist in the awareness of transference and countertransference. Supervision will also assist in identifying any blind spots and to ensure that the touch used in therapy has a clear rationale. Engaging in supervision can minimize potential pitfalls and strengthen ethical therapeutic practice. "Not being reflective practitioners makes us liabilities to our profession" (Vanderheyden (Berendsen), 2006, p. 17).

Case Example of Using Touch/Physical Contact with a Teenage Client

Julie, a 13-year-old, was residing in a girls' group home. Her biological mother suffered from severe substance abuse and, consequently, when Julie was eight years old, the Children's Aid Society removed her and her younger sibling from their mother's care and placed them in a foster home. This arrangement worked for awhile. However, as Julie grew, so did her temper and her depression. This proved to be too much for her foster mother to handle. Unfortunately, the placement broke down and Julie ended up living in the group home. Her younger sibling remained in the foster home.

I was the therapist serving this group home and was having my usual weekly meeting with Julie. We had been working together for about five months at this point. Therapy focused on stabilization, safety and containment, adjustment to group home living, and coping skills. However, this particular Monday, Julie was *very* upset. Her mother had been scheduled to have a visitation with Julie and her sister on the previous weekend. It did not go well at all. Julie's mother showed up two hours late. When she did show up she was intoxicated, and the visit was terminated by the social worker.

Julie sat in front of me, looking completely deflated. Her eyes were lifeless and downcast and her shoulders slumped. I had seen Julie in a discouraged state before, but never had I sensed her hopelessness as I did this day. [*Attunement. Being able to accurately read verbal and non-verbal cues.*] I reflected to Julie what I was observing and let her know that I could see her distress. I also let her know that it looked like she might be feeling hopeless. At this point her eyes made brief contact with me and then turned toward the floor again. [*Attunement, creating connection to self and others.*] I encouraged her to take her time to speak (or not). [*Attunement, collaboration and permission.*] I let her know that I felt badly seeing her suffer. I suggested that I really did not know what to do except to be with her.

We sat in silence for a while until Julie was able to and chose to speak. [*Understanding trauma physiology and the nervous system, as Julie needed time to settle and perhaps formulate words for her experience.*]. She began with, "It doesn't matter . . . why do I care . . . I always get disappointed . . . I'm so mad at myself for hoping that things will be different with my mom . . . that she will do what she says and fucking show up . . . and show up sober! If she doesn't care about me why should I care about me! I'm not worth the time." At this point, Julie began to sob. Perhaps wailing would be more accurate. I asked Julie if it would be okay to move a little closer to her. [*Permission and proximity facilitating containment and safety.*] She nodded yes. [*Touch helps the client access/process pre-verbal material—the likelihood of this client remembering all the times when she was disappointed by her mother was pretty high.*]

After a few minutes of proximity and more tears, Julie went on to describe how hopeful and excited she was to see her mother. [*Touch increases disclosure.*] She had made something in art class for her mom and was looking forward to giving it to her. As she kept waiting for her mother she reported that she became more upset, sad and confused. She shared that she was worried her mother would not come.

She talked about feeling lonely and alone, which worsened as minutes and hours passed by. In all of her upset, she ripped up her artwork.

I could observe that Julie was a bit more settled by sharing her frustration and anger and being somewhat comforted by closer proximity. [*Touch eliciting comfort and facilitating communication.*] She didn't seem as agitated and was making more eye contact, and her posture was not as slumped. Her breathing was smoother and deeper, and colour was coming back into her face. [*Touch increases aliveness.*]

I had an idea which came into my awareness that I thought might help Julie. [*Therapist commitment to self-awareness and being attentive to her own body.*] I imagined me sitting beside her, parallel, on the armrest of the couch she was sitting on, and having her slowly lean into me. I posited that it could be an interesting experiment to actually feel what it is like to lean on somebody. I wondered if being able to lean into someone who was there might give her a different experience of being met. The thought remained persistent, so I told Julie about what I was thinking. [*Intention precedes touch.*] I inquired as to whether Julie would like to try out this idea as an experiment (or not). [*Collaborative.*] I assured her that it was quite okay if she didn't want to try anything right now. [*Permission seeking and collaborative.*] I also suggested that she could take her time and think about it before she gave me an answer. [*Facilitating containment and safety.*] Julie replied, "Sure."

I moved to the armrest and sat beside her. After I did this, I invited Julie to notice what she became aware of in her body or her thinking. Julie shared that she didn't seem to notice much. This indicated to me that I needed to give Julie more time. [*Attunement and understanding of trauma physiology and nervous system. Closer proximity might need time to settle and get used to the transition.*] It was important to let her nervous system settle with the activation of someone being closer to her. When I sensed that Julie was settled, [*therapist attentive to her own body*] I encouraged her when she was ready to begin to lean into me. I assured her that I would just be there for her to lean into. I communicated that my intention was for her to perhaps have an experience of leaning on someone and to see what it was like for her. [*Intention precedes touch.*]

Julie began to lean into me very slightly at first. As she was doing so, we were exploring what her felt sense was of this experience. Sometimes there was just silence. I noticed that Julie's body seemed stiff at first. Gradually, I sensed increased softening and relaxation. I

felt the increasing weight of her body leaning into me. At this point, Julie began to cry . . . softer tears coming from her eyes this time. [*Touch promotes comfort, awareness, and sense of self.*] “I don’t think I’ve ever felt this before.” “Felt what?” I replied. “I feel myself relaxing more. I didn’t realize I was so tense . . . that I held so much in. I feel like I can breathe and that my stomach isn’t in knots . . . it’s like I am having a nap sort of . . .” I encouraged Julie to lean into me as long as she wanted, that she had all the time she needed to soak up this new experience in her body. [*Permission and touch eliciting comfort and awareness.*] Eventually, Julie began to pull herself away from me and sat upright on the couch. [*Touch increasing empowerment as Julie was taking initiative to pull away.*] I took that as my cue that I perhaps could move away back to my chair. I checked in with Julie [*Permission*], who indicated that she wanted me to stay where I was. [*Touch increasing empowerment as Julie was asking for what she needed.*] I complied. [*Collaboration.*] We talked further, exploring this new sensation/experience of leaning on someone. I could see from Julie’s eyes that this was a truly new experience for her, an “aha” moment of sorts. Her eyes seemed more alive and brighter, with the sadness still there but more in the background. [*Touch increases aliveness.*] She suggested that I could go and sit in my chair. [*Touch increasing a sense of empowerment.*] I was struck by the softness of Julie’s face. [*Therapist understanding of trauma physiology.*] The quality of her eye contact with me was so much more engaged. [*Touch supports connection with others.*] It appeared that she was more energized. [*Touch promoting aliveness.*] Julie indicated to me that she was okay now and wanted to end our session. [*Touch increases a sense of empowerment.*] So we did.

Approximately 30 minutes later, group home staff approached me asking, “What did you do with Julie?” I was perplexed by their curiosity and inquired why they were asking me this question. A staff replied, “Almost immediately after your session with her, Julie came to us with a bag of broken glass. She told us that she was planning to use the glass to cut herself and maybe even try to end her life, if she cut herself badly enough. Instead, she handed in the glass voluntarily stating that she “didn’t need it anymore.” I was stunned and grateful at the same time. Julie’s sudden change gave me an opportunity to share with the group-home staff team about the power of touch and nervous system regulation. That was a turning point for all of us. We saw and experienced the potency of a seemingly small intervention that unknowingly yielded life-saving results.

Conclusion

Touch can be an important and powerful intervention for trauma treatment. Van de Kolk (2014) suggests that “learning to experience and tolerate deep emotions is essential for recovery from trauma” (p. 6449). He also asserts that “competence is the best defense against the helplessness of trauma” (p. 6402). One of the ways that clients can learn to tolerate intense emotions and gain competence as a means of dealing with trauma is through touch. As evidenced by Koole, Sin and Schneider (2014), interpersonal touch alleviated existential concerns among individuals with low self-esteem (p. 30). Touch that is sensitively utilized by a skilled and well-trained clinician can assist in self-regulation, an absent characteristic of traumatized clients. Adhering to S-A-F-E-T-Y principles and acquiring knowledge about nervous system regulation as well as the threat response cycle supports the foundation for integrating touch into therapy. Additionally, understanding the responsibilities of the therapist and the guidelines for safe and effective touch therapy promotes ethical practice.

Aging-mentor Morrie Schwartz, in the poignant movie *Tuesdays with Morrie*, tells Mitch Albom, “In the beginning of life, when we are infants, we need others to survive, right? And at the end of life, when you get like me, you need others to survive, right?” His voice dropped to a whisper. “But here’s the secret: in between, we need others as well.” Touch is one of the ways that we need each other.

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