Paper
“A dangerous thing to go throwing about”: Trainee Clinical Psychologists’ Views and Experiences of Touch in the Therapeutic Relationship

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Bangor
“A dangerous thing to go throwing about”

Trainee Clinical Psychologists’ Views & Experiences of Touch in the Therapeutic Relationship

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“touch can be acceptable and beneficial, but should be considered carefully”
A ‘touchy’ subject?

**For**
- ✓ Deepen emotional processing?
- ✓ Grounding?
- ✓ Affective soothing?
- ✓ Enhance rapport?
- ✓ Attachment: touch deprivation?

**Against**
- X Slippery slope?
- X Boundary violations?
- X Complaints?
- X Re-traumatising?
- X Issues of power?
Previous Research

• Quantitative

• Qualitative:

  Harrison, Jones & Huws (2012)
  Sheret (2015, unpublished thesis)
  
  Decision making processes in qualified clinical psychologists working in AMH settings
Study Aim

• To explore the views and experiences of trainee clinical psychologists relating to touch in the therapeutic relationship
Recruitment

• Currently enrolled on BPS accredited DClinPsy
• Semi-structured interviews
• 9 trainee participants
• 8 female, 1 male
• From across all 3 years of training experience
Interpretative Phenomenological Analysis  
(Smith, 1996)

- Double hermeneutic
- Reflective diaries & researcher triangulation

- **Descriptive:** conscious decision not to use touch
- **Linguistic:** ‘hold out on’ → be rejecting, not meet needs, be selfish?
- **Conceptual:** Feels has no choice, but acknowledges it does exist → remorse for touch exclusion
Superordinate Themes

1. Secrecy to Confession

2. Fear of the External Monitor

3. Conflicting Identities
Superordinate Theme 1: **Secrecy** to Confession

“inherent rules”  (Libby)  

“implicit messages”  (Olive)
Superordinate Theme 1: **Secrecy** to Confession

“you tend to just listen to little snippets of what other people say and watch what other people do [...] sort of gauging what everybody else does and okay that person doesn’t do it all, that person does it quite a lot. [...] if you’re somewhere in the middle then that must be okay but it’s always guesswork I think cos nobody really talks about it.”

(Daisy)
Superordinate Theme 1: Secrecy to **Confession**

“really worried” (Chloe)  
“panicking” (Izzy)
Superordinate Theme 1: Secrecy to **Confession**

“I didn’t touch him, he touched me you know and I held my hand out like this” (Olive)

[demonstrates, palm parallel to floor]
Superordinate Theme 2: Fear of the **External Monitor**

“I suppose any situation for an onlooker, a bystander could be misinterpreted because they are not in that situation so, erm. I suppose if you were just trying to comfort somebody and it, somebody else might see that through a doorway and think that’s not appropriate”  (Chloe)
Superordinate Theme 2: Fear of the **External Monitor**

“litigation”  “accused of malpractice”
(Theo)      (Libby)
Superordinate Theme 2: **Fear** of the External Monitor

“I think it would help to know you know that you weren’t going to be immediately kicked off the course and everything like that if somebody found out that you’d you know, tapped somebody on the shoulder or something”  

(Theo)
Key findings

• Professional silence does not prevent trainees using touch in therapy however

• Trainees’ fear of personal repercussions may inhibit willingness to discuss and use touch openly
Clinical Recommendations

• Clinical training:
  o Wider impact of minimal/absent touch tuition → trainees still touch
  o Stimulate touch dialogue
  o Case studies, role plays, peer discussions, experts by experience, disseminate literature and research, e.g. imaginal touch (Jakubiak & Feeney, 2016)
Clinical Recommendations

• Clinical supervision:
  o Initiate touch discussions
  o Consider stating own position and self-disclosure
  o Provide feedback
  o Practice recommendations: explore trainee motivations, permission seeking, processing meanings with clients, modelling, TF and CTF
Thank you

Any questions?
Conflicting Identities

“And when I don’t, it almost feeling a little bit kind of, yeah like I say, apologetic, like I know that this would be the right thing to do but I’m not going to do it. And as I said before, almost a bit inhuman, almost like I’ve kind of, ‘now I’m professional’, when throughout the whole of the therapy what I’ve been to you is a human, somebody trying to, kind of make metaphorical contact with you and understand you, where you are and now you’re here, and I’m not doing it.”

(Theo)
Quantitative research examples

Pope, Tabachnick and Keith-Spiegel (1987) determined that psychologists most frequently used handshakes and hugs, with handshakes considered ethically sound by the majority of respondents (93.6%).

90% American) working in adult psychotherapy practice reported rarely offering touch to clients psychologists (Stenzel & Rupert, 2004)
Sheret (2015)

- grounded theory methodology
- psychologists’ touch decisions were extremely idiosyncratic
- some touch behaviours were classified as:
  - entirely acceptable (handshakes)
  - unacceptable (sexual and aggressive touch)
  - ambiguous (hugs, touching arms, hands or shoulders to communicate reassurance)
Jakubiak & Feeney (2016)

- imagined touch of romantic partner/ verbal support/ control (partner/neutral)
- Cold pressor task (submerge ice water)
- Trier social stress test (speech task and serial subtraction)
- Imagined touch buffers stress and pain better than verbal support & control
• “And that might be useful right now but I’m not going to do it I’m going to hold out on you; because I’m worried. Which feels pretty rubbish as somebody’s who’s employed to be a helping, caring person”.
• **Descriptive**: conscious decision not to use touch

• **Linguistic**: ‘hold out on’ → be rejecting, not meet needs, be selfish?

• **Conceptual**: Feels has no choice, but acknowledges it does exist → remorse for touch exclusion
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