A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation of Counselling Psychologists' experience of the role of body in the therapeutic encounter

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Abstract

This portfolio was submitted to the University of Surrey for the completion of the Doctorate (PsychD) in Psychotherapeutic and Counselling Psychology. It is comprised of three dossiers which reflect the academic, clinical and research work undertaken as part of this degree. The academic dossier consists of three essays. The first essay presents Freud's dream interpretation theory and Jung's dream theory and elaborates on the features of each theory respectively. The second essay describes Compassion Focus Therapy, its therapeutic benefits and challenges and some of its divergences from Cognitive Behavioural Therapy. Finally, the third essay provides an understanding of anorexia nervosa from an attachment perspective, offering some clinical implications for therapeutic work and discussing some of the challenges and benefits of using this theoretical framework in clinical practice. The therapeutic dossier provides a description of my clinical placements over the four years of training. Within this dossier there is also a 'final clinical paper' which gives an explicit account of my professional and personal development towards becoming a counselling psychologist. The research dossier contains a literature review and two research projects conducted during the four years of my training. The literature review explores the role of the body in psychotherapy. The first research report is a qualitative study that examines counselling psychologists' experience of the use of body in the therapeutic encounter. Finally, the second research report is a quantitative study that explores therapists' attachment styles and how they impact on their use of touch in clinical practice with adult clients. The research dossier concludes with a copy of the poster presentation delivered at the Annual Conference of the Division of Counselling Psychology in Cardiff, 2013.
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Statement of Anonymity

To ensure the confidentiality and anonymity of all clients and research participants, pseudonyms have been used and all identifying information has been changed throughout this portfolio.
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Contents

Introduction to the Portfolio 7

Academic Dossier

Introduction to the academic dossier 14

Essay 1: 'The Two Dreamers' of Psychoanalysis
An overview and a comparison of Freud's dream Interpretation
and Jung's dream theory 15

Essay 2: Integrating Compassion Focused Therapy in Cognitive
Behavioural framework 28

Essay 3: Understanding anorexia nervosa from an attachment
perspective 41

Therapeutic Dossier

Introduction to the therapeutic dossier 55

Description of clinical placements 56

Final clinical paper: Building a house 61

Research Dossier

Introduction to the research dossier 79

Literature Review: The role of the body in psychotherapy 80

Qualitative study: Mind the body: Exploring counselling
psychologists' experience of the role of body in the therapeutic
encounter 109

Quantitative study: Therapists' attachment styles and the use of
touch in their clinical practice 167
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Introduction to the Academic Dossier

This dossier includes three theoretical essays written throughout my training.

The first essay presents Freud's dream interpretation theory and Jung's dream theory and elaborates on the features of each theory respectively. It identifies some similarities and differences between the two and it offers some reflections on the use and quality of dream analysis in psychoanalysis as well as some considerations regarding its use in counselling psychology.

The second essay describes the Compassion Focus Therapy, its therapeutic benefits and challenges and some of its divergences from Cognitive Behavioural Therapy and how it can be integrated into a cognitive behavioural therapeutic context.

Finally, the third essay provides an understanding of anorexia nervosa from an attachment perspective, offering some clinical implications for therapeutic work and discussing some of the challenges and benefits of using this theoretical framework in clinical practice.
‘The Two Dreamers’ of Psychoanalysis

An overview and a comparison of Freud’s dream Interpretation and Jung’s dream theory

Introduction

Sigmund Freud and Carl Jung were pioneers in developing theories of dreams and their interpretations. The aim of this paper is, in the first part, to present these two theories and elaborate on the features of each one. In the second part, the author will point to some similarities and differences between the two theories. The conclusion will offer some reflections on the use and quality of dream analysis in psychoanalysis as well as considerations regarding its use in counselling psychology.

Freud’s theory of the Interpretation of Dreams

Freud was the first person to undertake the development of a scientific method of dream interpretation and he established it as a central aspect of psychoanalysis. According to Freud, dream analysis gives us the opportunity to understand the enigmatic nature of neurotic disorders, specifically hysteria, and to "open the road to the royal path towards the unconscious" (Freud, 1976, p.30). In the 1890s, it was believed among scientific circles that the mental processes that occur in dreams, their bizarre and confused content, were an outcome of irregular excitation of parts of the cerebral cortex through physiological processes occurring during sleep (Jones, 1910). However, Freud argued that dreams, despite their irregular attributes, are similar to other mental processes in terms of their origin and, in this light, they can be psychologically traced. Consequently, according to Jones, Freud’s biographer, Freud, understood dreams as having a meaningful place in the sequence of mental life (Jones, 1910). He declared that "dreams are physical phenomena of complete validity... they are the disguised fulfilment of suppressed and repressed wishes" (Freud 1976, p.33). According to his statement, some wishes are unconscious motives that are unacceptable to the individual and are nearly always erotic in nature. In Freud’s definition and explanation of dreams, all psychic needs have partially their own
special meaning, but they are also connected to a patient's daily activities, presented in the dream in a disguised manner (Freud 1976). Freud included in his theory an explicit explanation of dream types, their content and their mechanisms.

Freud delineated two levels of dream content. The manifest content of the dream can be characterised as the surface of the dream, the content that the dreamer remembers and relates to in his waking life (Jones, 1910). Additionally, Freud acknowledged that some parts of the manifest content typically correspond with a certain part of the latent content. He identified symbols in the manifest content, which usually have a fixed meaning of a more or less sexual nature. In contrast, the latent content is the hidden part, "as the dream we remember is not the right thing but rather a deformed substitute for a dream" (Freud, 1963, p.116). In other words, the manifest content can be regarded as an allegorical expression of the latent content and in order to clarify a dream's meaning, a transformation of the manifest into the latent content is required. This transformation became the foundation of psychoanalysis, in which the exploration of dreams was used to reveal unconscious motivations underlying the patient's conflicts and/or symptoms (Herman, 2001).

The manifest content is formed by various mechanisms that have been an important part of the Freudian theory of dream interpretation. Freud devoted a considerable amount of his work to theoretically develop these mechanisms. They can be grouped under four headings: condensation, displacement, censorship and distortion. Condensation and displacement are arguably the main mechanisms in dreams, producing the transformation of latent content into manifest content. Condensation is a mechanism in which two identically similar elements in the latent content are fused into one element in the manifest content (Jones, 1910). The second main mechanism - displacement - refers to a non-association between the physical intensity of a given element in the manifest content and the associated elements in the latent content. Thus, a central element or feature of the dream may represent the least significant underlying dream thoughts. In contrast, a non-essential and transitory feature in the dream may
signify the main theme of the dream thoughts (Jones, 1910). These two mechanisms can illuminate the dream's seemingly bizarre nature, a nature that varies with the extent to which these mechanisms have been operative in shaping the dream (Jones, 1910).

With regard to the material and the sources of which a dream is made up, Freud found it significant that dream thoughts stem only from the dreamer's personal interest (Jones, 1910). He characterised dreams as "egocentric" because of people's tendency to dream about issues that mainly involve themselves and not others; these issues have concerned them while they were awake (Jones, 1910, p. 306). In other words, every dream's manifest content represents an individual's mental process as experienced in his last waking interval. However, other recent experiences, which have not occurred in the day preceding the dream, are treated in therapy in the same way as more ancient memories (Jones, 1910). In fact, the latent content of the dream emerges from antecedent mental processes that extend back to early childhood.

For Freud, the main aspect of the act of dream interpretation is the translation of the manifest content into the latent content which surfaces through the dreamer's free associations; the mechanisms of transformation are openly acknowledged. According to Freud, a typical process of working with free associations in therapy is asking the patient to describe the dream and then invite him/her to engage in free associations stimulated by a certain element of the dream (Herman, 2001). Following the spontaneous flow of thoughts and feelings (free associations), the patient is asked to describe the full content of the dream, being as objective as possible. According to Freud, there is "a rule that must not be broken: when telling (dreams) s/he must not leave out any idea even if s/he gets one of four objections: that the idea is irrelevant, too senseless, that is not connected with the issue or is too embarrassing" (Freud, 1963, p.117). He emphasised that applying such a rule would ensure an efficient relationship between the analysand and the analyst (Freud, 1963, p.117). However, in many cases, the analysand may have difficulty or confusion with regard to how to transform or grasp the unconscious content of the dream even with free
associations. Likewise, the analysand may be reluctant to accept some of the therapist's elaborations. As Freud suggested, there is a defensive mechanism (resistance) that keeps certain mental processes unconscious, preventing dream thoughts from reaching consciousness. It is as if "something resists to be expressed" (Freud, 1976, p. 196) in a process that can be understood as censorship. It should be noted that Freud's dream theory is only understood in the context of his structural model of the mind. In this model, Freud postulated a tension between the id and the ego, the former being the container of unacceptable, irrational, amoral urges and the latter being the agent of consciousness and the one that must use defence in order to protect the person from anxiety.

**Jung's theory of dreams**

Carl Jung is the other prominent scholar who demonstrated a lifelong interest in dreams. In his book *Memories, Dreams and Reflections* (1963), Jung recounted some of his own dreams and fantasies from early childhood, considering his inner life to be more "eventful" than his outer one (Jung, 1963, p.49). At the beginning of his work he was a close follower of Freud but subsequently distanced himself from him; this break stemmed, in part at least, from a dream. Freud's attempt to interpret one of Jung's dreams as wish-fulfilment (the main concept of Freud's dream theory) conflicted with Jung's view that the dream contains a collective content. This particular dream was instrumental in their intellectual rupture and contributed to the development of Jung's theory of the unconscious. Jung partially agreed with Freud's theory of a dream as wish fulfilment or repression (Mattoon, 1984). However, for Jung, a dream can also be a manifestation of both an individual's personal unconscious and future desirable actions and wishes (teleological activities) (Weitz, 1976). Dreams also expose hidden conflicts by revealing an unknown or hidden side of the dreamer's character. Additionally, Jung hypothesised that all psychic content of the dream has its roots in the collective unconscious. He based this idea on the assumption that all behaviours and ways of perceiving experience must be potential within a person before they become real. These potentialities are contents of the
collective unconscious, a second psychic system following the personal unconscious of a collective, universal and impersonal nature that is identical in all individuals (Jung, 1959). “This collective unconscious does not develop individually but is inherited. It consists of pre-existent forms, the archetypes, which can only become conscious secondarily and which give definite form to certain psychic contents” (Jung, 1959). It is therefore important to clarify its meaning and role in dreams. An archetype is not a motif, a specific image or an idea which has been obtained by humanity. Instead, Jung described it as “a possibility of representation” (Jung, 1959, p.155), as a predisposition to an image that cannot be experienced on itself but it is only known from its effects in dreams, other mental contents, emotions and actions.

Jung provided explicit definitions of the various aspects of dreams: their language, mechanisms, structure, content and their interpretation. For the language of dreams, Jung claimed that it is as complex and as variable as the language of consciousness. Dream language is shaped mainly by non-verbal images. On a simple level, dream language is often figurative, as for example “the lion, the king” is presented in a dream as a manifestation of power (Mattoon, 1984 p.54). On a more complex level, dream language consists of metaphors; abstract thoughts are expressed through concrete imagery (Mattoon, 1984). For example, a dream image of crossing a bridge can be a metaphor of an important transition in the dreamer's life.

Although Jung insisted that “the dream follows no clearly determined laws or regular modes of behaviour”, he acknowledged that there are mechanisms that help shape the dream language (Jung, 1960, p, 535). Jung listed six of those mechanisms: condensation, contamination, doubling, concretising, dramatising and archaic mechanisms. For instance, dramatising is the expression of content in a story form, whilst archaic mechanisms translate unconscious mechanisms into archetypal form. Lastly, concretising is the use of figurative language including the presentation of complexes in embodied form (Mattoon, 1984).
In addition, Jung argued that the majority of dreams have a narrative nature with a fairly complete structure resembling a classical Greek tragedy usually consisting of four parts. The first part of the dream is the exposition: the scene, the time and people who are involved. The second phase is the development of the plot (essential change) which then leads the dream into the third phase, the culmination. In this phase, something decisive happens and leads the dream towards the fourth phase: the lysis, which is the solution or result (Jung, 1974).

According to Jung, every dream must be respected for its integrity and specificity (Kafka, 2002). It cannot be interpreted from its text alone as its symbolism must be translated as well. Every dream is an unknown language, every symbol and image in the dream is amplified by the dreamer's personal experience, namely those facts regarding his environment and other dreams he may have had in the past (Mattoon, 1984). Jung emphasised the importance of the dreamer's personal associations for his dream, based on the assumption that the dream is not disguised but, instead, means what it says (Mattoon, 1984). In practical terms, a Jungian analyst may use direct associations by asking the dreamer to specify how the dream is meaningful to him by encouraging him to amplify each symbol, by asking about the dreamer's personal attribution of emphasis and emotional connection with the image of the dream (Mattoon, 1984). However, it becomes essential for the dreamer to make associations to images as they actually appear in the dream. Sometimes though, a dreamer may stay away from direct associations by introducing irrelevant facts, thoughts and feelings. The analyst should attend to that material, as irrelevant as it may be. While the analyst has to explore the archetypal images of the dream, he must allow for all the possibilities for personal associations to emerge in therapy.

Hence, for Jung, dream images as symbols are interpreted as aspects of the dreamer's inner world (subjective interpretation) and also aspects of his existing real world and experience (objective interpretation) (Giannoni, 2003). Based on that, Jung addressed their complexity, offering a deep understanding of the dreamer and making individual meaning-making available to consciousness. When the amplifications of the dream images are gathered and all the above have
been taken into consideration, both analyst and analysand are ready for the next step: the interpretation. According to Jung, it is important for the analyst at this stage, whilst using certain tools for the interpretation, to avoid theoretical assumptions and to approach each dream as something unknown to him. In addition, the analyst must be aware of the impact of the personalities of both dreamer and interpreter and of the fact that a dream symbol could be psychic fact information about the dreamer's personality (Mattoon, 1984).

A comparison between Jung’s dream theory and Freud’s dream interpretation

Both Jung and Freud placed great significance on the role of dreams in therapy and their interpretation, considering dreams a valid and critical source of information about the analysand’s internal world. However, it seems that Freud’s dream interpretation theory is more expanded in the literature and better-known than Jung’s. While Freud’s work is clearer and more systematised, making his audience understand this argument, Jung’s language is more poetic than scientific. According to Mattoon (1984), a Jungian analyst who wrote a number of books on Jung’s work, his work on dreams was dispersed among his various works making it harder to put together this argumentation.

As mentioned earlier, Freud described the interpretation of the dream as “the royal path to knowledge of the unconscious activities of the mind” (Freud, 1953, p.608). Jung initially accepted this statement, but later on modified it as “the complex is the royal road to the unconscious and the architect of dreams and symptoms” (Jung, 1966, p.25) by claiming that dream interpretation aims to discover both the complexes and what the unconscious says about these complexes.

According to Freud, dreams are repressed wishes that demand, in the dream world, a hallucinatory fulfilment. In contrast, Jung suggested that dreams represent the main problem of the dreamer in a compensatory form and they may act as a sign for the dreamer’s future actions. Freud interpreted dreams through an idea of causality, primarily questioning the cause of the dream, while
Jung considered dreams more of a sign of a dreamer's core problem, looking for the purpose of the dream. For Jung, the initial dream was often brought as a statement of the analysand's key issues and complexes, personal and archetypal perspective (Mattoon, 1984)

Freud and Jung also disagreed over the content of the dream that must be interpreted. On the one hand, Freud insisted that the meaning of the dream is beyond the manifest content, residing in the latent content that will come to light with free associations. On the other hand, Jung maintained the position of interpreting the manifest content (the images themselves) because he believed that the dream is not a disguise. Consequently, the two men differed in their views of dream symbolism.

Freud used the word 'symbol', giving a fixed meaning to the dream image, usually of sexual nature. Jung did not assign a fixed meaning to dream images, as he took into consideration his interpretation of the dreamer's personal experience, cultural and archetypal context. Nevertheless, he acknowledged that some symbols are relatively fixed. By fixity, it seems that he meant that they have valid interpretations without being determined by personal amplifications; personal amplifications could modify fixed symbols to a certain degree but cannot necessarily change them.

Both Freud and Jung underscored the significance of the therapeutic relationship in the interpretation of dreams, although they used a different method in their dream work. Both acknowledged that no interpretation or amplification can be made without the dreamer's consent. For Freud, the analysand's free associations are the most suitable method, as it seems that the meaning of the dream is articulated only by the dreamer. However, the literature abounds with criticisms regarding Freud's free associations as a method, as there is a risk of creating a secondary dream which can be irrelevant to the initial one (Lippmann, 2000). Equally, there is a degree of ambivalence in Freud's position. Although he emphasised in his work the importance of the use of free associations and the analyst's openness, dream interpretation seems limited in the sense that everything is linked to sexual drive without bearing in mind the influence of
other important factors in the dreamer's life. Conversely, Jung pays attention to
the dream's atmosphere, structure, personal, cultural and archetypal context. He
acknowledges the significance of the analyst's knowledge of symbols and
theoretical background, but he also encourages the analyst to be creative and
flexible in his dream interpretative work. For Jung, dreams can be better
interpreted through amplification and an active imagination rather than
interpretation and free associations.

Freud believed that his breakthrough discovery was the expression of wish
fulfilment in dreams. However, a century later, his most enduring contribution
might be considered the technique of free associations and the concept of latent
content. Equally, Jung can be considered as more in tune with contemporary
thought on the topic, given his ideas about relatedness and conceptualising
dreams based on their context. It appears that the dreamer's fulfilment for
individuality through the therapeutic relationship is more in agreement with
contemporary research on socio-cultural and interpersonal relationships.

Both scholars brought to the surface each other's personal complexes (as
illustrated in their work) and through their disagreement, conceptualised
different approaches to dream analysis as well as to general psychological
theories (the latter is beyond the scope of this essay).

Conclusion

Throughout the rapid growth of psychoanalysis we see increased attention being
given to other phenomena such as object-relations, the therapeutic relationship,
transference and countertransference (Bass, 1993). These developments raise
the question of whether or not dreams are used in the same way, with the same
frequency and purpose as a few decades ago. In recent literature, the
phenomenon of transference has become a crucial aspect in dream work, so the
assumption that the analyst is a classic blank screen or a neutral observer and
interpreter of dreams, as the classical psychoanalysis of Freud and Jung suggests,
can no longer be sustained (Bass, 1995).
A dream may serve as a source of information for the quality of the relationship between analyst and analysand, since the analysand's dream content or narrative may be influenced by the analyst's stance, style and views about dreams (Bass, 1995). Through the dream work, the analyst's dream interpretations or associations and the analysand's reflections can bring to light aspects of their relationship. Dream interpretation seems to be a collaborative work, as it requires on one hand, the analysand's creativity in order to recall the dream and on the other hand, the subjectivity of the analyst in order to interpret the dream. Both participants are influenced by their transference and countertransference within therapy. In addition, based on his/her transference and his/her theoretical understanding, the analyst has to interpret the analysand's dream based on a particular context, which is in a sense a highly subjective situation. The analyst must be the "objective outsider," yet he must simultaneously share the subjective situation of the dream in order to interpret it (Frey-Wehrlin, 1962).

Reviewing the literature, it appears that dream work in contemporary psychoanalysis and its emphasis in the therapeutic relationship does not differ radically from Freud's and Jung's premises: some of these premises are still considered a useful therapeutic tool in psychodynamic-oriented therapies. Learning from his mistakes in his therapeutic work, Freud shifted from being only an interpreter of dreams and allowed transference and resistance to become vital principles in his dream work (Bass, 1995). Similarly, Jung acknowledged the fact that the analyst must introduce an entirely new theory of interpretation to every dream, based on the stage of therapy and his relationship with the analysand (Weitz, 1976).

Despite their differences in dream theories, both Jung and Freud acknowledged and emphasised the centrality and purpose of dreams in psychoanalytic work. In contemporary psychoanalysis, dream work may not be as significant as suggested by Freud's and Jung's works. It is, however, relevant.
Final thoughts

Reviewing Freudian and Jungian dream theories invites questions and thoughts about the role of dream work in counselling psychology. According to Jung, a dream could be an indication of the quality of the therapeutic relationship; therefore dream interpretation requires collaboration between client and therapist, a good therapeutic relationship and the therapist's capacity to get into the client's world. Interestingly, all of the above are considered as some of the main characteristics of counselling psychology. Despite its focus on these aspects, which are simultaneously key tools for dream work, counselling psychology does not make explicit the role of dreams in the counselling psychologist's therapeutic work. Taking into consideration the fact that counselling psychologists value and focus on the therapeutic relationship, it would be worth considering working with dreams to become a key aspect of the therapeutic work.
References


Integrating Compassion Focused Therapy in Cognitive Behavioural framework

Introduction

For almost 20 years, Cognitive Behavioural Therapy (CBT) has been considered the most effective therapy for various mental illnesses such as depression and anxiety disorders (Lambert, Berging & Garfield, 2004). CBT aspires to bring about emotional change in individuals by altering their thought process. Based on this, there is a wealth of evidence of improvement to people's wellbeing and functioning, based on a structured process of focusing on and reframing their thinking styles, altering their behaviour and consequently achieving emotional shifts (Clark & Steer, 1996).

However, for some people with longstanding difficulties who experience high levels of self-shame and criticism, it appears that this process fails to engage them on an emotional level. For this reason, Compassion Focused Therapy (CFT) focuses on these clients aiming to provide an emotional shift which, it seems, cannot be fully achieved through CBT.

The aim of the first part of this paper is to present the Compassion Focused Therapy model, its therapeutic benefits and some of its divergences from CBT and to narrate how it can be applied in a CBT context. The second part of the paper will illustrate these though clinical examples of CFT application based on the author's clinical experience. Lastly, some of the challenges and rewards of using this approach will be presented.

Cognitive shift versus emotional shift... when CBT is not 'effective enough'

Recent advancements in theory have argued that CBT, which focuses on thoughts and behaviours, tends to neglect the role of emotion in psychopathology. In clinical practice, many clinicians commonly experience this failure with clients who say: “I can see the logic of CBT but is does not change how I feel about myself. I know logically I am not a bad person but still I feel like this.” (Gilbert, 2009). In these cases there seems to be a divergence between what the person
understands from a cognitive perspective and what he/she experiences emotionally. This discrepancy constitutes a substantial challenge for the cognitive behaviour therapist working with these groups, as it is rare to observe psychological improvement and symptom reduction maintained over time. It seems that this partly happens because, without the congruent emotional shift, the alterations in thinking style seldom retain their capacity to shift behaviours (Lee, 2005). Thus, the therapeutic process requires attention to emotional-based reasoning rather than cognitive-based reasoning, which is likely to be achieved within Cognitive Behavioural Therapy (Lee, 2005). Clearly, this is a dimension that CBT has not fully addressed and its limitations are more evident when it is provided to people with longstanding difficulties.

The aim of Compassion Focused Therapy

For the above reasons, the development of Compassion Focused Therapy (CFT) moves cognitive behavioural therapies in a different direction. This model of therapy aims to understand and help individuals who experience high levels of shame and self-criticism by focusing on emotional-based reasoning rather on cognitive reasoning (Lee, 2005). Drawing from CBT, evolutionary theory, Buddhist psychology and neuropsychology, CFT is underpinned by the goal of applying compassion and its healing benefits to the therapeutic context.

Influences on the development of Compassion Focused Theory

The healing benefits of compassion have been presented in various areas within the literature. For example, in Buddhist psychology compassion has its centrality as it has been influenced by Buddhism. The Dalai Lama often emphasises that "If you want others to be happy – focus on compassion. If you want to be happy yourself – focus on compassion." (Dalai Lama, 1995; 2001) In contrast, in mainstream western psychology an individual’s personal relief from depression or anxiety is based on building self-esteem and self-regulation and is often less focused on developing acceptance, compassion and kindness (Gilbert, 2005). Interestingly, some western theorists started considering compassion as a healing process, inviting the discipline to embrace it as a psychological concept.
For example, Neff (2003) was influenced by aspects of social psychology and Buddhist tradition related to compassion, kindness, openness, acceptance, warmth towards the self and others. Specifically, compassion involves being open to, and being moved by, the other's experience of suffering (Neff, 2003). It also entails engaging with people with patience and a non-judgemental understanding that recognises that all humans are imperfect (Neff, 2003). Gilbert, a British professor of clinical psychology, drawing from the evolutionary model of social mentality theory, suggests that humans co-create different role relationships (sexual, attachment) via the exchange of different signals. Different social signals activate different brain and physiological systems; for example, activation of the soothing system is related to the ability to be compassionate towards one's self and to others (Gilbert, 1989). Gilbert considers compassion as an ability which is linked to motivational, emotional and cognitive-behavioural capacities such as the desire to care for the wellbeing of others, the capacity to recognise and process distress, the empathy to understand the sources of distress, and finally, the will to do what is necessary to help in a non-critical manner (Gilbert, 1989).

For the above reasons, Compassion Focused Therapy seems to be suitable for people with high levels of shame and self-criticism. Such people usually experience difficulty in being kind to themselves and feeling self-worth. It has long been known that issues of shame and self-criticism originate in histories of abuse and generally in neglectful abusive environments (Gilbert, 2009). People with these experiences become highly sensitive to threats and criticisms from the outside world and they are quick to activate an internal self-critique (Gilbert, 2009). Based on this perception, they are in a constant state of being attacked from both the external and their own internal world, as if there is no place where they can be safe. Usually, this client group has been engaged in cognitive behavioural tasks in therapy and has been educated to acknowledge and express alternatives to their negative thoughts; however, they do not manage to internalise their alternative thoughts (Gilbert, 2009).
Basic concepts of Compassion Focused Therapy

Drawing from neuropsychology, Compassion Focused Therapy attempts to fill the gap in CBT by asking: What are the affect systems that enable us to feel reassured or to register human warmth? Research suggests that there are three types of affect regulation systems: a threat and protection system, a drive resource-seeking and excitement system and a contentment, soothing and safeness system (Depue & Morrone-Strupinsky, 2005). A detailed account of the neuropsychological functions of each regulation system is beyond the scope of this paper. It is worth stating though that in CPT, the therapist's formulations and thoughts are organised around the three affect regulation systems and mainly on the contentment and soothing system (Gilbert, 2009). It is believed that these three systems can become unbalanced and one of the goals of therapy is to rebalance them (particularly that of the contentment system). In particular, the contentment system develops through caring behaviour and physical proximity (Gilbert, 2010). Thus, parental caring behaviours stimulate soothing over arousal in the individual, stirring a sense of relief and calm. In CFT, it has been hypothesised that people with a high level of shame experience heightened over-activity of the threat protection system, whilst the soothing system is insufficiently accessible to them (Gilbert, 2010). A possible explanation for this is that the soothing system was under-stimulated during their early life when parenting was perceived more as threatening than reassuring (Gilbert, 2009).

The clinical practice of Compassion Focused Therapy

Based on this hypothesis, the CFT approach follows a different route from that of CBT. For example, some people who feel unlovable because they have few emotional memories may not respond to objective evidence that they are lovable - offered to them within a CBT framework. Therefore, the CBT emphasis on threat processing in order to reduce safety behaviours or on trying to find objective evidence which reject the thought that 'I am unlovable' may not help these people access feelings of safety. On the contrary, research has shown that self-compassion deactivates the threat system and activates the soothing system (associated with positive feelings). Therefore, CFT, and particularly
Academic Dossier

Compassionate Mind Training (CMT), was developed to help people learn to develop self-compassion and compassion for others via the practice of certain tasks and exercises, with the intention of activating their soothing system. CMT is based on the idea that people can learn to change their thoughts, feelings and related behaviours through mind training. The aim of the group is to help clients learn some basic skills of compassion that involve creating warmth, kindness and support; these skills help clients develop an internal compassionate relationship with themselves in order to replace self-blame and self-criticism (Gilbert, 2009). Hence, CMT encourages people to accept and be compassionate with their automatic reactions, to understand them not as any fault of their own but as the outcome of biological factors, conditioning and learning (2009). Instead of trying to frame these automatic thoughts as distorted cognitions, CFT views these initial reactions as safety behaviours, considering that through them people are trying to regulate painful emotions, memories and situations. It invites people to stand back and reflect on their automatic defences with compassion and therefore upstage their self-critique (Gilbert, 2010). Interestingly, Compassionate Mind Training avoids using some CBT language such as cognitive distortions but does deploy certain CBT techniques like Socratic questioning, guided discovery, psycho-education and a modified version of imagery.

The second part of this paper presents some clinical examples and reflections based on the author’s clinical experience with CMT and CFT.

**Clinical examples of Compassionate Mind Training**

I had the opportunity to co-facilitate a Compassionate Mind Training group in my current clinical placement, a secondary case service. Taking into consideration Gilbert’s case studies on CMT, we offered 12 weeks of CMT group therapy to 10 individuals with longstanding difficulties who were experiencing high levels of shame and self-criticism. During the group therapy, various compassionate techniques were used such as a modified version of imagery the ‘perfect nurturer’ that generates warmth, understanding and compassion towards the self (Lee, 2005). Clients were invited to form a human image or a safe place image, either of which have the capacity of extending compassion and warmth.
towards them (Lee, 2005). The main idea was that when people were struggling to generate alternative thoughts (a form of cognitive restructuring) or feelings to their self-blame, they could focus on their compassionate image and consider "What would my perfect nurturer say to me?" Unsurprisingly, most of the people in the group found this technique extremely hard to practise and when they tried they heard mainly critical voices from their perfect nurturer. Any client names mentioned in the following part have been changed for confidentiality reasons. However, during the later sessions of the group, Louise, who really struggled to practice this exercise throughout CMT, managed to form the image of Mother Teresa (whom she had met while working as a nurse in Africa) as her perfect nurturer, generating warmth and soothing her. Another client, Ashley, who was suffering from PTSD and intrusive flashbacks, was initially very upset when trying to form a perfect nurturer image. However, during the later stages of CMT, she managed to form an image of her beloved grandmother, the only caring figure she had known in her life. It was a very powerful experience to see people, who had initially come to the group with a high degree of self-blame thoughts/emotions, developing new emotional responses and self-soothing strategies.

Rewards and challenges of working with Compassion Focused Therapy

By exploring the literature on CFT and reflecting on my own experience of working with this approach I formed the impression that working with people with high levels of shame and self-criticism could be both a rewarding and challenging experience.

Taking into consideration the outcomes of CMT and the follow-up sessions with our clients, CMT appeared to be effective in that most of them developed the ability to soothe themselves. A significant reduction of their depressive symptoms and anxiety was also observed, which coincided with Gilbert's and Procter's study's results (2006) on CMT with people with chronic difficulties. It is worth mentioning some of our clients' responses to the group when they were asked about it in the follow-up sessions. Susan found CMT beneficial because, she said: "I discovered a part of my brain which I didn't know existed. I learned how to sooth
myself, how to cuddle myself when I wanted to harm myself... I learnt that it is not my fault for what happened to me and it is OK to feel the way I feel”. Laura, another client who had been suffering from severe depression for 5 years, said: “I learnt that I cannot change the life I've lived, but I can change the life I am living... and that helped me to be more compassionate with myself when I think about my past.”

However, it should be mentioned that some members of the group found CMT stressful as it activated powerful negative feelings such as sadness, grief or emotions of abuse associated with shame. For some people, compassion and self-kindness were viewed with suspicion as if such self-indulgence was not deserved. This resonates with the literature which suggests that it is a common phenomenon for such people to enter therapy as very vulnerable and needy, with an attitude of intense suspicion towards the therapist, something that I experienced as a therapist in the initial stages of CMT group. I remember feeling very intimated by the way the clients looked at me and I recalled my supervisor’s strong recommendations to be very mindful of my facial expressions and body posture. According to the literature, people with a high level of shame tend to monitor and interpret certain signals as threatening or safe and, specifically in a therapeutic context, the therapist needs to notice the client’s signals indicating distress (facial and postural expressions, verbal comments) and respond by sending clear signals of empathy, a non-judgmental stance and a positive regard towards the client (Trevarthen & Aitken, 2001). Also, developing self-compassion generates not only suspicion but also gender stereotyping issues (mainly in male members of the group). For example, Richard, a male ex-drug addict, found it very shameful to be compassionate towards himself because, as he said: “Compassion is for women who are soft. Men don’t ‘do’ emotions, we are tough”. Interestingly, Richard was able to establish a good therapeutic relationship with the group facilitators which helped him challenge and change this belief by generating some compassionate thoughts, thereby activating his soothing system.

Establishing a good therapeutic relationship is, therefore, a key feature of the process as it constitutes the first source of compassionate relating and activates
the client’s soothing system (Leahy, 2001). For these clients, an internal source of soothing is not available to them, so they turn to external sources, including the therapist. This may be a challenge for the therapist, as he/she will be tested for his/her trustworthiness in order to prove his/her emotional availability to the client. Thus, it requires an open discussion between the therapist and the client, with the therapist exploring what is potentially threatening or what might feel safe, while validating the client’s feelings of insecurity, shame and suspicion in an empathic manner. It may also require that the therapist negotiates access to the patient (via telephone or emergency consultations) outside the session (Linehan, 1993).

After using both CBT and CFT approaches, I noticed some differences in the way I had to work. With CFT, I did not necessarily have to set an agenda at the beginning of the session; I was less directive than I had to be with CBT; I tended to allow more space for silences, letting the client reflect on how he/she was experiencing the therapy and I avoided asking him/her a series of Socratic questions (Gilbert, 2007). This was fairly challenging as I had to slow myself down as I was employing the CBT approach with other clients. It felt more as if I was ‘being’ with clients rather than ‘doing things’ with them such as setting an agenda or carrying out behavioural experiments. As Gilbert tellingly claims in his book: "When we have to train therapists from other approaches, particularly CBT, we have to slow them down... to teach them how to use one's tone of voice, non verbal communication....to provide emotional context where the client can experience the therapist as compassionately alongside him" (Gilbert, 2010, p. 8). This coincides with the literature’s contradictory accounts of therapists’ experience of applying CFT. One the one hand, it seems that therapists who apply both CFT and CBT with voice hearers find that when they use CFT with these clients, the experience is rewarding and they manage to establish a quicker therapeutic alliance (Mayhew & Gilbert, 2008). On the other hand, it seems to be a quite common phenomenon for therapists who apply CFT with severely disturbed clients to neglect their own needs for care while they devote their energy to the needs of their clients (Figley, 2002). The task of listening conscientiously and compassionately to narratives of pain and abuse can easily
erode compassion and increase personal distress and insecurity within the therapist in what is referred to as compassion fatigue (Skovholt, Grier & Hanson 2001). Thus, from time to time, therapists are allowed to become needy persons who seek support, empathy and compassion from skilled supervisors as well as from other professional and non-professional figures (Gillath, Shaver & Mikulincer, 2005). In my own experience as a co-facilitator but still a trainee therapist, there were times when I found listening to the CMT group clients' self-critical statements and narratives of pain extremely challenging. Debriefings and supervision with other facilitators were a good source of support and an opportunity for self-reflection as a therapist.

**Final thoughts**

Despite its recent development, Compassion Focused Therapy can be considered useful both as a theoretical concept and as a beneficial therapeutic approach, which can be integrated into a broader CBT therapeutic framework. As a therapeutic approach, CFT manages to engage clients emotionally and bring out about emotional shifts while increasing the possibility of maintaining symptom reduction over time. It can also advance the emotional immediacy between client and therapist which can in turn bring about therapeutic change. CFT addresses the significance of compassion as an intervention and a therapeutic skill but also as a personal quality and a 'survival mechanism', not only in a therapeutic context but also more generally in our individualistic society. As a theoretical concept, CFT moves CBT therapies in a different direction, towards integration which interestingly is in line with counselling psychology's integrative approach to psychotherapy. As Gilbert claims, "It adopts the philosophy that our understanding of psychological and neurophysiological processes is developing at such a rapid pace that we are now moving beyond 'schools of psychotherapy' towards a more integrated, biopsychosocial science of psychotherapy" (Gilbert, 2009, p.199). Based on that integration, on a practical level the therapist in CFT becomes implicated (intellectually and emotionally) in the process by using CFT with the client and being with the client, in contrast with the CBT therapist who is mainly the facilitator of a process. This integration seems important yet it
Academic Dossier

hides many challenges for the therapist and good support is therefore needed when practising this approach.

Hence, CFT has eventually succeeded where CBT therapy could not: in developing specific interventions with certain client groups, relieving people who experience a high level of shame and self-criticism from personal distress, and providing them with a greater sense of wellbeing. Also, its increased research evidence indicates that it is a promising and possibly effective treatment approach for this client group. Thus, it could be suggested that NHS should rethink its emphasis on CBT therapies, namely on quantifiable and structured models of engaging patients, which despite their significant evidence-based effectiveness, do not after all seem to respond to all possible manifestations of suffering. The way forward appears to be the adoption of more integrative psychotherapies in NHS.
References


Understanding anorexia nervosa from an attachment perspective

Introduction

In the last three decades, anorexia nervosa has received substantial attention from both clinicians and researchers for a number of important reasons. It is a complex condition with an increased prevalence in western societies and has the highest mortality rate among all mental health difficulties (Herzog et al., 2000; Neumarker, 1997, Grenon, 2010).

Anorexia is characterised by an intensive and constant fear of gaining weight and maintaining body weight (APA, 2000). It occurs mainly in women and it is known that approximately 1-4% of adult women have been diagnosed with anorexia (APA, 2000). These individuals frequently suffer from various mental health presentations such as depression, anxiety, personality disorders and substance addictions (Grilo, White, Masheb, 2009). The origins of anorexia seem to vary. It is thought to develop as a result of interactions between biological predisposition, family dynamics, developmental challenges and socio-cultural influences (Nagel & Jomes, 1992). Interestingly, despite the fact that the above risk factors should help us predict who is more likely to develop anorexia, it is still undetermined whether they are enough to address the underlying issue in such severe difficulties. Anorexia nervosa has been conceptualised in various theoretical frameworks such as psychoanalytic, systemic and cognitive theories and most recently by attachment theorists.

The main aim of this paper is to provide an understanding of anorexia nervosa from an attachment perspective, to present some research evidence and some clinical implications for therapeutic work and to offer some thoughts and reflections on the difficulty through the prism of this particular theoretical perspective.

Even though the aim of this paper is not to focus on the diagnostic aspects of anorexia, it is nonetheless worth presenting them. From a medical perspective, DSM-IV includes a mixture of weight, behavioural and psychopathological
constructs for anorexia. It has been defined as a) refusal to maintain body weight at or above a minimally normal weight, b) intense fear of gaining weight or becoming fat, even though underweight, c) disturbance in the way in which one's body weight or shape is experienced, undue influence of body shape on self-evaluation, or denial of the seriousness of the current low body weight and d) in postmenarcheal females, amenorrhea (APA, 2000).

Interestingly, among mental health difficulties, anorexia may be considered as one of the conditions that has clear and documentable behavioural features and common quantifiable metrics, which is a benefit for good classification (Hebebrand & Bullik, 2011). However, the language around anorexia is still esoteric and vague. Based on Hebebrand & Bullik (2011), the term ‘underweight’ is rather less than precise as the line between healthy and harmful underweight is not sharp and it cannot be defined in terms of weight-specific cut off. However, a further analysis of anorexia from a medical perspective is beyond the scope of this paper.

**Attachment theory and anorexia nervosa**

Attachment theory has received increased interest from clinicians who seek a relational understanding for anorexia. Specifically, Bruch (1974) who was the first researcher in this field, presented some psychoanalytical ideas that were vastly influential for the development of the attachment perspective of anorexia. According to Bruch (1974), anorexia is developing in family environments which are characterised by overprotection, an intrusive mother-daughter relationship with few opportunities for self-expression. She argued that these interactions lead the child to develop a highly compliant ‘false self’, where self-starvation becomes a way of underlying communication of protest and attempt for autonomy (Bruch, 1974). Bruch (1974) was the first to characterise anorexia as the failure to successfully complete the developmental task of separation, that is, the individuation process which becomes particularly acute throughout adolescence.
Over the years, a number of attachment theorists have been influenced by Bruch’s proposal that early relationship difficulties possibly lead to the development of anorexia and to the failure of separation and individuation process (Bruch, 1974). More specifically, they suggest that anorexia is a manifestation of the quality of attachment (usually an insecure attachment) of early relationships with parents. In particular, it assumes that individuals suffering from anorexia fail to develop autonomy from parental figures and consolidate a separate identity from these figures (Sours, 1974). Taking into consideration this concept, research has focused on examining separation anxiety by exploring participants’ experience of separation from their attachment figures. The findings indicate that separation from an attachment figure triggers deeply-held beliefs and emotions associated with these situations (O’Shaughnessy & Dallos, 2009). Also, the findings show that insecure attachment styles are associated with extreme difficulties of separation and individuation from the attachment figures (mother and father) to the point where they are unable to discriminate cognitively between short or long breaks (Ward, Ramsey & Treasure, 2000; Armstrong & Roth, 1989; Troisi et al, 2005). A common significant result in these studies is the participants’ strong need to be looked after and, at the same time, a fear of intimacy and rejection by others (Armstrong & Roth, 1989; Troisi et al, 2005). Specifically, insecurely-attached individuals tend to divert their attention away from their attachment-related concerns (separation anxiety) towards an external goal of body image. Therefore, it seems that anorexia and extreme concerns over body image acts as a manifestation of their autonomy (Cole-Detke & Kobak, 1996). This concept echoes with Bruch’s early ideas, that anorexia is the manifestation of autonomy, following the individual’s failure with the separation and individuation process. This is an indication that her ideas remain alive and influential.

**Anorexia as a ‘proximity-seeking behaviour’**

Another attachment concept that is useful to an understanding of anorexia was developed by Orzolek-Kronnner (2002) who claimed that anorexia is the expression of re-enacted proximity-seeking behaviour. Based on Bowlby’s
Academic Dossier

concept (1969), proximity-seeking behaviour is one of the main forms of attachment behaviour in children. It serves to protect the child from physical and psychological danger by calling for the caregiver who, by satisfying the infant’s physical needs, enables the infant to develop physical and psychological security (Bowlby, 1969). In the case of anorexia, Orzolek- Kronner (2002) defines proximity-seeking behaviours as food restriction, self-induced vomiting and laxative abuse. These behaviours often increase the physical proximity between the adolescent and the mother. It seems that the close physical proximity that results from the feeding experience between infants and their mothers is re-enacted through the anorexic’s refusal to eat and the mother’s numerous feeding attempts to the anorexic individual (Orzolek-Kronner, 2002). In this case, it appears as if anorexia is a manifestation or representation of early infantile child attempts to seek parental proximity (Orlolek-Kronner, 2002). Interestingly, this pattern has been confirmed in clinical self-report observation among mothers and their anorexic daughters, who claim: "we feel more connected" (Orlolek-Kroner, 2002, p.423). However, this perspective is relatively innovative in this field and more research is needed to develop and support it.

A transgenerational perspective of anorexia nervosa

Other attachment theorists address the mother-daughter relationship in various ways: some have used the term 'transgenerational transmission' of attachment patterns from mother to daughter, or 'unresolved attachment style' from mother to daughter (Ward et al, 2000; Fonagy et al, 1996). There is evidence that attachment patterns remain across generations, making the transmission of attachment circularity a transgenerational affair (Ward et al, 2000). In their study, based on the concept of transgenerational transmission, Ward et al. (2001) found that both mothers and daughters shared a significant common characteristic, the dismissive attachment style. Interestingly, this observation could be understood from two different perspectives. From the mother's perspective, her dismissive stance derives from the suppression of her own needs on those of her infant which lead to a limited reaction towards the infant's emotional attachment needs, especially when these stir up negative feelings
(Ward et al., 2000). From the child’s perspective, growing up unable to differentiate his/her needs from his/her mother’s leads to a defensive stance, a turning away from painful material, in the case of anorexics; this material could be the denial of hunger (Ward et al., 2000). Evidence produced by Ringer & Crittenden (2007) examining mothers’ experiences of their anorexic daughters seems to be in line with this perspective, acknowledging that anorexia reveals the anorexic’s mother’s unresolved loss or trauma (which influenced the attachment style) which has an indirect impact on her anorexic daughter. The findings emphasise the mothers’ own experiences of trauma and loss as well as their strong desire that their daughters “should not be affected by this” (Ringer & Crittenden, 2007, p. 128). Additionally, another study by Ward et al. (2001) highlights the mothers’ hesitance to share any of their experiences; only 50% of mothers agreed to participate, suggesting that they were potentially fearful or unable to engage in discussions about their own past and its relationship with their daughters (Ward et al., 2001). Unspeakable threats and unprocessed traumas tend to become ‘family secrets’ that become buried within the family. Consequently, a mother’s anxieties and traumas and a daughter’s attempt to communicate her need for love, soothing and care from her mother can lead both of them to the development of insecure attachment styles and later on to dysfunctional communication within the family (O’Shaughnessy & Dallos, 2009).

**Father-daughter relationships and other family factors in anorexia nervosa**

Interestingly, attachment theory embraces a systemic comprehension of anorexia, indicating that it is not a single narrative but rather an overall framework which seems essential for anorexia given that most clinical cases present dysfunctional family relationships and dynamics. Attachment theory therefore pays attention to the mother-daughter relationship, but also expands its investigation into the father-daughter relationship (Zachrisson & Skarderud, 2010). Ward et al. (2000) found a strong but stressful attachment between father and daughter, whilst daughters perceived their fathers as more admired and influential than their mothers (Gurevitch, 1993). The strong but stressful attachment style between father and daughter could be explained within
research evidence organised around the fathers' characteristics (Gurevitch, 1993). The fathers were highly judgemental of others' characteristics, including those of their daughters; they valued achievement, ambition, appearance and thinness (Dixon, Gill & Adair, 2003). The daughters, aware of their fathers' dissatisfaction, desperately sought approval and feared their rejection (Gutzwiller, Oliver & Katz, 2003). Whilst the father-daughter relationship and attachment style have been acknowledged as a significant part of the development of anorexia, research is fairly limited. It is worth considering whether this derives from the researchers' limited interest or from the fathers' unwillingness towards or fear of participating in these studies, or the type of their relationship with their daughters.

The above discussion echoes Selvini-Palazzoli's (1974) suggestions that high parental demands, dysfunctional communication, poor conflict resolution within family members and self-sacrifice are central features of 'anorectic families'. Tellingly, studies have shown that these issues are more noticeable by individuals with anorexia than by their parents (Cuncha, Relvas & Soares, 2009). These individuals perceive their families as less capable of redefining stressful events in order to make them more manageable (Cunha et al, 2009). This agrees with the findings of Dancyger et al. (2005) that daughters experience family functioning as more chaotic and unhealthy than their mothers did. Taken together, these issues and dynamics are seen to prevent communication, leading the daughter to feel unable to express and therefore suppressing her need and consequently to develop anorexic symptoms.

**Clinical implications**

The attachment framework could be useful to give therapists a broader understanding of their client's attachment style and the potential difficulties to emerge in therapy, especially the intricacy of establishing a therapeutic relationship with anorexic clients. It can also provide some indications of how therapists can create an atmosphere in which clients can experience a secure attachment relationship.
For anorexic individuals, developing a therapeutic relationship is often a frightening process due to the fact that these individuals often tend to have more severe separation and attachment issues (Barth, 2008). The fear of being abandoned and disappointed by their therapists as the latter get to know more about their symptoms leads some clients to hide them until "a therapist has passed a number of tests" (Barth, 2008, p. 359). Therapists could enable the development of a trustworthy and safe relationship through a genuine acceptance of the individual’s anxiety about trusting therapy. Gradually, therapy turns into a safe place in which the individual can shape a new attachment relationship, disclosing his/her symptoms to the therapist (Barth, 2008). In parallel, it would be beneficial for therapists to formulate a systemic understanding of expectations regarding relationships with parents by looking at the meaning of the relationships and exploring the coping strategies that families use in dealing with difficult situations or challenging family systems beliefs.

Individuals with anorexia can form a very challenging client group who can stir up emotional reactions in the therapists from a lack of commitment and patience or worse to aggression and rejection. Thus, it is important for the therapist to set clear boundaries, to seek support and supervision from skilled supervisors or even undergo personal therapy.

Critical evaluation

To sum up, attachment perspectives of anorexia have received increased interest from clinicians who seek a relational understanding of anorexia. Firstly, this could be because it integrates and simultaneously challenges ideas from different psychotherapeutic traditions such as psychoanalysis (Fonagy, 1998), cognitive therapy (Liotti & Pasquini, 2000) and family therapy (Kozłowska & Hanney, 2002). The multidisciplinary basis of the theory provides a tool for a better understanding of the individual with anorexia within a family and societal context. In the case of anorexia, there is a balanced combination of the above approaches; they adopt a fairly flexible stance related to the risk factors of anorexia (the mother’s role, cognitive dysfunctional patterns which lead to body dissatisfaction or family dysfunctional relationships) and attachment theory. It is
worth emphasising that attachment theory aims to understand a) the quality of attachment in the early relationships of individuals with anorexia and b) parental behaviours yet not their parenting per se. Therefore, in contrast to psychoanalytic approaches, it attempts to reduce the mother's blame in two ways: a) by trying to understand the mother's early history and the potential reasons which have led her to develop this maternal stance towards her anorexic child and b) by bringing to light the importance of father-daughter relationship, an aspect which has been neglected for years.

A large body of research has been devoted in examining the types of attachment styles and family patterns which are associated with anorexia, leading to inconsistency in results and overgeneralisations. Two areas of research which indicate high inconsistency in their results are the attachment styles associated with anorexia and the transgenerational transition of anorexia from mother to daughter. Specifically most of the research evidence has shown inconsistency in the styles of attachment (e.g. insecure, dismissive) related to anorexia (Troisi, Massaroni & Cuzzolaro, 2005; Armstrong & Roth, 1989). However, this inconsistency may be explained by the limited research on the subject. The same could be argued about the research suggesting that there is a transgenerational transmission of anorexia from all mothers to their daughters or that all mothers have experienced early loss or trauma. Again, the inconsistency between the theorists and the researchers, who have attached different meaning to loss and trauma, leads to a vague understanding of what is defined as a loss or trauma experience and how this relates to anorexia. Similarly, Selvini-Palazzoli (1974) suggests a specific description of 'anorectic families' as an attempt to portray the characteristics of a family of individuals with anorexia. However, this could be characterised as an overgeneralization, given that no specific family type or historical constellation has been found that either predicts or explains anorexia. Therefore it is suggested that, as therapists, we should keep in mind a) these ambiguities in terminology and b) not over-generalise the limited and contradictory research results and use them as clinical guidelines for clinical work.
Concluding Remarks

It could be argued that a clear categorisation of attachment styles would give a clearer understanding of both the psychological and behavioural aspects of anorexia and clear clinical guidelines on how to work with them therapeutically. However, any attempt for a clear categorisation of attachment styles raises a number of questions for both therapists and individuals with anorexia. It is worth considering, as counselling psychologists, how helpful a clear categorisation of attachment styles would be for us in our clinical work. Would it be a diagnostic tool which would give use some guidance on how to work in therapy? Or would it be a diagnostic tool which would lead us to label the client and dismiss his/her experience, something that is against our principles as counselling psychologists?

There is also a dilemma about how useful this categorisation would be for the client. It could be argued that for the majority of clients, a clear categorisation of their attachment style might lead to a positive therapeutic outcome. Specifically, by recognising their attachment style (through therapy), it would possibly give them a chance to start being open to the fact that their distress is not self-induced, which would facilitate the development of a less punitive self-concept. Also, they might see this classification as the beginning of externalising their problem. In other words, once they identify a disruptive attachment style in their early relationships, it would be easier for them to express their repressed feelings towards their mothers.

The fact that attachment theory has a multidimensional stance in relation to anorexia might explain the difficulty in formulating a precise categorisation of attachment styles related to anorexia but also for the vague language. Specifically, the precise categorisation of attachment styles based on eating symptoms or generalising that all clients with anorexia have a history of loss or that they are necessarily embedded in dysfunctional family relationships, can diminish the range of exploration of an individual's experience and dynamics.
What seems to be the best way to formulate a picture of anorexia is to listen to individual narratives and understand their phenomenological experience (Dallos & Denford, 2008). The multidimensional stance of attachment theory allows the individual with anorexia to be seen as the centre of a matrix in which biological, family and social factors combine in the development of anorexia. Therefore, it is suggested that instead of focusing on a specific attachment style, the therapist should consider more the requisites of an individual's current attachment behaviour, personalising this attachment pattern as 'unique'. Understanding his/her interpersonal strategies and how they have developed in their social and cultural context and life experiences could be more beneficial rather than simply categorising the problem as one of attachment styles.

What seems to be crucial here is that attachment theory has sufficient commonalities with counselling psychology in the way it approaches anorexia, since it acknowledges respects and validates the individual's experience and distress. In other words, counselling psychologists have to adopt a phenomenological stance in exploring the individual's attachment patterns within the period of therapy, as well as curiosity and a non-judgmental stance on how clients understand and experience anorexia, its symptoms, its function and its meaning (Barth, 2008). Potentially as counselling psychologists it will be more helpful to consider the severity of the anorexia and the level of human distress, rather than focusing on symptoms and diagnosis.
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Introduction to the Research Dossier

This dossier contains a literature review and two research projects conducted during the four years of my training. The literature review explores the role of the body in psychotherapy. The first research report is a qualitative study that examines counselling psychologists’ experience of the use of the body in therapeutic encounters. The second research report is a quantitative study that explores therapists’ attachment styles and their use of touch in clinical practice by investigating whether therapists’ attachment styles influence their use of various types of touch in their clinical work with adult clients.
Abstract

This paper aims to provide a chronological overview of the literature on the role of the body and its applications in psychotherapy. It follows developments and divergences in psychoanalytic thought, including the work of the controversial body therapist Wilhelm Reich, widely considered one of the forefathers of therapeutic discourse on the body. It continues by examining the work of other key figures from the Gestalt, psychodynamic, biosynthesis, and humanistic schools of thought. The paper concludes with ethical and cultural considerations about working with the body, a critical synopsis of the existing literature and recommendations for further research.

Keywords: body, psychotherapy, touch, body work
Introduction

Throughout the years the body has been seen variously as a repository of sin by various religious groups, an object of scientific research by biology and neuroscience or something to be medicated and treated with medicine (Young, 2006). In the context of psychotherapy, the use of body has been both acknowledged and disowned over the years due to the interchange of cultural, societal, religious and ethical factors.

In the early years of psychotherapy, the exploration of the relationship between psyche and soma was an integral part of the clinical work of various psychotherapists. Janet, a French psychologist, was the pioneer of introducing the use of the body into clinical practice. He used the body as an essential tool and a source of information for the difficulties of his clients (Young, 2006). Subsequently, his work on the use of bodily aspects seemed to influence analysts such as Freud and Jung who both recognised the importance of the body as a means of expression of unconscious material and attempted to conceptualise the underlying meaning of physical symptoms and somatic disorders (Wyman McGuinty, 1998).

Indeed, Freud was influenced considerably by Janet’s work. In his early theoretical work, Freud described the ego as “the first and foremost body ego” (Freud, 1923, p.364), acknowledging that body image is the basis of the ego. Additionally, Freud himself occasionally used bodily techniques such as touch to help patients express their feelings (McLaughlin, 2000). However, as he further developed his work, he gradually replaced touch with the analysis of transference and the technique of free association. He was concerned that the use of touch might raise issues such as the stimulation of sexual feelings in both analyst and client (Phelan, 2009). Some analysts followed Freud’s path away from touch but others, such as Ferenczi, continued to use various modes of touch and body work (Smith et al. 1985). This split among psychoanalysts eventually became an entrenched dogma which, over the years, unavoidably influenced the stance of psychotherapy with regard to the role of the body (Jones, 1955).
The split in psychoanalysis with regard to the use of the body was enhanced by cultural and philosophical influences such as the Cartesian body-mind dichotomy. Therefore, an increased tendency towards body disownment and an augmented favouritism of understanding the mind was established (Young, 2006). Psychoanalysis as a talking cure became the dominant approach over the years. It shifted exclusively from the more drive-based models of understanding to a more object-relational understanding which focused on the interpretation of transference and countertransference with limited reference to, or appreciation of, the body (Lemma, 2010). However, there were some psychoanalysts such as Reich, for instance, who, with his controversial theory, shifted away from classic psychoanalysis and developed body-oriented approaches. Reich's work influenced a number of theorists and clinicians such as Perls, Lowen and Boadella who made their own contribution to body-oriented psychotherapy.

During the last 40 years, philosophical influences, research and clinical developments have contributed to a shift from the body-mind dichotomy to body-mind unity. An example of this is Merleau Ponty's work (1962) in which he rejected the Cartesian dualistic view which had dominated psychotherapy. For Merleau Ponty, the body is the means by which people engage with the world and how they understand the environment. Therefore, a more embodied view gradually developed in psychotherapy along with increased research. Research evidence showed that phenomenological experiences of bodily reactions of both the therapist and the client could serve as a source of information in the therapeutic encounter (Shaw, 2004).

In addition to theoretical influences, social and cultural influences have transformed the body into something that must be controlled by diet and exercise (Young, 2006). It could be argued that the high prevalence of mental health difficulties such as health anxiety, eating disorders and body dysmorphia has brought back the focus on both clients and therapists' bodies in contemporary psychoanalysis (Herzog et al, 2000; Rief, Buhlmann, Wilhelm, Borkehnagen & Bra, 2006). For Orbach (2003), a contemporary British psychoanalyst, both the therapist and the client use their bodies in clinical work.
The client undoubtedly uses not only the psyche of the therapist but also the therapist's body. The body of the therapist serves as a container for the client's body-related anxieties while the therapist uses his/her own bodily reactions to the client's unconscious material as a valuable tool and source of information (Orbach, 2003).

Despite the recent increased interest in the body within psychotherapy, the use of the body remains a complex phenomenon which is surrounded by fear and suspicion. Perhaps this explains why a large amount of research has focused on sexual misconduct and the risk of the use of body and touch and not on its usefulness as a tool or as an adjunct to clinical work (Stenzel & Rupert, 2004).

The purpose of this paper is to review the theoretical concepts which developed chronologically in the literature and to provide a critical evaluation with regard to the role of the body in psychotherapy. An in-depth analysis of each theoretical concept is beyond the scope of this review. The paper also aims to raise the ethical and cultural considerations around the use of the body and provide recommendations for further research.

The body in psychoanalysis

Psychoanalysis has been one of the main theoretical paradigms in which the body has had a controversial place throughout the years. Despite the fact that Freud (1960, p.60) described the "first and foremost body ego" and emphasised non-verbal expression, especially with clients who were hesitant to talk, a strong verbal bias was established in psychoanalysis. As Geller (1978, p.357) pointed out, a belief was developed among psychoanalysts that improvement in the wellbeing of clients is derived from "language and discourse". Even today, psychoanalysis continues to focus on verbally communicated content with the therapist's verbal interpretations still considered to be the most effective form of therapeutic intervention. However, there are several psychoanalytic concepts that acknowledge the importance of the body in therapy.
Reichian Theory

Wilhelm Reich (1949) was the first psychoanalyst to challenge the strong verbal bias in psychoanalysis. As he stated, the form of the expression of language, which is used by the client when communicating his experience, is far more important than the content of the language. The form of expression determines the unique nature of the client's resistance and transference reactions (Reich, 1949).

Reich's work could be described as controversial as he placed substantial focus on the body in clinical work, in contrast with the classical psychoanalytic position. He introduced somewhat unconventional explanations regarding the function of the body and its meaning. For instance, one of his most significant theoretical contributions was the concept of muscular armour. As he explicitly described in his book *Character Analysis* (1949), muscular armour is developed as a result of the chronic conflict between the individual's instinctual demands and the counter-demands of the social world. This conflict could generate an alteration to the functioning of the body which is defined as a "neurotic character" (Reich, 1949). This neurotic character serves as a narcissistic protective mechanism and is formed for protection against punishment of the child's instinctual expression by parents or other agents of the social world (Smith et al. 1985). For Reich, a neurotic character is manifested through the body as, for example, chronic muscular rigidities.

Reich also developed a type of touch called "Character Analytic Vegetotherapy". Its aim was to awaken muscles and release body tension (muscular armour) which, over the years, subconsciously becomes an inseparable part of the body. With this technique, Reich was hoping to increase people's awareness of the tension of their muscles and the impact this has on their emotional development and cognitive functioning (Smith, et al. 1985). Reich's technique included bodily contact between the therapist and the client, both for diagnostic and therapeutic purposes. As a diagnostic tool, Reich tended to assess the client's 'muscular armouring particularly by feeling his/her body and focusing on body points of bound energy' (Smith et al. 1985). As a therapeutic tool, Reich used to touch
clients in order to relax their muscles and release energy from their body by pressing on the points of tension. Reich’s use of touch was characterised as invasive, painful, yet powerful (Bean, 1971). Apart from Bean’s characterisation, there is no empirical evidence to indicate the effectiveness of Reich’s body work or how his clients experienced it.

In Mann’s and Hoffman’s book (1980) *The man who dreamed of tomorrow: A conceptual biography of Wilhelm Reich*, Reich was described as a dreamer but also as a controversial figure, who was both admired and condemned. Perhaps this can be explained by the fact that he introduced several controversial theoretical concepts, breaking the classic stance of psychoanalysis in which touch and any type of physical contact is prohibited between the client and the therapist. It is possible that his unconventional stance was also one of the reasons for his limited respectability and the lack of validation of his work within the professional community (Mann & Hoffman, 1980; Raknes 1971). Despite that, Reich as a supervisor and a trainer became the inspiration for a number of people such as Lowen and Perls who left their own mark in psychotherapy with attention to the body.

**Winnicott's concept of mirroring**

While Winnicott had a similar psychoanalytic training to Reich, he conceptualised the individual’s body development and image in a different way. In his work as a paediatrician, he devoted a significant amount of time to observing the interaction and relationship between mothers and infants. In most of his theoretical concepts, the role of the mother seemed significant for the emotional development of the baby and the development of the image it has of its body. According to Winnicott (1949), the infant perceives its mother as a part of itself and is fully dependent on her. It attempts to communicate with her and the environment through its body with movements and spontaneous gestures. Therefore, Winnicott (1962) defines the good enough mother as the mother who presents herself as an object respecting “the infant’s legitimate experience of omnipotence” (Winnicott, 1969, p.112). If the mother mirrors the infant, the infant sees itself in her face and gets to know itself. The continual mirroring gaze
of the mother is a founding experience which establishes the infant's bodily image and serves as a template in the infant's ego (Winnicott, 1969).

**Active imagination**

Jung acknowledged the significance of the body as a means of expression of unconscious material in a similar way to Freud (Wynan-Mc Guinty, 1998). He also recognised that traumatic memories could remain in the body. He therefore developed the concept of active imagination; a method of envisaging unconscious material or traumatic memories by letting them be acted out through gestures or images (Wyman-Mc Guinty, 1998). In his book *Memories, Dreams and Reflections* (1961), he presented a series of case studies illustrating his capacity to focus on the body. He noticed that some of his female clients used their bodies to communicate with their unconscious through spontaneous dance. A characteristic example is his work with a schizophrenic woman and his attempt to communicate with her through imitations and reflections of her bodily postures (Wyman-McGuinty, 1998; Jung, 1961).

**Authentic movement**

Winnicott's concept of mirroring and Jung's concept of active imagination were the sources of inspiration for the Jungian analyst and dance therapist Mary Whitehouse. She developed the technique of authentic movement which focused on the physical expression of inner experience (unconscious feelings) through movement (Whitehouse, 1979). Authentic movement could be better described as a form of active imagination in which attention is given to somatic unconscious, the unconscious as it is experienced and expressed in the body (Wyman - Mc Guinty, 1998). The client is encouraged to focus on his/her inner experience, to note carefully any bodily sensations, images and feelings which are utilised as the impetus for self directed movement.

The main goal of authentic movement is the re-experiencing of somatic memories in therapy. The analyst serves as a silent witness to the client's explorations and simultaneously aims to develop a holding, trusting environment for the client. In this holding environment, the client is comfortable to revive past
traumatic experiences or allow unconscious material to emerge and reunite the somatic experience with the mental image (Mitrani, 1996). By observing the movements of the client, the witness (therapist) has the opportunity to observe the formation of a symbolic representation before it is verbally articulated. At that stage, somatic countertransference is an essential guide for the therapist to understand his/her reactions towards the client. This process could be described as being similar to Winnicott's concept of the intermediate area. According to Winnicott, through this intermediate area, the individual could explore and experience a transitional space between his/her inner and outer world where the somatic experience and mental images can be connected (Winnicott, 1949). The witness in authentic movement can be characterised as Winnicott's 'good enough mother' who is able to hold, metabolise and reflect back to the infant a comprehension of its inner world. Likewise, in authentic movement the witness provides the transitional space for the client, uses somatic countertransference and mirrors the bodily movements of the client (Wyman-McGuinty, 1998). The witness functions as the mother who, through her words and bodily responses, communicates with the infant (Winnicott, 1951).

Generally, Jungian analysts who use this technique, argue that authentic movement could be very beneficial in helping clients make contact with bodily traumatic experiences which have been disintegrated from their consciousness (Mitrani, 1996; Wyman-McGuinty, 1998). As Wyman McGuinty (1998) tellingly said, using authentic movement gives the opportunity to the analyst-witness to observe the subtle evolution of how fragments of somatic experience emerge on the analytic stage where they may be integrated, depending on the ego's capacity to tolerate the accompanying affective dimension. In other words, authentic movement is an opportunity for the body to tell its story in its own words. The goal of this procedure is not the catharsis of the client but holding and integrating the intense feelings that arise from somatic memories (Wyman-McGuinty, 1998). By evoking somatic memory, authentic movement offers an opportunity to relive and segregate previously undifferentiated feelings states into a more coherent narrative (Wyman-McGuinty, 1998).
Contemporary psychoanalytic views

Over the years, psychoanalysts have seemed to reintegrate the importance of body development. Taking into consideration the increased prevalence of mental health difficulties related to the body (health anxiety, eating difficulties, body dysmorphia) they developed and offered some very interesting ideas and explanations related to the body. Specifically, Lemma and Orbach, two British psychoanalysts, seemed to shift psychoanalysis from a dualistic and medicalised to a more embodied and relational paradigm. Both appear to consider not only the early experiences of the individual but also the influence of cultural norms, society's pressure, media and lifestyle in body development and image.

For example, as Lemma argues “we cannot think about the body outside of the cultural, social and political discourses that frame all of our lives” (Marles, 2003, p. 149). In her book *Body Modification*, she examines what drives some individuals to pierce, tattoo, use cosmetic surgery or otherwise modify their bodies. She also examines the role that unconscious conflicts and internalised relationships play in fuelling these often uncompromising bodily communications (Lemma, 2010).

Based on her observations of her clients, people who are unable to bear and reflect on their experience of trauma and pain, turn to the body or skin as a means of communication. Such clients often reveal long-held, compulsive fantasies and actual plans for cosmetic surgery, in an unconscious attempt to manage unbearable anxiety and contain their feelings of rejection and loss (Lemma, 2010).

Lemma also talks about ‘the Botoxing experience’ and addresses the increasing use of surgical operations for bodily enhancement, linking a cultural preoccupation to a more primitive drive to reinvent the self. This, she argues, can function both as an attack on the given body or an attack on the mother who is hated – ‘What you have given me is not good enough, I need to give myself something beautiful’ (Marles, 2013, p.149). According to Lemma (2010), a body
modification is a way of either severing ties with the hated object or creating a phantasised ideal self who will be loved after all.

Similarly, Orbach emphasised the importance of the body itself and not of the body as a vehicle of the mind. Orbach's work (2003) enhanced an embodied understanding in psychoanalysis particularly of the aetiology of eating disorders and the mother's perception of her body image and its impact on her daughter's body image.

With regard to the mother's perception of her body image, Orbach agrees with Winnicott's concept of the mother's important role of mirroring. However, she stresses the importance of the relationship that the mother has with her own body and how this is reflected when she mirrors and responds to her baby's bodily expressions (Orbach, 2003). She also considered additional factors which influence the infant's development of the body such as social and cultural norms around bodies, sexuality and gender. As she distinctively said in her article There is no such thing as body, "The baby's subjective sense of its own body...is an outcome of relationship, fantasy, projection, role, prescription and culture enforcement" (Orbach, 2003, p.11). The mother's relationship with her body and her beliefs about gender identity and body image could influence not only the baby's psychological sense of self but also its physical subjective sense of self (Orbach, 2003).

Furthermore, through her work with "clients with very troubled bodies", she recognised that the client's body self needs the same attention as the client's psychological self. Therefore, for Orbach (2004) the tools to understand the client's body self and therapy process are the use of body countertransference and the therapist's body itself. She defines somatic countertransference as the therapist's physical reactions towards the client's unconscious material; a guide to understand the physical development of clients and the ways in which they understand and treat their bodies as an object (Orbach, 2004). Understanding how clients treat their bodies and whether they abuse, manipulate or soothe their bodies could help therapists understand and help clients treat their bodies differently (Orbach, 2004). She suggests that a safe therapeutic relationship can
help therapists and clients start deconstructing the defences that the clients have developed to manage their scrutinised bodies (Orbach, 2004). The main goal of therapy is to help clients face the pain which is provoked by the body itself (Orbach, 2004).

In the process of deconstructing defences, unavoidably the therapist’s body is used by the client. As Orbach argues, clients use therapists’ bodies in the same way as they use therapists’ psyches (Orbach, 2004). However, the question that therapists need to consider is whether they feel safe enough to let their clients use their bodies in the same way as they encourage them to use their psyches. It could be argued that this would be a great challenge and a controversy for classic psychoanalysts who mainly work with the psyche and focus on verbal communication in therapy. Orbach (2004) encourages therapists to use countertransference and the capacity to reflect upon not only their own emotional processes but also their bodily feelings and nuances. She sees psychoanalytic treatment as being more effective with people with body issues only when psychoanalysts become more open and curious to explore their own physical responses towards their clients and their own relationship with their bodies.

**Gestalt therapy**

Going back to the classic psychoanalysts, Reich trained and supervised a number of people who were inspired by him and subsequently developed their own distinct therapeutic approaches. One of them was Fritz Perls, an analysand of Wilhelm Reich and the founder of Gestalt therapy. Perls was drawn to Reichian concepts but his approach was also influenced by other sources, such as psychoanalysis, existential philosophy, Gestalt psychology and Eastern religion (Smith, 1976).

Perls was influenced by Reich in several ways, given that he incorporated some of his concepts while, at the same time, rejecting others. For example, he placed emphasis, as Reich did, on the therapeutic process and the therapist’s style. He encouraged therapists to have a direct confrontational style and to try to elicit
powerful emotions from their clients (Smith, 1985). However, Perls had a different view from Reich on emotions. For Reich, emotions derived from past and present experiences were disturbers of the peace which both the therapist and the client must work in therapy sessions, with the aim to eventually getting rid of them (Smith, 1985). In contrast, for Perls emotions were not something undesirable but natural elements in the homeostatic cycles of the organism (Smith, 1985). Based on this, Perls considered that emotions arise naturally and indicate the individual's needs which must be met. However, it seems that Perls followed a different direction from Reich by declaring that dealing with any emotions which are not experienced in the here and now is a waste of therapeutic time (Perls, 1969).

With regard to the therapeutic process, he agreed with Reich that a mind-body dichotomy had been established in western culture and specifically in psychotherapy. Therefore, part of Perls' attempt was to reintegrate the body into clinical work. He considered the body and its sensations as an essential part of Gestalt therapy. Clients' non-verbal communication, voice quality, body posture and gestures are a valuable source of information for the therapeutic process. The main goal of the therapist is to enhance the client's awareness by focusing on the client's non-verbal behaviour (Perls, 1969). Gestalt therapists use techniques that make clients more aware of their bodies functioning or help them become more aware of how they can use their bodies in order to communicate their feelings in therapy and/or in their interpersonal relationships. For example, the therapist may point out to and explore with the client how, while he/she smiles, he/she concurrently expresses anger (Smith et al. 1985).

Another example of Perls' differentiation from Reich is his focus on the use of body contact in sessions. Although body contact is sometimes included in Gestalt therapy, it is not emphasised as a treatment mode as it is in Reich's work (Smith, 1985).

Perls seemed to be one of the few people who, though strongly influenced, managed to shift away from Reich by developing his own distinctive body-oriented approach. It seems that his ability did not lie in combining all his
sources of inspiration to develop an eclectic approach. Conversely, he created a new approach which, in essence, goes beyond the constituent elements (Smith, 1985). This might be a good explanation of why Gestalt therapy has been considered effective with increased research evidence of its effectiveness in contrast with Reich's work. According to the research, Gestalt therapy has been successfully employed in the treatment of psychosomatics and as a brief crisis intervention. It has also been considered an effective therapeutic approach for various mental health difficulties such as post-traumatic stress disorder, depression, anxiety and personality disorders (Corey, 2000).

**Bionergetic Analysis**

Following a similar path with Perls, Alexander Lowen was also trained and analysed by Reich. However, Lowen eventually separated from Reich and developed his own theoretical and therapeutic 'Bionergetic Analysis' approach. Like Reich and Perls, Lowen also attempted to integrate mind and body. Bioenergetics combines bodily, analytic and relational therapeutic work based on an energetic understanding.

Lowen's definition of Bionergetic Analysis as "the study of personality in terms of the body" gives a rather 'embodied' perspective on personality theories. In contrast with other personality theories which focused on individual behaviours, Lowen suggested that the personality is perceived as the way the individual is in the world, body-wise (Smith, 1985). In other words, the way a person moves and holds his/her body are the diagnostic tools to identify character styles. More explicitly, the concept of character styles was initially developed by Freud and subsequently Reich elaborated it further in his book on Character Analysis. Lowen, influenced by Reich, suggested a more systematic and extended organisation of character styles and their relationship (Smith, 1985).
He suggested five basic holding patterns:

1. Holding together in response to a fear of falling apart, which defines schizoid character
2. Holding on, responding to the fear of rejection or being left, which defines the oral character
3. Holding up against the fear of falling down, which defines the psychopathic character
4. Holding in the fear of letting go and exploding into release of feelings, which defines the masochistic character
5. Holding back in response to the fear of falling forwards and being swept away to feelings of love and surrender, which defines the rigid character.

These patterns can be read directly from the physical structure of the body. For this reason, bioenergetics relies on 'reading the body' as a means of assessing the personality of the individual. Therefore, the role of a bioenergetic therapist is to view the client's body, his/her posture and movement in order to diagnose the character via the body structure. The therapist reads the body of the client, resonates with its energy, feels the emotions, listens to and answers the words. The language of the body (posture/gesture, breathing, mobility and expression) is in focus as it indicates the status on the way to personhood, from the past to the present and future (Lowen, 1972). Techniques are used which address the energetic aspect of the individual, including his/her self-perception, self-expression and self-possession (Lowen, 1975). These also include work with body contact, grounding and the understanding of muscular tension as indications of somatic and psychological defences against past traumatic experiences. The goal of the therapist is to release and heal the client's chronic muscular tensions. However, the ultimate goal is to facilitate the personal development of the client, including new ways of relating to others (Lowen, 1975). As in most therapeutic approaches, bioenergetic therapists could achieve
this by providing a containing safe therapeutic frame and a strong therapeutic relationship.

It could be argued that Lowen further developed Reich's concept of character styles while maintaining a rather psychoanalytic stance. An indication of this is his analytic interpretations to clients with regard to (following a 'reading of the client's body) their past significant or traumatic experience and their effects on body structure (muscular tension). In addition, Smith (1985) interestingly identified another difference between Lowen's and Reich's work regarding the style and focus of their writing. According to Smith, "Reich's works are profound, complex and written for a sophisticated reader...I see the bioenergetics writings of Lowen as less profound and in places fraught with oversimplification...but more easily read than Reich's...I believe Reich is to be studied...Lowen is to be read..."(Smith, 1985, p.18). It seems that Lowen's approach could be described as more readable and popular in scientific circles and in the general population than Reich's work. Therefore, one could assume that given its 'popularity', Bioenergetics Analysis would have more research evidence examining its effectiveness. However, as with Reich's work, Lowen's approach lacks research interest and evidence related to its effectiveness (Smith, 1985).

**Body psychotherapy**

Among the theoretical approaches described above, it seems that psychoanalysis mainly focused on verbal interaction during therapy with limited reference to the body. However, both Reich's and Lowen's work offered an emphasis on body-mind unity and contributed to the development of the branch of body psychotherapy. According to Young (2006), body psychotherapy emphasises the importance of mind-body unity and their reciprocal relationship. Verbal interaction is still essential in clinical work yet, simultaneously, emphasis is given to the body. The body of the therapist becomes a tool and a guide in therapy. Therapists could use their own physical reactions towards the client's narrative or material in order to explore the process and the dynamics of therapy. Also, the client's non-verbal communication (including facial expressions, movement and physical reactions) is considered an invaluable source of information for both the
client and the therapist. Generally, the body becomes an essential tool in helping clients become aware of their sensory and emotional changes and in facilitating an insight into the client's emotional state (Young, 2006).

The development of body psychotherapy as an independent branch encourages the integration of mind and body and suggests a more embodied stance in the dominant 'talking-oriented' psychotherapy.

**Biosynthesis**

David Boadella is a contemporary body psychotherapist and a strong believer in the integration of body and mind and embodiment in clinical practice. Boadella's favouritism towards an integration of body and mind is even reflected on the name of his approach; Biosynthesis, a Greek word which means "integration of life". Boadella strongly suggests that a somatic psychosocial and spiritual understanding of human problems must be integrated into body psychotherapy. He argues that if these aspects are not included, then body psychotherapy will degenerate into a reductive energetic approach in which embodied language and the subtle attunements of the therapeutic relationship would be neglected. Consequently, the client will then become sub-personalised to a bunch of drives and tissue states. Therefore, to avoid these dangers, Boadella suggests an integrative model which considers seven basic dimensions. As he tellingly said in one of his speeches: "In this formative approach [Biosynthesis] we draw on embryological and morphological insights into the organisation of the energetic and emotionality of the person and take these as aspects of seven basic dimensions of experience... we see these dimensions as life-fields of expression... each of these life-fields' dimensions has somatic, psycho-dynamic and spiritual levels of experience" (Boadella, 1997, p.2). These seven dimensions are movement, breath, emotionality, image, channels of contact, touch and language (Boadella, 1997). A brief description of each one of these dimensions follows:

For Boadella (1997), the movement of the body is a source of vitality effect but also intrinsic to expression or repression. Outer movement expression is deeply
connected to the inner states of feelings; therefore, a focus on the client's movement is essential in clinical work.

In a similar way, *breathing* modulates not only energy but also consciousness. Specifically, the rhythm of breathing reflects the emotional state of the person and through therapeutic work the therapist helps the client to rebalance his/her breathing.

With regard to *emotionality*, Boadella (1997) draws upon neuropsychological concepts and suggests that our emotionality is supported by the activation or inactivation of the two branches of the nervous system; the sympathetic (preparing for the fight and flight response) and the parasympathetic system (preparing for resignation or relaxing). All neurotic states can be understood as an imbalance in one of these directions. Therefore, in clinical practice, clients will on the one hand show emotional repression or suppression and on the other hand emotional impulsivity (Boadella, 1997). Therapeutic work includes work with emotional expressiveness between the two systems, aiming to teach the client to regulate his/her emotional process.

Working with *images* is another essential dimension of Biosythesis. According to Boadella, through somatic work with the client, the therapist can evoke images which create new motoric experiences. Working on the relationship between sensory-motor states and bodily images indicates a deep relationship between the awareness of the body self and body imagery (Boadella, 1997).

*Channels of contact* are another way by which the therapist can communicate with the client or use as tool. For example, the sound and the meaning of voice interaction or good mirroring through eye contact are considered valuable aspects of therapy.

Boadella distinctively said "we can speak and listen through our hands" (Boadella, 1997, p.6) indicating that the use of *touch* could be a useful aspect of clinical work. He encourages therapists to use various types of touch to invite or elicit movement, to raise or lower muscle tone, to deepen or relax breathing, to soften or strengthen boundaries.
Lastly yet importantly, Boadella introduced the embodied language. In simple terms, therapists become the translators between speech and gesture, opening channels of communication between verbal expression and somatic experience (Boadella, 1997). He advises therapists to use embodied language specifically with clients who use language to intellectualise their experience and avoid any embodied transformation. Therefore, the therapists’ aim with embodied language is to help clients translate their experience downwards, from their head to their bodies (Boadella, 1997).

For Boadella, the above dimensions are considered as relational: “Breath is relational, touch is communicative, movement is interactive and emotionality is contact oriented” (Boadella, 1997, p.7). Generally, Boadella’s work could be described as an embodied approach which turns away from the medical model of psychotherapy and moves towards a rather humanistic holistic model.

**Humanistic paradigm**

Similarly, the humanistic approach has, since its development, suggested a holistic view with regard to the body and mind. For example, Prouty (1994), a humanistic therapist, suggests that a dimension of psychological contact, one of the core conditions, is the awareness of client’s body, by focusing on his/her bodily and facial expressions. According to Prouty (1994), these non-verbal reflections can help therapeutic work in two ways: a) to develop effective contact between the client and therapist and b) to facilitate the client’s growth and change. In a similar way to Prouty, Cooper (2001) defined embodied empathy as an internal mirroring of what the client was sensed to be experiencing inside the therapist’s body. He suggested that embodied empathy could give greater perceptual clarity to therapists with regard to their clients’ experiences.

More recently, Leijseen’s (2006) ideas relating to body work is considered a good example of how humanistic therapists work. According to Leijseen, “therapist and client are never just ‘talking’, they are always ‘bodies interacting’” (Leijseen, 2006, p.1). Therefore, therapists could perceive and work with the body in four different ways: 1) therapists could perceive and work with the body from inside,
2) from outside, 3) they can focus on clients’ non-verbal expressions and 4) they can use touch. Taking a similar line, Lude (2003) a humanistic therapist, agrees with Leijseen’s opinion that touch can be a powerful intervention and a tool in therapy. As he tellingly said in an article, “Touching a client’s body with respect and the intention of inviting ‘what is’, whatever wants to happen let it happen……. creates a space in which client and therapist can enter a therapeutic dialogue which can be entirely physical and non-verbal for quite a length of time”(Lude, 2003, p.2).

Therefore, touch as a bodily aspect which therapists could work with is considered in the humanistic approach as an open, honest and natural expression of genuine emotion. Indeed, the study of Pope, Tabachnick, Keith & Spiegel (1987) agrees with this, indicating that 30% of humanistic therapists, compared to therapists from other theoretical approaches, believe that non-erotic touch (hugging, or holding a client’s hand) could be beneficial for the client.

Considerations for the use of the body

Over the years, the use of the body in clinical work has been perceived by psychotherapists with enthusiasm, fear and suspicion due to a number of cultural, ethical and theoretical factors.

Some of these, which seemed to have created a fear of using bodily interventions, were also Freud’s concerns that the use of touch might raise issues such as the stimulation of sexual feelings in both the analyst and the patient. In addition, Reich’s accusation of sexual harassment created some fear about the scientific respectability of psychoanalysis and psychotherapy in general. In order to avoid this, psychoanalysis, as the dominant psychotherapeutic approach, led to the disownment of the body in clinical work by implicitly defining itself as ‘talking therapy’.

The taboo and fear of using the body may also be rooted in other factors such as homophobia and the misuse of power, cultural and gender differences. According to Clacne & Petras (1998), male therapists may avoid hugging, holding or using any bodily interventions especially with male clients due to their deep fear of
being perceived as homosexual by their clients or due to their views that touch and body work could be harmful. In contrast, women often view the use of touch as a feature of communication and a healthy expression of feelings, which according to Pope et al. (1987) explains why it is more prevalent when both the therapist and the client are female.

The use of the body is considered as inappropriate in some cultural contexts and appropriate in others. For example, neither Anglo-Saxon nor Asian culture are considered body-oriented, as people avoid any prolonged form of bodily contact (Phelan, 2009). In contrast, in Mediterranean countries, touch and body contact are a favoured way of communication in interpersonal relationships (Phelan, 2009).

In an attempt to capture all the above considerations, to minimise the risk of sexual misconduct and fear, various guidelines have been developed for the use of touch and the body in therapy. With regard to the use of touch, Durana (1998) pointed out in his clinical guidelines the need for proper training, whilst raising as ethical considerations the therapist's understanding of his/her own responses, motivation and attitudes to touch, along with the dynamics of power, gender and boundaries.

With regard to body work, the majority of the principles of the BPS (2009) code of ethics apply to the use of body techniques as an adjunct to verbal psychotherapy. Before proceeding with any body work and physical contact with the client, the therapist must ask for the client's consent, explain his/her intentions, and describe exactly what he intends to do (Leland, 1976).

Furthermore, a number of body techniques such as bioenergetics, massage and sensory awareness require the client's partial nudity (Leland, 1976). In this case, the therapist must provide information and ask for the client's permission. In addition, when using these techniques, the therapist must be aware of, and sensitive to, the increased feeling of shame, vulnerability and sexual arousal that may be triggered both in the client and him/herself (Leland, 1976). Due to this emphasis on the body, therapists are required to undergo body-oriented
personal therapy and adequate body training (Rowan, 2000). Lastly and also importantly, it is vital for therapists to have good supervision in which the supervisor will help the therapist to resolve any distress or sexual countertransference which might occur (Rowan, 2000; Leland, 1976).

**Conclusion**

This literature review was an attempt to provide an overview of how various theoretical paradigms conceptualise and use the body. By reviewing the literature, it became apparent that Cartesian dualism has influenced and divided psychotherapy into verbal therapies in which the mind is the master of the body and body therapies in which the body has a central role.

In verbal therapies, the established dogma of the prohibition of use of the body, which derived from psychoanalysis, has generated fear and suspicion in psychotherapists who abandoned the use of the body and focused on the mind. It was as if the powerful unconscious was disembodied. Despite this, body-oriented therapies increasingly developed. Reich's controversial work was a source of inspiration for Perls, Lowen and Boadella. Undoubtedly, their work filled a gap in psychotherapy by suggesting a holistic view of body-mind work.

Interestingly, in the last 40 years, a number of philosophical and social influences and research developments have contributed to the reintegration of the use of the body into verbal psychotherapy. The work of Merlau-Ponty on embodiment and phenomenology was instrumental as it offers the opportunity to verbal therapies to develop a more embodied therapeutic relationship. For example, Rowan (2000) developed the concept of linking, which is defined as the therapist's embodied empathy. For Rowan, the use of embodied empathy could create a deeper connection between the therapist and the client. In a similar vein, Shaw (2004) examined therapists' experience of bodily reactions to clients. His results seemed to somewhat confirm Rowan's concept of linking. His study indicated that therapists seem to use their somatic experiences as a navigator for the process of therapy and that the therapists' attunement to their bodily
reactions to their clients’ material could generate an embodied empathy and better understanding of their clients.

In parallel, some social influences such as the high prevalence of eating disorders, health anxiety and body dysmorphia seemed to draw the attention of some psychoanalysts such as Orbach and Lemma, who devoted a large amount of their work to using the body not only symbolically but literally. For Orbach (2004), the effectiveness of psychoanalysis could be increased if therapists provided a more embodied approach to “clients with troubled bodies” and paid attention to their physical reactions towards the clients’ unconscious material. Orbach’s (2004) suggestions offer the therapist a new role: to stop being ‘blank screens’ and to become more relational and embodied. However, in order to become embodied therapists, they must develop a reflective, open stance towards their physical reactions and the curiosity to explore their personal relationship with their bodies. Lemma (2010) emphasises the importance of the client’s body and how body modifications can give an insight with regard to unconscious conflicts and internalised relationships.

Despite the increased interest from some clinicians, a large number of therapists remain ambivalent to the idea of developing an open stance toward physical reactions and focusing on the body of the client. There is a rather conservative view that any body work or reference to the body itself belongs to a medical profession and not to therapy. This ambivalence on the part of therapists towards including the body in their clinical work may be due to their fear that they might not be competent to interpret the client’s body language and that they will come across as, and feel, unprofessional or incompetent therapists (Miller, 2000). It seems that therapists have yet to make use of the multitude of emotions that stem from the body, possibly because they do not have a sufficient body vocabulary with which to make sense of them.

Unavoidably, the ambivalence and fear of using the body stance is also reflected in research. Most studies have focused on the risks, precautions and ethical considerations of the use of the body. Gradually, research interest developed in body work effectiveness in specific groups such as women survivors of sexual
abuse. Price's study (2002) on the effectiveness of body work (as an adjunct to verbal psychotherapy) in women survivors of sexual abuse provided the literature with encouraging results. According to Price (2002), women who suffered from PTSD due to childhood sexual abuse experienced a significant reduction to their symptoms after having body work. However, further research is needed to examine whether body work or bodily interventions (as part of verbal psychotherapy) could be beneficial in other client and age groups; as for example, in adults with anxiety disorders, chronic conditions or children with development and neurological deficits. With regard to research methodology, the use of qualitative methods could enrich the research literature, offering useful insights into how clients experience any bodily interventions in their therapy.

Following this extensive overview of various theoretical perspectives and revealing the various dilemmas and considerations with regard to the use of the body, it is worth ending this paper by noting that it is only though the integration of body and mind that the full story of one's self can be revealed.

Reflections on the use of self

Writing this literature review has been a stimulating and difficult process which evoked mixed feelings and thoughts both on a personal and professional level. On a personal level, I have always found it difficult to verbally express my feelings and my needs for attention and care from my significant others. On the contrary, I felt more comfortable to express my feelings through my body and was very aware of my physical reactions in different circumstances in my life. Therefore, experiencing psychosomatics over the years has been my way to express my feelings and needs for attention and care from my significant others.

On a professional level, starting professional training and having to express myself in a different language has been a challenge for me. Through my clinical work I became aware of ways of managing my difficulty in expressing myself in English as a non-native speaker. This experience helped me discover the power of non-verbal communication in the therapeutic encounter. I come from a
background in which the body is a significant tool of communication and a
vehicle of expressing emotions. Hugging and touching have always been present
in my environment as signs of comfort, love and support, especially in close
relationships. Working with students, who were also struggling with similar
language difficulties, made me consider that the body could also be a tool of
communication in my clinical work. I started to notice how facial expressions,
gestures and even different body postures were significant sources of
information both for me and my clients. I also realised how they can enrich
therapeutic work and strengthen the therapeutic relationship.

In parallel, I started attending a mindfulness course which increased my
awareness of my physical sensations, to increase my tolerance of unpleasant
physical sensations and especially when I was experiencing any psychosomatic
symptoms. Practising mindfulness techniques, such as body scanning and
mindful breathing and walking, helped me familiarise myself with these
techniques and use them as an adjunct to my clinical work.

Through my readings of the existing literature around the body, I came across the
strong influence of Cartesian body-mind dualism in psychotherapy and how it
splits psychotherapy into body-oriented and talking therapies. This made me
sceptical about where I would like to belong as a practitioner and a counselling
psychologist trainee, given my increased awareness and relationship with my
body and my preference for using body techniques in my clinical work. In
addition, the lack of reference with regard to counselling psychology's stance
around the body intrigued me enough to further investigate counselling
psychologists' perceptions with regard to the use of the body in their clinical
practice.
References


Appendix

Library services and electronic databases were used for the searching the literature. Databases were used were: PsychInfo, PsychArticles, PsychBooks and Google Scholar using terms: “body in psychotherapy”, “value of the body in psychotherapy”, “body work”, Gestalt”, “Reich”, “body in psychoanalysis” etc. By using these words a large number of articles were found. After reading all the abstracts, suitable and relevant articles were selected and the full texts were downloaded. The next step on searching was to locate some articles cities in those downloaded. Therefore, in this way I ensured that during the literature search all relevant references were included. Consequently, the conclusions of this review were accurate as possible.
Qualitative study

Mind the body: Exploring counselling psychologists' experience of the role of body in the therapeutic encounter

Abstract

Objective: The role and use of the body in psychotherapy has been influenced by a number of theoretical, cultural, philosophical and ethical factors. For example, psychoanalysis expresses concern in its potential use within the therapeutic relationship whilst the humanistic paradigm acknowledges the body as a channel for communication for both clients and therapists. However, in counselling psychology there is limited reference to the importance of the body in therapy. This study aims to enrich the literature by exploring counselling psychologists' experience of the role of the body and its meaning in clinical practice.

Method: Semi-structured interviews were conducted with 5 qualified counselling psychologists working in private practice. Data was analysed using Interpretative Phenomenological Analysis (IPA).

Results: The results of the analysis revealed a number of themes. The participants acknowledged the significance of the use of the body, such as bodily techniques and touch as important tools in therapy. At the same time, they expressed mixed thoughts and considerations which they take into account when using such tools. Therapist's and client's characteristics, their personal relationship with their bodies and, the lack of reference to body-oriented theories in their training appeared to be influential factors on their perceptions of the body as well as how and when they use it in therapy.

Conclusion: The results of this study highlight the need for counselling psychology to reconsider the place and meaning of the body in therapy and in training to encourage professionals towards a greater involvement with bodily aspects.
Introduction

The meaning and the use of the body has been an ongoing debate in psychotherapy over the years due to various divergences among theoretical paradigms, philosophical and cultural influences.

In the early years of psychotherapy, the exploration of the relationship between the psyche and the body was a vital part of the clinical work of various psychotherapists such as Freud (Freud, 1960). Freud acknowledged the importance of the body as a means of expression of unconscious material and attempted to conceptualise the underlying meaning of physical symptoms and somatic disorders (Wyman-McGuinty, 1998). However, his preoccupation with gaining scientific respectability for psychoanalysis, along with his concern that physical contact could stimulate sexual feelings in both the analyst and the client, led him to replace the physical use of the body with a symbolic reference to it (Phelan, 2009).

Over the years, Freud's rigid stance with regard to the use of the body created conflicts with other analysts such as Ferenczi and Winnicott, who continued to use bodily aspects in their work (Phelan, 2009). Apparently, the split in psychoanalysis was also enhanced by the cultural and philosophical influences of that time, notably Cartesian dualism in which the body was considered the vehicle of the mind. Therefore, this split resulted in a preference for understanding the mind and a disownment of the body. The mind became the main aspect and tool of psychotherapy and the body was left to be treated by medicine (Phelan, 2009).

The dualistic stance of psychotherapy, along with the prohibition of the use of body and touch in psychoanalysis, unavoidably generated fear and misconceptions in the research field. A considerable amount of research focused on the ethics and risks surrounding the use of the body and touch, examining both the experience of clients and the perspective of therapists on the use of touch in therapy (Stake & Oliver, 1991). Some research suggested negative results, mainly deriving from the clients' experiences. Specifically, in 1982, Gelb's
study considered the effects of touch on therapeutic outcomes from the client's perspective, where 10 out of 231 participants (4.4%) reported negative feelings from having experienced touch from their therapist. These outcomes reported that physical contact with the therapist was labelled as intrusive, seductive or sexualised (Gelb, 1982).

However, the development of both humanistic and phenomenological movements brought the body back into the spotlight after, as Boadella remarked "60 years in the cold" (Boadella, 1997, p. 31). Indeed, Merlau-Ponty's work (1962) on embodiment and the lived-body paradigm helped provide a new theoretical framework which moved away from traditional psychotherapeutic discourse of the disownment of the body towards a way of viewing the therapeutic encounter as an embodied experience for both the client and the therapist (Shaw, 2004). For Merlau-Ponty (1962), embodiment is a dynamic concept in which the body is not a still entity but rather a fluid one inscribed with individual as well as cultural meaning. The concept of embodiment is very similar to the lived-body paradigm. According to Merlau-Ponty (1962), the lived-body paradigm allows an interaction with the environment. The latter is not just an external stimulus to which the body responds in an automatic matter. In contrast, the body becomes involved in the centre of being. It serves as a means for individuals to understand the environment and make sense of the world via their bodies. Merlau-Ponty's work inspired a number of therapists who became interested in exploring therapists' and clients' bodily phenomena in the therapeutic encounter. An example of this is Field's study (1989) on exploring his own bodily phenomena. He broadly defined these bodily phenomena as embodied countertransference, explaining that this represents some types of pre-verbal communication. In a similar vein, Mathew (1998) through her own psychotherapy practice, became aware of her powerful physical reactions to clients which she defined as somatic countertransference. For Mathew (1998, p.17), "The body is clearly an instrument of physical processes ... a sensitive instrument which has the ability to tune in the psyche ... to listen to its subtle voice, hear its silent music and search into its darkness for meaning".
In addition, in humanistic paradigms, both the client's and the therapist's body have been considered as an inseparable part of the therapeutic process. For Leijseen (2006) "therapist and client are never just 'talking', they are always 'bodies interacting'" (Leijseen, 2006, p.1). According to Leijseen, a holistic view with clients is achieved only if therapists pay attention to the body, suggesting that body-oriented interventions can be directed to different aspects of the body. Specifically, Leijseen suggests four different ways in which therapists could work: a) with the body as sensed from inside, focusing on the client's body-sense in relation to any specific situation; b) with the body as perceived from outside, which means the therapist makes use of the client's facial expressions, body posture, gestures, breathing, but also voice quality, sighing, laughing; c) with the body in action, in movement, and other non-verbal expressions. The therapist introduces expressive arts (dance, drawing, painting, sculpting, music, sound) as an alternate path for exploration and communication; and d) by using various types of touch (Liejseen, 2006). Apparently, touch as a therapeutic intervention is considered in the humanistic approach as an open, honest and natural expression of genuine emotion. Indeed, the study of Pope, Tabachnick, Keith & Spiegel (1987) agrees with this, indicating that 30% of humanistic therapists, compared to therapists from other modalities, believe that non-erotic touch (hugging, or holding a client's hand) could be beneficial for the client.

The increased influence of the humanistic paradigm and the lived-body paradigm seemed to shift psychotherapy away from the constraints of Cartesian dualism and enhance an embodied and holistic philosophy. Based on this holistic view, therapists' and clients' bodies are not only considered as physical bodies or objects but as subjects which are related to culture, politics and society. This phenomenon has received great interest from researchers who have examined how therapists conceptualise or understand their bodies in relation to their training, culture and gender. For example, with regard to gender, women seemed to be more open to using the body, viewing the use of the body and touch often as a feature of communication and a healthy expression of feelings, which according to Pope et al. (1987) explains why it is more prevalent when both the therapist and the client are female. Other studies examining therapists' orientation and
gender provided some interesting results. In particular, according to Clance and Petras (1998), therapists who do not touch are mainly male therapists who have undergone psychodynamic training. They consider touch as harmful and they have lacked body work experience or touch in their personal therapy and training.

Drawing upon humanistic and existential-phenomenological values, counselling psychology as a discipline emphasises human consciousness, subjective experience and interrelationships (Gkouskos, 2011). Therefore, human beings are seen in a holistic way and as distinctive individuals whose phenomenological and subjective experience must be understood (Gkouskos, 2011). However, due to the limited references to the role of the body in the literature, it is unclear whether counselling psychology’s preference for a holistic view and its rejection of the medical model implies a rejection of the longstanding medicalised and dualistic approach of psychotherapy with regard to the body. In addition, counselling psychology adopts a humanistic view that therapy is primarily a transactional encounter where the counselling psychologist’s role is to be with the client (Gkouskos, 2011). However, again there is limited research into whether the therapeutic relationship is considered specifically as an embodied relationship. Despite this lack of references, counselling psychology’s training regulations do not specify if counselling psychologists are allowed to embrace body-oriented interventions (Wahl, 2003 as cited in Woolfe, Strawbridge, Douglas & Dryden, 2003).

Regarding the existing literature, the body is an emotionally powerful and therapeutic form of communication but it has also been considered as ethically inappropriate for both the client and the therapist. In addition, cultural taboos and gender considerations regarding its application in therapy are significant and influential factors that add confusion to its role and use within the therapeutic encounter. It is possible that the above reasons may have led to the conducting of some quantitative studies mainly focusing on body work, the use and meaning of touch from both the therapist's and the client's perspectives and very limited qualitative studies on therapists' experience of their somatic

113
phenomena in the therapeutic encounter (Shaw, 2004). Qualitative research has been considered particularly appropriate where the field of interest is characterised by complexity, ambiguity and a lack of prior theory and research (Richardson, 1996). In relation to counselling psychologists' experience of the role of the body in therapy, there is no clear reference point and, therefore, an increased need exists for qualitative research to be conducted in this area (Wahl, 2003 as cited in Woolfe, Strawbridge, Douglas & Dryden, 2003). Furthermore, such a methodology suits the practice of counselling psychology as it focuses on subjectivity and aims to understand rather to reach an objective truth (Rennie, 1994).

Reflective box 1: Choosing this topic

Although the lack of research on this topic within the discipline of counselling psychology points to a need for an exploration of the body-touch issue, the research topic also derives from my personal interest.

On a personal level, I have always found it difficult to verbally express my feelings and my needs for attention and care from my significant others. On the contrary, I felt more comfortable expressing my feelings through my body and was very aware of my physical reactions in different circumstances in my life.

On a professional level, starting professional training and having to express myself in a different language has been a challenge for me. Through my clinical work, I became aware of ways to manage my difficulty in expressing myself in English as a non-native speaker. Coming from a different cultural background in which the body is a significant tool of communication in interpersonal relationships, using the body became a tool to communicate in my clinical work. Surprisingly, I realised how facial expressions, gestures and even different body postures were significant sources of information, both for me and my clients, and how they can enrich and strengthen the therapeutic relationship. Additionally, having a rather traumatic experience related to the inappropriate use of touch with my first male therapist (while I was doing my first degree in Greece) led me
Reflective box 2: The phenomenon under investigation

Initially, my supervisor and I had defined the topic as “Counselling Psychologists' experience of the use of the body in therapeutic practice”. This choice was informed by the lack of literature and attention by the discipline towards the very broad area of 'the body within psychotherapy'. As further reading gave me a more in-depth understanding of the literature, I realised that my research question risked creating confusion among the participants, not to mention in myself, due to this lack of specificity. Whose body was I referring to? The client’s or the therapist’s? And what exactly is meant by the term ‘use’ – purposeful, conscious, predetermined, spontaneous? Would I be inviting my participants to comment on too diverse aspects of bodily presence in psychotherapy? After much reflection, and with two of my interviews under way, I decided against narrowing down the research question for two reasons. The first pertains to the phenomenological epistemology which embraces ambiguous definitions and the openness of inquiry. The aim of the research would be to gain an insider’s perspective of what counselling psychologists' (my participants’) experience of ‘the role of the body in psychotherapy’ was and to become curious as to what aspects they considered relevant; in other words, what constitutes their own experience of working with their clients’ bodies in their clinical practice. The second reason, which is related to the first, concerns the exploratory nature of this research and the fact that I did not want to impose restrictions on the phenomenon under investigation when so little about it is currently understood and addressed in counselling psychology research.
Reflective box 2: The phenomenon under investigation

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Method

Design

Interpretative Phenomenological Analysis (IPA) was chosen as the method of analysis (Smith, 2003) as it facilitates the detailed, in-depth exploration of psychological phenomena under investigation, whilst enabling the uniqueness of each participant’s experience to emerge. Smith (2011, p.37) states that “without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen”. This double hermeneutic reflects how “the researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn, 2003, as cited in Nuttall, 2006, p.434). The contribution of the researcher's subjectivity to this dynamic and iterative process with the data is therefore inevitable and fully acknowledged (Smith, 2003). Exploring the wholeness and uniqueness of the individual (Malim, Birch & Wadeley, 1992) and analysing each case in depth, represents the idiographic nature of IPA which, as a whole, fits with the exploratory nature of this study. In addition, IPA is considered particularly useful when it aims to investigate ‘unexplored territory’ where a theoretical pretext may be missing and it is concerned with understanding what a participant thinks or believes about the topic under investigation. That is, IPA is interested in exploring the nature of the gap that can exist between a situation and an individual’s perception (Chapman & Smith, 2002; Reid, Flowers & Rankin, 2005).

Participants

A purposive sampling was the selection strategy used. Particularly, in this study the topic itself defined the relevant sample. Thus, the inclusion criteria were qualified counselling psychologists who work in private practice. It was hoped that working in private practice offered practitioners more flexibility to use any bodily techniques. In addition, the procedure of acquiring NHS ethical approval for this study was considered time-consuming and did not meet the researcher’s project deadline. The initial aim was to recruit 6-8 qualified counselling psychologists. However, five counselling psychologists eventually agreed to participate in the study. Of the
five participants, three were women and two were men. Participants were from Europe and Asia. Specifically three participants were British, one Pakistani and one Greek. Their ages ranged from 32 to 60. One male participant was qualified as both a counselling psychologist and a sex therapist. All of the participants had 10-15 years of private practice experience and were based in London and the county of Surrey.

**Data collection**

Data was gathered via a semi-structured interview to help the participants elaborate on their views and articulate comprehensive details of their lived experience, which ensured the richness of the research data (Langdridge, 2004). The interview schedule (Appendix C) consisted of four open-ended and non-judgmental questions which were developed on the basis of insights gained from a recent literature review (Kouloumbri, 2010) on “The role of the body in psychotherapy”.

The format allowed the participants to determine how the interview proceeded (Smith, 2003). After the interviewer had established a rapport with the participants, they were asked to describe their understanding of the body in therapy and their clinical experience with regard to the body and its aspects in their practice. Questions ranged from a more general (“What is your opinion about the role of the body?”), to a more specific focus (“Do you think a client’s background plays a role?”) with the purpose of teasing out deeper meanings and insights from the participants’ experience. The interviews were audio recorded and later transcribed for analysis using the IPA approach. At the start of the interview, the researcher made sure that the consent forms were signed and that any relevant questions about the study were answered. The participants were assured that the recording of the interview would be kept confidential and that pseudonyms would be used when writing up the research. They were also informed that they would have the opportunity to end the interview at any time and that they could refuse to answer any question that made them feel uncomfortable. After the end of the interview, participants were debriefed and
were encouraged to talk about anything they felt was important and had not been covered during the interview.

**Procedure**

The participants were recruited from the researcher’s network of professional contacts. In the first instance, the researcher contacted possible participants via e-mail with the outline of the study. Five individuals agreed to participate and were asked to contact the researcher either by e-mail or telephone. An ‘information sheet for participants’ (see Appendix A) was circulated via e-mail. Participants were interviewed at their private practice, with interviews lasting between 45 to 70 minutes. They were recorded using digital equipment.

**Evaluation of the study**

The importance of establishing some means of assessing the quality of qualitative work is well recognised. Following Yardley’s (2000) guidelines, the quality of the current study drew upon the following criteria: sensitivity to context, commitment and rigour in relation to the topic and the process of analysis, transparency in the process of data collection and analysis, coherence of presented material, as well as the importance of the project. The study demonstrated sensitivity to context by the researcher being familiar with the existing relevant empirical and theoretical literature relating to the role of the body and touch in psychotherapy. Subsequent insights assisted in the formulation of a question designed to address gaps in the current literature. In addition, the age and cultural background of the participants was taken into account at the analysis stage, as this may have affected why particular views were or were not expressed, or the way in which they were expressed. Furthermore, the analysis attempted to show sensitivity to the data by not simply putting forward the researcher’s themes or interpretations but also being open to alternative interpretations or acknowledging the complexity of the data.

In terms of the commitment and rigour of this study, the researcher has demonstrated a professional commitment to its importance, the suitability of the sample and the analysis of the results. The contribution of the study to the field of
counselling psychology derives from a perceived need for further insights into the views of professionals about the body and touch within therapy. At the same time, the researcher's personal and professional interest as a counselling psychologist trainee resulted in extensive commitment yet undoubtedly influenced this study. This is fully acknowledged in a reflexivity section. The research procedure and process was fully described in order to ensure transparency for the reader and establish credibility (Shaw, 2010). In addition, the selection of a small but homogenous sample (Qualified Counselling Psychologists) gave the opportunity for an in-depth microanalysis of the data.

Additionally, coherence was present throughout the study, since a good understanding of IPA and its procedures is evident and presented in a language appropriate to the method. In addition, sufficient raw data has been provided clearly and explicitly in the form of examples in order to enhance transparency and coherency and to enable readers to judge the validity of the interpretations. The researcher is also transparent in the procedures followed and reflective about the ways personal features might have influenced the study throughout this paper.

Finally, the implications and future research recommendations of this study illustrate to the reader the impact and importance of this research. This study attempts to bring about new understanding by offering a detailed analysis of the subjective experience of counselling psychologists and the personal meanings they attach to the use of the body and touch within the therapeutic encounter. It can also offer suggestions and advice to counselling psychologists and simultaneously raise ethical considerations regarding the use of the body and touch in practice. Furthermore, it highlights areas for further exploration in qualitative and quantitative research, providing data on trends by offering an individual context. Although the findings are not empirically generalised, they can be theoretically generalised with context-specific insights that might apply to other professionals in similar circumstances (Yardley, 2000).
**Ethical considerations**

The current study did not need ethical approval from the University of Surrey's Faculty of Arts and Human Sciences (FAHS) Ethics Committee. The study recruited participants who were fully consenting adults and were not considered as vulnerable. This decision was reached after consulting with the ethical flow chart published by the FAHS Ethics Committee. The participants were provided with full details of the nature of the research. They were assured of confidentiality and anonymity, informed both verbally and in writing of the potential for publication and of their right to withdraw at any point in time. The researcher also agreed to offer them a copy of the research paper upon its completion (Appendix A). Data has been kept safely stored and will be destroyed after the completion of the researcher's course viva.
Analysis

IPA "proceeds through the methodology of reduction, the analysis of specific statements and themes, and a search for all possible meanings" (Creswell, 1998, p.52). Initially, each transcript was read several times. A descriptive coding was conducted in the left-hand margin regarding any key phrases or interesting processes, any associations or connections. Then, titles that aimed to capture a deeper essence of the text were noted in the right-hand margin. The given titles reflected a higher level of interpretation but remained grounded in the participants’ words (Smith, 2003). Themes were then clustered together and named to produce a set of major themes. Emerging themes were identified while new issues and repeating patterns were acknowledged. This procedure was repeated with all the transcripts. Eventually, the initial list of emerging themes from each transcript was analysed alongside themes from other transcripts (Appendix D). This gave rise to a list, with extracts from the transcripts grouped under each theme heading. At the final stage, the researcher checked and renamed some of the master themes in order to be more interpretive and less descriptive.

Results

Three master themes emerged from an analysis of the data from the five participants and nine sub-themes were identified. The three themes were: a) mind the body, b) integration or disownment?, c) a controversial concept. These are fully presented below with their associated sub-themes supported by direct quotations from the participants. In the presentation of the data, square brackets [ ] suggest omissions of material. Clarifications appear within brackets ( ).
Mind the body

The first master theme captures the participants' opinions with regard to the role of the body on both a professional and a personal level. On a professional level, the participants addressed the importance and the benefits of using both bodily techniques and physical contact (touch) as interventions in their clinical work. On a personal level, all the participants mentioned that their personal relationship with their bodies seemed to play a role in how much they value the body in general.

A significant tool

All the participants addressed the significance of the body within therapeutic encounter: Anna acknowledged:

"I think it is very important tool... it is an opportunity to look at all the communication that is coming out and not just verbal language".

Similarly, Miriam emphasised that:

"Clients can talk a lot about things but when they personalise to the body they have a different slant on it ... for example, when a client is expressing his pain by touching a part of his body... this gives me a lot of information about the client..."
It seems that, for Anna and Miriam, the focus on the client's body and non-verbal language has a place in their encounters with clients. It is a valuable source of information and a guide to understand their clients' psychological and physical state but it can also elicit material which is contradictory to the clients' verbal language.

In addition, Ryan spoke about the usefulness of references to the body, specifically in work with eating disorders. As he stated:

"Some difficulties are very linked to anxiety, like eating disorders... there is a bodily component in this and you will miss something if you don't work with this side so... I tend to bring it up...."

According to his account, with such clients an embracement of the client's body and mind is necessary.

Most of the participants offered various examples of how they work with the client's body. For example Anna said that:

"There are bodily-focused aspects in my work such as relaxation techniques....listening to somebody talking through his body; it is very powerful."

It seems that Anna does not use relaxation exclusively as a technique for clients to manage their anxiety or become more aware of their breathing. For Anna, a client's rhythm of breathing seems to be an alternative way or language which the client uses to communicate.

She went on to say:

"Sometimes I use mirroring... I use it especially with some clients who I really find it very difficult to say anything to...and [mirroring] conveys feelings and moods."

For Anna, mirroring her client's nonverbal language through her body seems to facilitate not only her client's disclosures but also it serves as her 'lifejacket' whenever she finds it difficult to express something verbally herself.
Ben, having a dual professional identity as counselling psychologist and sex therapist, seems to use the body in a different way from Anna. He stated that:

"I do quite a lot of behavioural work. I do get people to do behavioural work, it is often around body work or touch and clients have to come back and talk about sex and their bodies (...). And it's interesting talking about it in a detailed way that people are not used to ... it's interesting because we are talking about the body in like... 'What is your attitude? What do you like or not like? And 'Why you don't try this?'"

Possibly due to his professional qualification as a sex therapist and counselling psychologist, Ben could be characterised the “bravest” of the participants. Ben goes a step further; he perceives the client’s body not only as an organ of information about his/her psychological state but also as a body with sex drives and fantasies. Therefore, he appears to devote a significant part of his work to providing a safe space and encourages clients to become more open to talk about their bodies, their desires and fantasies. Ben seemed very intrigued by this and rather surprised as it is a topic that people seemed to find it difficult to discuss. It is as if, as a topic it is almost 'forbidden' to be discussed in such detail outside the context of therapy.

A personal connection

It is interesting to note that all the participants seemed to have a starting point, a trigger or significant personal and professional experience which led them to develop a connection and validation for their bodies and their sensations.

Stephanie talked about her own starting point towards the appreciation of her body:

"Initially at a personal level I didn’t value the body in general ... to be honest ... this has changed a lot ... maybe the last six years ... and that's on a personal level but I think that it has affected my views for my therapeutic practice as well. I didn't think that it was too important (...) I was like ... 22 - 23 and I joined a theatre group and we had a director ... she paid a lot of
attention to movement and the body and how we express as actors through the body ... so she paid a lot of attention to that and all the rehearsals we did were around the body, breathing and being aware of our body ... bits of our body and being in touch with that and expressing things through movement [...]. So that experience really brought me into contact with my body, to be honest and I really appreciate the energy that came out through the body ...”

The focus of the director from the theatre group on body techniques and awareness could be characterised as the inspiration that facilitated her gradual connection with her body. It seems that Stephanie’s views about her therapeutic practice were influenced by this experience. Potentially, on a deeper level, Stephanie has parallelised the client and the therapist as the actors who give a performance and therefore pay attention to their bodies. She might adopt the role of the director herself, becoming the director of her encounters and ‘performances’ with her clients, encouraging the client’s body awareness.

Miriam seemed to discover her deep personal connection through a different experience derived from her training:

“Immediately in my first year of training I had many suicidal clients...and I was always overwhelmed and tearful for my clients [...] I remember one of my supervisors saying “You are very empathic” but there wasn’t something that I could identify with in my personal life, when I reflected back [...] I could really put it down to my deep connection with my body which has been there since I was little ...”.

For Miriam, working with suicidal clients seemed to be something more than a common challenging experience for a beginner therapist. It seems that it was the starting point of becoming aware of aspects and qualities of herself. She soon realised that her feelings were something more than being emotionally attuned to a client’s difficulties or being empathic, as her supervisor told her. She gradually discovered a personal quality, having an embodied empathy as an individual.

Miriam went on by giving a specific example of her bodily reactions from her work with a client:
“I am very connected to my body ... I am connected to what I feel ... For example, I had a client who we work around the anxiety of the trauma ... She was talking about her stomach ... When she spoke about that I felt a knot in here in this zone (puts her hand on her stomach) very powerfully .... And then when I asked her to locate where that pain was in her body, she showed exactly that point ...”

Miriam described a powerful experience from her work. Her personal deep connection with her body seemed to be her guide to her client’s emotional reactions but also to her own feelings. It seems that the primitive forms of her feelings are bodily reactions, which then are translated into words.

In contrast, Peter seems to have a different relationship and connection with his body compared to others:

“It might have something to do with the fact that I am not confident, how I am feeling with my body as it is congruent with my disability... Although I believe that my body works for me as a disabled person, it puts me in a difficult position because, if you are disabled, your structure, your function is very different from other people.”

For Peter, his physical disability inevitably affects his personal relationship with his body. It seems that on a practical level, Peter knows and accepts his body’s limits and capacities. Yet, on an emotional level, there is another part of him for which his disability makes him feel uneasy, lacking in confidence and different from other people.

The power of touch

Interestingly, all the participants raised the importance of physical contact and specifically touch as an important element in their encounter with clients. For Anna:
"Touch releases something to clients that is quite powerful if it works for them..." whilst Stephanie added: "It's not only therapeutic, I think sometimes it is more human and genuine if a therapist touches a client..."

Both Anna and Stephanie give various functions and meanings to touch. Anna referred to touch mainly as an intervention or a tool which the therapist could use. In contrast, Stephanie's words could be interpreted as a reminder that therapists are also human beings, and that therapist-client contact is an interpersonal contact in which touch could be used genuinely.

Miriam shared an example of when and why she uses touch in her clinical work:

"I rarely touch, but when I do there is something behind it that's quite powerful ... and in one particular session my client was crying and crying and I felt the heaviness just here (points to her chest). I wasn't concerned about suicide or her doing something to herself but it was nothing to suggest ... But I just felt she needed something, a little more ... this is my arm and she was sitting on the sofa and me on the armchair and I looked at her and I said to her, "Would you mind if I held your hand?" And she just held my hand literally for five minutes and the following session she came back and she said, 'You knew that I needed that' ... It was really touching ...(tearful)"

Miriam's example illustrates how sometimes 'words are not enough' and initiating a form of physical contact could be more powerful than words. It is as if sometimes the body itself could 'hold' physically and emotionally both clients and therapists more than any verbal interpretations. Also, Miriam's narrative could be perceived as another indication of how embodied, empathic and devoted to her clients she is.

Integration or disownment?

It is interesting to note that most of the participants reflected on their journey to becoming counselling psychologists in order to understand how they developed an opinion with regard to the role of the body in their clinical work. They talked
about the challenges, fears and obstacles of being counselling psychologists. Interestingly, it came up that the role and importance of the body is vague within the discipline. Thinking about the future of counselling psychology, there was a strong sense of uncertainty and pessimism about the place of the body; a dilemma over whether the body would be included or excluded from the counselling psychology discipline.

Foundations

Stephanie reflected on her experience of her counselling psychology training. She said:

"In my counselling psychology training, neuropsychology stuff was out of the window... Like 'We are therapists and this has nothing to do with us!' And because there is always this competition between clinical and counselling psychologists...clinical psychologists do neuropsychology and we don't because we want to differentiate our training ... But I think it is important that somebody's relevant lectures be included..."

There is a sense from Stephanie's account that she has some negative reactions with regard to the nature and structure of her training. For Stephanie, the verbal-oriented training seemed to reflect counselling psychologists' implicit attempt 'to set their boundaries' and develop a different identity from clinical psychologists and their medical-oriented training.

Ryan, who had the same training as Stephanie, seemed to agree with this:

"I don't remember any specific lectures on the role of the body or any direct focus on the body itself at all... Although it was acknowledged as important, I do remember in supervision groups, people bringing up dilemmas about clients who want to shake your hand or hug you... so it was there... Indirectly it was there..."

However, Ryan does not appear to have experienced the same frustration as Stephanie with regard to the nature of their training. For Ryan, in his training the body was acknowledged despite the fact that there was no direct reference to it,
no lectures or workshops. Ryan’s words reflect potentially the vague approach of counselling psychology in training with regard to the role of the body.

Boundaries or restrictions

The participants talked about how they experienced their role as counselling psychologists: Anna stated:

“*We are a bit constrained about our title ‘talking therapy’ and in some way it means that it’s about talking and not about other things... In a way, we are forced to describe... that a counselling psychologist is this person who does this and that, and is constrained actually, and moving out from that, means you move out from your area of expertise. It’s more risky... It is bordering.*”

For Anna, being a counselling psychologist seems to feel sometimes like ‘being trapped’, creating feelings of frustration and fear. Anna used the word “force”, which possibly indicates that she experiences an underlying pressure to be titled a ‘talking therapist’ which seems to frustrate her. Yet simultaneously, it seems that Anna finds it difficult to take the ‘risk’ and shift away from this role and her comfort zone (her areas of expertise) possibly because of the fear.

However, Ryan offers a different view about counselling psychology’s stance.

“They think we probably draw lot of implicit boundaries... We do this and not that... but then, if you think about it, this is how groups work... A group without boundaries is not a group or part of a bigger group... In a way you have to have the boundaries in order to separate... so you have to kind of be this and not that...”

For Ryan, establishing boundaries seems to be a way of developing a professional identity. He addresses the need for the establishment of boundaries in order to demarcate himself as an individual, and also to separate counselling psychology from other professions.

Hopes and concerns
Some participants reflected upon the place of the body in counselling psychology and it seems to them that its place will not be expanded or established within the discipline; rather it will be further diminished. Peter said:

"There is a split and I don't see it improving. I would like to think that body would become an adjustment in counselling psychology but I don't see evidence of it ... In fact, I see the body in the opposite direction [...] the importance of the body tends to be more and more marginalised in counselling psychology."

Despite Peter's hopes that the use of the body will be embraced by counselling psychology, he seems aware that his hope and vision goes against the reality. It seems that despite counselling psychology's aim to integrate different theoretical approaches, the use of the body does not seem to be a part of this integration. Possibly, the marginalisation of the body is related to the fear or concerns of counselling psychologists to embrace something in which they have not been trained.

Ryan does not seem to share Peter's hope for the future. He said:

"If I imagine us as a discipline trying to move more into body work I think the risk is that you will try to become an expert at everything and master of none...I don't know how that will look like, really."

Ryan's words indicate his hesitancy at the idea of the enhancement of body work in counselling psychology. His hesitancy and concern about including any body work seem related to an underlying anxiety about counselling psychology losing its identity.

A controversial topic

It is interesting to note that all the participants expressed both their validation and concern about the role and use of the body in their clinical work. It seems that, as an issue for discussion or as a tool in therapy, bodily and physical contact is 'food for thought and reflection' as it raises dilemmas and considerations.
To touch or not to touch?

While the participants acknowledged the healing benefits of using touch in their work, they also expressed their dilemmas about its use and its consequences. Ryan stated:

"The boundaries are more blurred when you talk about touch".

In addition, Stephanie believes that:

"For some clients, touch can be very threatening; for some others it's appropriate or it might be out of control ..."

Both participants seemed to be sceptical with regard to the application of touch with their clients, noting that touch could have an ambiguous meaning. It could be assumed that therapists have a clear rationale about why, when and with which clients they could use touch. However, for clients, touch as an intervention or a gesture by their therapists might have a vague meaning. Possibly touch creates uncertainty in some clients for whom it may be considered as 'crossing boundaries'; in contrast, it be healing for others.

Ryan seems to move from a sceptical position towards a more clear position around touch.

"I have never initiated it in therapy... ever... and I think it might be to do with several things. It might be with the fear around touch and with codes of conduct. Certainly since I finished my training and started working in private practice, I know people who have had allegations made against them and it’s a nightmare" [...] Also, I work on aspects that are... It’s more important to understand what the needs are than act on them...."

Ryan’s scepticism seems to derive from various sources such as his concern that using touch could lead to a breach of the Codes of Conduct or to him having allegations made against him as has happened with his acquaintances. For Ryan, these concerns have created fear and, therefore, a hesitancy to use touch in his
clinical practice. One main way of dealing with his fear is by thinking and reflecting on the meaning of using touch with his clients.

A matter of culture

Interestingly, most of the participants acknowledged that both therapists' and clients' understanding and validation of the body are grounded within their cultural background which they bring into the room and is expressed through their bodies. Anna said:

"Cultural background plays a part, really... because it's about norms. There are clearly cultures that communicate more with their bodies. If I work with a client with a quite different cultural background from my own, I would like to find out more about that... I may then be able to comment on that, saying that 'there is a lack of the body in the room'... It may lead you to talk about a sort of cultural clash... and we should be aware of it even if we don't work with it."

Anna seems very aware of how powerful cultural norms are and how much they could influence the way that feelings and thoughts are conveyed through the body, by both therapist and client. Possibly this is one of the reasons which intrigued her and made her open to embrace both the client's and her own cultural norms and how these are communicated through their bodies. Anna's words "there is a lack of body in the room" leave the reader with mixed thoughts about whether she is referring to the client's physical body itself, indicating a splitting from the client's mind, or to the lack of the body as an organ which conveys the client's thoughts and feelings.

Similarly with Anna, Stephanie appears to be very aware of how her own 'cultural upbringing' reflects her non-verbal communication. As she said:

"I come from a Mediterranean culture. I know that, as people, we are expressing more in general with the body, with touching and hugging... without thinking about it too much... Whereas here it is different... or even
the way I talk, I use my hands a lot... and I don't know how it looks to the client, if it's threatening...

For Stephanie, being Mediterranean but also a therapist who works in England appears to have created some confusion and an underlying comparison between the way she expresses herself through her body and what her clients do. Stephanie brings her 'cultural body' into the room with clients who seem to relate and express themselves in different way. This makes her feel uncertain whether she is perceived as threatening or welcoming.

Peter did not talk about his own 'cultural body upbringing' but talked about his clients' cultural upbringing. As he says:

“I have touched clients and I think is a cultural thing. You work with these American clients who will hug you for goodbye”.

Peter seems comfortable enough with initiating or accepting physical proximity as he respects and responds to his clients' cultural norms or rituals related to physical contact. Peter continued expressing his opinion about cultural clashes, deriving from personal experience. He said:

“I think people from America, Greece, Spain have a different way of being ... I have just come back from Italy and you know... you walk around there and people don't apologise for touching you. If you go to the tube here, people are bumping to each other but it's remarkable how separate they could remain... There is a physical distance and I think British people want more physical distance than others...”

Peter's observations about people from a Mediterranean background and his comparison with British people seems quite similar to Stephanie's views. It appears that different cultures give a different meaning to physical intimacy. For some cultures, physical intimacy seems to be a typical way of relating or communicating while for others, it is a violation of personal space.
**Self-awareness**

Despite the importance of cultural sensitivity and awareness, all the participants acknowledged that their personal awareness is a key aspect. As Anna said:

"It's just to be aware of how, when and why you do what you do and if it is appropriate or not."

Similarly, Peter said:

"Self-awareness is what keeps you safe as a therapist and what is safe for them. When we initiate physical contact with the client, we have to be clear and aware what is it about."

For both Anna and Peter, personal awareness has been the source for filtering the appropriateness of their bodily-oriented interventions and their armour of not breaching any boundaries with clients.

Miriam also stated:

"I have touched clients and I am not necessarily against it... if the client hugs you at the end of the session or he wants to shake your hand, I think in certain cases it would be more disturbing if you did not shake his hand. However I am very aware that actions have their meaning."

For Miriam, personal awareness relates to responding to the client's own invitation to physical closeness with a reflective and balanced response or stance and being neither dismissive nor fully responsive.
Reflective box 3: Analysing the data

Analysing the interviews and deciding on the master themes and sub-themes was a much more complicated process than I had anticipated. Worrying that my own feelings and assumptions would shadow the participants’ comments about their experience followed me to the end of the completion of this paper.

Therefore, my fear led me initially to maintain the analysis on a rather descriptive level. Complicating things even more was the fact that I had been exposed to a psychodynamic-oriented placement, where everything seemed to be interpreted and analysed. Finding the fine line between description and interpretation of the participants’ words was a challenging but thought-provoking process.

Discussion

This study aims to explore qualitatively how counselling psychologists experience the role of the body in the therapeutic encounter. This section will discuss the themes arising from the participants’ accounts in relation to the existing literature, and will draw on both research and clinical implications after reviewing the contributions and limitations of the current study.

Acknowledging the importance of the role of body as a whole, including body posture, facial expressions, and so on, is a main theme of this study. For the participants, the client’s body is “a source or tool of information” which communicates emotions or unconscious material. Specifically, one participant mentioned that “when clients personalise their pain in the body they ve a different slant to it”. This resonates with what Alessandra Lemma (2010), a prominent psychoanalyst and clinical psychologist, argues; namely that it is not only important to focus on how clients refer verbally to their bodies but also on how clients treat their bodies. For Lemma, for example, body modifications can give an insight with regard to unconscious conflicts and internalised relationships. Based on her observations of her clients, people who are unable to
bear and reflect on their experience of trauma and pain, turn to the body or skin as a means of communication.

In addition another participant emphasised that paying attention to bodily components is essential, especially in work with clients with eating disorders. Orbach’s (2003) extensive clinical experience with eating disorders aroused her interest in the role of both the client’s and the therapist’s body. She emphasises that therapeutic work could become more effective only if therapists generally adopt a more embodied and relational approach with clients, but also particularly with (as she characterised them) ‘clients with troubled bodies’. It could be argued that Orbach’s (2003) suggestion could be extended to counselling psychologists regarding an enhancement of their understanding and a focus on both clients’ and therapists’ bodies and possibly for their work with clients with eating disorders.

In addition, the participants talked about their own personal relationship with their bodies which seemed to influence their appreciation of the body in general. Most of them recognised that a deep connection with their own bodies had helped increase their understanding of, and perhaps even their empathy towards, their clients. This increased empathy with their body could relate to Rowan’s concept of linking, a special type of therapist’s empathy: an embodied connection between therapist and client (Rowan, 2000). For Rowan, the use of embodied empathy could create a deeper connection between the therapist and the client. Similarly, with Rowan, Shaw (2004) examined therapists’ experiences of their bodily reactions to clients. His results seemed to confirm somewhat Rowan’s concept of linking. His study indicated that therapists seemed to use their somatic experiences as a navigator for the process of therapy and that the therapists’ attunement of their bodily reactions to the clients’ material could generate an embodied empathy towards, and better a understanding of, their clients. In a similar vein, Orbach (2003) goes a step further, suggesting that therapists’ attunement could be used not only as a guide to their own physical reactions but also to their clients’ unconscious material. Orbach (2003) defines this as somatic countertransference and she suggests that therapists should become more aware
of their own issues related to their bodies, as it is inevitable that clients use not only the therapists’ psyche but also their bodies. She also stressed the importance of therapists needing to be comfortable with touch and with their own bodies and noted that they should be aware of their own issues around physical contact. Therefore it is suggested that counselling psychologists can develop a) a more reflective, open stance towards their physical reactions to their clients and b) a curiosity to explore their personal relationship with their bodies and any related strong feelings that could serve as an obstacle to their somatic countertransference towards their clients. According to Gabbard (1995, p. 481-482) “the countertransference becomes an obstacle if what the patient projects into us corresponds too closely with aspects of ourselves that we have not fully assimilated. We do well to remind ourselves that our conflicts and transference are not fully resolved”. Therefore, supervision, personal therapy and peer groups could serve as a safe place for counselling psychologists to discuss and reflect on their physical reactions to their clients.

Interestingly, during the interview process, all the participants mentioned physical contact and, specifically, touch as an aspect of the body. This could be interpreted as recognition of the fact that psychotherapy goes beyond the physical presence of two bodies in a room; it sometimes involves a connection between those two bodies, and the most common medium for this is touch. All the participants appeared to value touch and its application. Giving examples from their practice, they sometimes characterised touch as more appropriate than other verbal interpretations or interventions. It is viewed as powerful, healing, human, and genuine. Similar reflections in the literature on the subject, frame touch as genuine expression on the part of the therapist, a sign of support and nurturing, and a powerful means of non-verbal communication, capable of bringing healing effects to therapy (Milacovich, 1998; Durana, 1998). The participants did, however, express concerns about the use of touch with certain clients. Concerns about the violation of therapeutic boundaries, possible sexual arousal and allegations against them were among their fears. These findings also chime with those of other studies which note therapists’ concerns that well-meaning and innocently-offered touch may be misinterpreted as sexual or
exploitative and result in harm or even litigation (Lamb & Catanzaro, 1998; Williams, 1997). For these reasons, contemporary psychotherapy is guided to a great extent by ethical considerations with regard to the use of body and touch. According to the BPS Code of Conduct, Ethical Principles and Guidelines (2009), psychologists are considered competent to use any therapeutic interventions, including bodily interventions, only if they have relevant training and adequate supervision. It is also advised that therapists should ask for a client's consent to any body contact interventions, making sure that he/she fully understands the reason for these and what is involved.

The participants' professional identity and training arose as important elements in this study which might influence their understanding and their increased concern around the use of body and touch. There was a sense of disappointment that their training as counselling psychologists had not necessarily provided them with sufficient knowledge about the use of the body and touch. Some of them referred to the limited number of lectures on body-oriented approaches, whilst others mentioned that there had been only indirect reference to the body, particularly in supervision sessions. According to the literature, the type of training and supervision encountered professionally has a direct impact on therapists' use of bodily techniques in the consulting room (Daniels, 2000 as cited in: Tune, 2001; Stenzel & Rupert, 2004). Therefore, some clinicians become more reluctant to use touch in their clinical work because of their training requirements and tight supervision. Possibly, in this study the implicit reference of the body in supervision might be related to the trainees' fear of talking about the use of touch in supervision and of being criticised by their supervisors that using touch was 'a therapeutic mistake' or a crossing of boundaries (Daniels, 2000 cited in Tune 2001, Gelb, 1982). Also, an embracement of bodily techniques potentially creates a dilemma about its meaning towards the parent discipline of the practitioners. Does that mean that counselling psychologists would be moving away from their areas of expertise and, by implication, their 'comfort zone'? The lack of reference and training made the participants sceptical. It is unclear whether the lack of reference and training reflects a) an attempt by counselling
psychology to establish its own boundaries as 'talking therapy' and gain its respectability b) a restriction or c) an area of development for the discipline.

Based on this, the participants expressed both their hopes and concerns regarding counselling psychology's stance. Despite their own validation and rather significant use of the body in their clinical practice, they did not feel that this could be established in counselling psychology practice. The participants' hopes and concerns with regard to the future of the body is also evident in the literature. Interestingly, when reviewing the existing literature, it was notable that there were so few references in counselling psychology textbooks to more body-oriented therapies and interventions. There is a mention in Wahl's chapter in the second edition of the Handbook of Counselling Psychology (2003) but this has been removed in the latest edition (Strawbridge, Dryden, Woolfe & Douglas, 2010). It is worth pondering on the meaning of this. Is it perhaps that the body 'is lost' in the integration of various psychological theories and approaches that counselling psychology is related to? The integration of various psychological approaches and theories within the discipline of counselling psychology seems to be problematic. The body and its aspects, being both a powerful and ambiguous element, are ignored in the process of integration because of its potential to produce a personal and cultural clash between the therapist and the client. At the same time, integration requires that the therapist develop a unique personal approach from the available frameworks and strategies (Woolfe, Strawbridge, Douglas & Dryden, 2003). It also requires a wide perspective, a necessary prerequisite to be an integrative therapist as required for counselling psychologists (Woolfe et al., 2003). It would seem that the limited presence of the body and its aspects in training, in counselling psychology textbooks and the integration of approaches would discourage its application in therapeutic practice. Nevertheless, the results of this study indicate that the body and its aspects are present and could be considered as a valuable tool in the practice of counselling psychology. It is also suggested that this study could possibly be used as a reference point in lectures related to the body on counselling psychology courses.
The participants also recognised the impact of the cultural background of both themselves and their clients on the role of the body within therapy.Interestingly, despite coming from diverse backgrounds (Pakistani, Greek and English), they all seemed to value and make significant use of the body within therapy. However, they may have related to the body differently; for example; one therapist of Mediterranean origin acknowledged that this enabled her to be more physically expressive within therapy. With regard to clients, the participants noted that cultural background can be influential in deciding the extent to which they will involve the body or use touch. This seems to accord with suggestions in the literature that cultural and social background is a consideration when using touch and bodily aspects in therapy (Leijseen, 2006). Particularly, the BPS Code of Conduct, Ethical Principles and Guidelines (2009) stresses therapists' considerations when they use bodily techniques of their clients' culture, religion, gender, developmental history, previous experience with touch or sexual abuse history. It is also suggested that, apart from the BPS Code of Conduct, Ethical Principles and Guidelines, therapists must consider the wider social context and the power of social norms. Unfortunately, the high prevalence of eating disorders and media pressure have constructed norms/stereotypes such as 'having the perfect body' and others, which inevitably both therapist and client bring with them into the therapy room (Herzog et al, 2000; Rief, Buhlmann, Wilhelm, Borkehnagen & Bra, 2006). Therefore, therapists are encouraged to understand the meaning and the role of their own and their client's bodies in relation to the context.

Considering the role of cultural background as an influencing factor in a therapist's orientation towards using the body in his/her work, we must also acknowledge the tantamount influence of the culture in which the therapist practices. This ties the cultural angle that this study has identified to the sub-theme of boundaries and restrictions. Boundaries are not only imposed by codes of practice and therapeutic frameworks; they also operate on a cultural level in the form of what is accepted as normal interpersonal contact. It would be interesting to examine the research question cross-culturally as this would shed
light on subtle differences in the role of the body in psychotherapy by taking into consideration the wider social context.

Lastly, the participants emphasised the importance of self-awareness. As an important element of a counselling psychologist’s identity, self-awareness seems to be the ‘armour’ for the participants, especially when it comes to the application of body techniques or the initiation of any physical contact. Therefore, it could be argued that, despite the fact that counselling psychology training does not involve any body-oriented training, it largely involves the development of counselling psychologists’ awareness of when, how and why an application of body technique and physical contact could enhance and give more space to the body in their clinical practice. Specifically, counselling psychologists could become aware of the motivation for using the body and touch, by taking into account that any bodily interventions must be for the client’s benefits and not for their own. Furthermore, the stage, the quality of the therapeutic relationship and adequate boundaries should be taken into consideration.

Limitations of the research and implications for future research

This study attempts to bring about new understanding, by offering a detailed analysis of the subjective experience of counselling psychologists with regard to the use of the body within the therapeutic encounter. It also offers suggestions and advice to counselling psychologists and, simultaneously, raises ethical considerations regarding the use of the body and touch in practice.

With regard to the limitations of this study, despite the small sample size of the research (5 participants) according to IPA guidelines, it was sufficient (Smith, 2011). IPA was also considered to be appropriate for this kind of research questions, as it allows ‘room for creativity and freedom’ (Willig, 2001). It enabled the participants to provide detailed and in-depth accounts of their own understanding of the body in therapy. In particular, although the findings are not empirically generalised, they can be theoretically generalised with context-specific insights that might apply to other professionals in similar circumstances (Yardley, 2000). Therefore, the results of this study do not aim to be generalised
for all counselling psychologists yet they still offer insights into the nature of some counselling psychology programme trainings.

Interpretative Phenomenological Analysis acknowledges that the "interpretative framework of the researcher is highly influential to the analytic process" (Aroll & Senior, 2008, p. 447). The researcher's personal experiences with clients and therapists both past and present could influence the data collection and analysis. The researcher is currently in training and therefore has limited experience in contrast with the participants who were qualified and more experienced. As someone who is not a qualified counselling psychologist, the researcher is aware of "the impossibility of unmediated access to the experience" (Westland & Shinebourne, 2009, p. 389).

It was interesting that all the participants, despite having had personal therapy themselves, oriented towards the topic almost exclusively as therapists and not as psychotherapy clients. There are several interpretations that could explain this finding. Firstly, it is reasonable to assume that talking about their clinical work was less exposing than talking about their experience of personal therapy. Secondly, as qualified and chartered counselling psychologists talking to a trainee, the participants seemed to have positioned themselves more as professionals and less as 'ordinary' human beings. However, it is also worth mentioning a constraint imposed on them by the interview schedule which the researcher employed. The second prompt in the schedule specifically probed into the participants' experience drawn from their clinical practice. This point highlights one of the pitfalls of having an interview schedule following the opening question, namely that the participant's phenomenology is subsumed, to some extent, within the researcher's analytical foci.

Ultimately, qualitative research needs to be conducted in order to enrich counselling psychologists' understanding of the meaning of the body. It is reasonable to assume that the participants, who work in private practice, have the opportunity to be creative and flexible with their clients and, therefore, it gives them the opportunity to consider and use more bodily techniques. However, it may be worth exploring the experiences of counselling psychologists
who are employed in NHS services and focusing on whether NHS settings and guidelines further influence their understanding with regard to the use of the body in the therapeutic encounter. Also, a focus on exploring clients' perspectives and experiences (specifically client groups such as sexual abuse or trauma survivors) of using body techniques in therapy is worth considering.

Reflective box 4: Final thoughts

Although conducting this study has been a fascinating experience, it has also allowed me to reflect on the difficulties I faced as a researcher being personally interested in the topic under investigation. I feel that I have managed to channel my collusion and over-identification in a constructive way, hopefully providing an alternative, more phenomenological view, of the experience of my participants. At the same time, I make no claims to have successfully bracketed all my assumptions. For instance, my belief that, as therapists, we must be more body-oriented constitutes an assumption that could have been picked up by the participants and in turn influenced their views of the topic. In conclusion, I recognise that in the course of this analysis I took a somewhat 'pro-body' approach to psychotherapy. This did not prevent me from engaging with the more controversial implications of this stance, as evidenced by the participants' concerns about boundaries, ethics and the potential for harming clients.
References


Appendix A

Information Sheet for participants

Title of study

Exploring Counselling Psychologists’ experience of the role of the body within the therapeutic encounter.

Description of the study

My name is Maria Kouloumbri and I am a 2nd year Counselling Psychologist trainee at Surrey University. As a part of my research project I am exploring Counselling Psychologists’ experience of the role of the body within the therapeutic encounter. According to the literature, the body within psychotherapeutic contexts has been perceived by psychotherapists with scepticism. Criticism of the role of the body in therapy stems from both the academic world as well as from therapists themselves for various reasons: cultural, religious and ethical. However, despite this scepticism, a number of quantitative and qualitative studies have been conducted regarding body work effectiveness, the use of touch in therapy, and clients’ and therapists’ somatic experiences within therapy.

What is the purpose of this study?

Considering the above information, a question is raised regarding Counselling Psychology’s position on the body’s role within therapy. Counselling psychology is concerned with the integration of different psychological theories, emphasising the therapist’s awareness and the significant role of cross-cultural issues in the therapeutic relationship. What I am asking is how counselling psychologists perceive the role of the body and touch within the therapeutic context.

Thank you for expressing an interest in participating in this research. If you do decide to participate in this study, the following section will inform you of what the process will involve.
What will be expected from you as a research participant?

I am looking for qualified Counselling Psychologists who work in private practice to share their experience of the role of the body within the therapeutic encounter. Participants are not required to have a special interest or training in any body-oriented therapies.

The research will be conducted using face-to-face interviews which are expected to last approximately 1 hour.

The interviews will take place in locations convenient to the participants and will be audio recorded. In cases where interviews may be conducted at a private address, e.g. your home, I will provide my supervisor with your name and the address where the interview will take place. This is a University requirement in order to protect both student researchers and potential research participants. You will have the opportunity to end the interview at any time you wish and you can refuse to answer any questions that make you feel uncomfortable.

Confidentiality

Anonymity and confidentiality are guaranteed in order to protect your privacy. Please note that you are free to withdraw your participation at any time without penalties. The data collected in this study will be transcribed but your name and any other identifying information will be removed so that you cannot be identified. The data collected in this study will be protected in the strictest confidence, and in accordance with the Data Protection Act (1998) http://www.legislation.gov.uk/ukpga/1998/29/contents. Your interview recording will be deleted, following the submission of my final portfolio to the University at the end of July 2013.
What will happen to the results of this study?

The final report will be assessed by academics at the University of Surrey. There is a possibility that this project may be published, which means that some quotes from your interview will be included. However, your identity will be protected. I promise to offer you a copy of my final paper.

If you are interested in participating in this study or if there is anything that is not clear or you would like more information please do not hesitate to contact me at the following e-mail address: M.Kouloumbri@surrey.ac.uk or on the following telephone number: 07593016409. You may also contact my supervisor, Dr Dora Brown at the following e-mail address: D.Brown@surrey.ac.uk

Yours sincerely,

Maria Kouloumbri
Counselling Psychologist trainee
University of Surrey
Appendix B

Interview Schedule

Research title: Counselling psychologists' experience of the role of the body in the therapeutic encounter.

Opening phase
Thank participant for agreeing to take part to the research. Introduce the research topic and explain the interview procedure. Inform them about confidentiality and anonymity. Obtain the signed consent form.

Questions
1. What do you think about the role of body in therapeutic practice?
2. Would you like to share with me any relevant experience from your clinical work?

Probes
-Any difficulties? Challenges? Thoughts? Learning as therapist or as an individual?

3. What do you think may be clients' views on the use of body within the therapeutic encounter?

Probes
-Any clinical example which illustrate client's experience?

4. What do you think will be the role of the body in the future in psychotherapeutic practice?

Probes
-Will it change? How? Suggestions?

Towards end of interview:
-Is there anything else you think I should know to understand your experience better?
-Is there anything you would like to ask me?

A close of interview:
Thank participant for taking part.
Ask for feedback about the interview or the questions
Appendix C

Consent Form

Research title: Counselling psychologists' experience of the role of the body in the therapeutic encounter

I, the undersigned voluntarily agree to take part in the study on 'Counselling psychologists' experience of the role of the body in the therapeutic encounter'.

I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do. I have been advised about any discomfort and possible effects on my well-being which may result. I have been given the opportunity to ask questions about the study and have understood the given information.

I give permission for the audio-recording of the interview.

I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice, and any details and/or information already gathered from me will be destroyed.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of participant (BLOCK CAPITALS) ..................................................

Signed ..................................................

Date ..................................................

Name of researcher (BLOCK CAPITALS) ..................................................

Signed ..................................................

Date ..................................................
Appendix D

TRANSCRIPT

All names and locations have been changed to ensure confidentiality

Interviewer: Hello
Respondent: Hello

Interviewer: Firstly I would like to thank you for taking part in this study. I have some questions here....
Respondent: Great

Interviewer: I would us to start with a general question. What is your view about the role of body in therapy?
Respondent: In terms of the body I think it plays a significant role if you are allowed it to... if you are attuned to your body, for example as I am with a client, maybe not consciously because its more in practice but I've done it on an unconscious level but attuned to my own body so the experience of being with a client as well attuned to my own body is giving me... not always... quite a lot of information about the client, for example, the client is expressing pain by touching some part of his body that also gives me a lot of information about the client. For me, using body... sometimes clients can talk a lot about things but when they personalise it to the body they give a different slant to it, particularly in terms...I guess owing some of these feelings... by keeping them inside themselves so I think this is very helpful in that sort of way....

Interviewer: Would you like to share with me any relevant experience from your clinical work?
Respondent: I have had a few clients...particularly working with trauma.
Interviewer: Right

Respondent: So sometimes what happens is... maybe is the counter-transference if you like...a client was speaking about a particular experience...for example, this client was talking about...there was a trauma but the work was around the anxiety around the trauma if you like ... so she was talking about ..she wasn't talking about her stomach or anything, she was talking about not being entitled when she spoke about that. I felt a nod in here in this zone (puts her hand on her stomach) very powerfully

Interviewer: Hmm

Respondent: And then when I asked her to locate where that pain was in her body she showed exactly that point...and the way I experienced it was really... terribly knotted. It was partly the conscious reality of her describing it and identifying with her body so when we did the work it was to try to find the way to soothe this part which is a lot of behavioural work... to look at how we could smooth these knots but I guess the deeper level was to identify what this knot meant and cope with it ... because for her was really preventing her from doing things that she wanted to do...it provided her with not wanting to go out so the coping part was really important and to so how do you begin to be assertive and do things that you can do...?

Interviewer: Very interesting ...were you able to share your experience with the client?

Respondent: Yeah... this one, when I asked her, 'Where is it? Here? it was very much...if I remember, it's going back a while here...which then made me respond more strongly about where it is and want more details about how it feels, like, 'When you say here, is it big, is it small?' So I guess what I was doing was being open
Research Dossier

to other possibilities but also aware of my own feeling. I had... my feeling was very, very powerful so when I did the exploration with her I was very much identifying very strongly that feeling so I didn't voice, I guess, how I felt in that particular case but sort of my feeling if you like, my essence did not allow me to elaborate and look at these areas maybe or may not look at... I don't know. I am very explorative. But sometimes you know... We are guided by our own experience, our perception. So I guess that was my own guidance where I go with my client...

**Interviewer:** Hmm, very interesting...

**Respondent:** It was a very powerful feeling... but it was when the client left the room... the client came when she had a lot of issues... complete mumbo jumbo... it was very difficult for her to find what was going on... emm... and we used the session where I described everything as a mess in order to try to find out her language that she may use to describe that... so she agreed with me... she was extremely tired, she was extremely exhausted, and she said often suffers from really acute headaches although she didn't have a headache in the session but when she left the room

**Interviewer:** She left you with the headache? (smiles)

**Respondent:** She left me with the headache indeed... and it was really powerful because it wasn't a slow headache that comes... it was very sharp... and once I had done my process notes I think it was tender there... almost it was left... there but I think it was immediacy. I got the headache when she left the room and bang (shows her head), I felt it very strong on this side of my face so it was quite powerful in that way
Interviewer: Hmm

Respondent: Which I guess for her probably goes on like that ... it comes out of the blue rather than being slow and progressive. It varies ... one of the experiences that I am very aware of and sometimes it concerns me if I am doing something right or doing something wrong ... I suppose these questions will be naturally asked in supervision of myself if you like, but a couple of times ... more than a couple of times ... but different clients ... Different places ... Different times, emm ... I am speaking here for a long period of time ... a few different experiences on different levels, nothing that I am common with ... I know that may relate to either my client or to myself. Because I think it's very important to be questioned if is it something about me or is it about the client? Or something that it was brought collaboratively ... I used to get a lot of information and sometimes I use it in the room with the client. An example is ... I saw a client yesterday for an assessment. The same client ... his addiction ... he is an alcoholic. I had seen him almost a year before and when he came and see me the year before he was heavily drinking. Really heavily drinking every single day ... I think that time it was 30-40 units per day ... quite a lot ... and one of the questions I asked him in the assessment that day was 'You have told that the most you have been clean is three months?' and during those three mouths he had times when he felt good but generally he goes back to the drinking because of the depression he has ... and a lot of external blame ... in the sessions when I was with him, I didn't really get a sense of absence of any feelings and this was quite a new experience with him. So when I did the assessment yesterday we were talking a lot about painful stuff ... fortunately he doesn't drink; he's been clean more than three months so I went back and
said to him, 'You haven't been clean for more than three months ... blah, blah... and he was speaking about a relationship that had broken down and actually came to an end the day before... emm... the language that he was using was very powerful, sharing, and I think someone hearing that language probably assumed that it was very painful, which is the assumption also cognitively that this is something really powerful he is talking about... the real feeling of sadness of everything... I was completely numbed with those words... so what I did say in the session to him is 'You are speaking a lot about difficult feelings' and I said, 'Whether it's the shock that it only happened yesterday or something more, I am feeling completely numbed by what are you saying' and he came back, 'I am completely numbed. I don't know what I am feeling.' So he was using these words without having a substance of feeling, and only felt numbed yesterday when I actually saw him

Interviewer:  
Hmm...

Respondent:  
So what I was able to say, that much was in that assessment... and for me be able to say that to him was quite powerful and important communication. I will be open to possibilities but I wonder whether it was simply a shock or whether that's how he has been functioning because I know with addiction when the pattern of drinking starts, your emotional development also stops and trying to identify and name feelings... I mean that's difficult for any client but for them is more difficult... So yeah for me, the body... I am very connected to what I feel... I am more connected or not... it's difficult to answer yes but at the same time it's no... because if I take on board this feeling that I was numbed and he was numbed, then in a way, yes... I am very connected to my body... that allows me to have this experience... but it only comes through being very open... when
I go back to my early days of training, I remember one of my supervisors saying... because I had a number of suicidal patients I worked a lot in CMHT'S and I had a lot of chaotic clients immediately in my first year of training... I remember one of them saying, 'You are very empathic' but there wasn't something that I could identify with in my personal life. I was always overwhelmed and tearful for my clients and during that year, clients trying to commit suicide so... I guess I mean that when I reflect back, nothing was ... later on identify with ... I could really put it down to something as a connection with my body... so I think it's both helpful and unhelpful.. (Smiles) No, I think it's helpful... very powerful in terms of working with clients...

Interviewer: You seem very open and attuned to your body

Respondent: Yes... I remember we had a lecture at the university about Gestalt therapy so... for me... I really valued that... because even before that, the body was important...

Interviewer: So it wasn't the training that enabled you to be more aware... it was beforehand...

Respondent: Yeah... I worked very much with images and with the body so that the dialogue that I have with myself... images sometimes. I will check where the client is... emm... sometimes I just hold it in my mind how the clients see some things without saying anything... Sometimes when I think it's appropriate I will share this image with my client and...

Interviewer: Do you think that it also depends on the client?

Respondent: Absolutely. And the same with the body... at times I don't immediately share with the client and is enough for me to know about it and other times, like with this client with the
knot... I remember myself becoming hunched in the session. I put myself up and shared that with the client. Feeling tight and hunched is something that you share or what it might be... and the client said she was very tight on her shoulders so sometimes I will share it when it feels right and not always share. I am not high in self-disclosure but there are places that self-disclosure is ok and appropriate... but I also think the language that you use is very important as well. It doesn't have to be right... emm... I think I find myself sometimes with different client groups, meeting them at their level if you like... so you know... working with addictions you may come across people who are very gang-like and they have their gang-like... I am not in this level to speak in gang style... but I think naturally, I tailor myself down and if I meet someone who is very high I will put myself to a more unconscious level... so I think in the same way when I am disclosing, I attune to the language, in the language that feels comfortable...

Interviewer: Hmm

Respondent: So maybe the words I use or the way I describe myself... for example the shoulder example; it was very comfortable just to say this is the sense that I get...and I notice myself feeling this and I shared that with her... it felt very natural and comfortable to be able to say that and she responded very well to that... emm... with the client yesterday again... it was quite natural to me to point out that dynamic, the way between him and myself... emm... in the way that I did... I don't think I would take it out of context. I think it has to be in the context... emm... and if I miss the opportunity I will let it go, holding it in my mind...

Interviewer: And if it comes up

Respondent: And if it comes up, fine, but sometimes you change your mind
about things... it's something that you have to force and if it comes out, I choose my words... I think in the early days of my training, my anxiety would be higher but now it's more natural and it flows from my own body and, as I said, if I actually feel it and I think this is where genuineness comes from, but also physical contact and touch could be genuine sometimes...emm... a client of mine – she was also that one who was suicidal in my first year of training – emm... she cam ... I mean she had a history of sexual abuse, really extreme, but what she presented was agoraphobia: What we tried to work on initially was agoraphobia and my sense was this was not appropriate. What she had difficulty with was receiving anything or taking anything out and being here for her was a big thing. She spoke a lot in metaphors and a lot of the language for her was in metaphors and images... emm... at one point we were maybe four-five months into the relationship and she... finally I guess was able to speak about her distress. She was doing it for 3-4 sessions prior to speaking about it... we had a box of tissues on the table and when she was crying she would always take tissue out from her bag... and these times I am very conscious of offering a tissue to the client and what I am communicating when I am offering a tissue. Am I saying 'Don't cry'? or just being respectful: 'Here is the tissue if you like.' What I am communicating, I am very conscious of things that go on in the session, so there were three sessions with a lot of tears each time... I mean literally. She is sitting here for example (shows the seat with her hand) and the tissues are there (shows the table). She always goes to her bag and takes a tissue... so on this particular occasion when she was tearful and the importance of crying... I could done it in two ways but I went with what I just felt comfortable with. If I go back I could have said, 'You often take a tissue from your bag and not from the
table' but I didn’t manage in that way. I did it in another way completely... When she moved to take one from her bag I offered her a tissue and I said to her, 'It's OK to take one.'

Interviewer: Hmm

Respondent: From that session there was a huge shift... What would happen was to say things using metaphors. I mean, when she came, she only was seeing the keyhole but when she left therapy she was able to see the keyhole on the door that was a huge shift... so in a way I didn’t touch her hand but I gave her the tissue and we made a contact through this tissue... another example with the client was three weeks ago, something like that... it's a very long-term client that I am seeing and we have done a lot of work together. She is very stressed, she has been through a lot with her husband; he has been disabled.

Interviewer: Hmm

Respondent: In an a traffic accident... and in one particular session she was crying and crying and I felt the heaviness just here (shows her chest). I wasn’t concerned about suicide or her doing something to herself but there was nothing to suggest that even the way she was she would attempt to... emm....but I just felt she needed something a little more... this is my arm and she was sitting on the sofa and me on the armchair and I looked at her and I said to her, 'Would you mind if I held your hand?' and she just held my hand, literally for five minutes and the following session she came back and she said, 'You knew that I needed that.'

Interviewer: Hmm

Respondent: It was really touching
Research Dossier

Interviewer: It sounds like...

Respondent: Yeah, I really touch but when I do there is something behind it that's quite powerful

Interviewer: Yeah... as you said you are very attuned to your body, you trust it...so I guess you know when it's appropriate or not for a client.

Respondent: Yeah and I think there are various clients... there are others that leave and you will always remember them, there are others that you will forget and that is very powerful information... a classic example .. I do some group work and there is one particular client who was constantly absent. I would go round and check in with everyone else and I would never hear his check in, what he said... emm... at least I would never recall that I hear him and... one particular session, out of the blue, I thought "Oh my God, I didn't realise that you were here"

Interviewer: Hmm

Respondent: I alerted myself and actually he was here and I said... I actually said the words... emm... 'You didn't check in'.

Interviewer: Hmm

Respondent: 'Did you come late?' You know... it was that blank for me... so, one, a real embarrassment and two, very powerful information that I discovered later. After three sessions, I think, he came out with the fact that he lived in his parents' house, his parents had a massive house and ever since he was 14 he'd became disabled so his parents had built him a house behind their house and they took food and drink there for him, shopping for him, he had a shower and TV there and he spent all his time after school, whatever, in that place and he didn't engage in the main house at all, so when he shared this information I did say
to him, 'That makes more sense to me now' where I couldn't see him and that was quite powerful for him to hear... so again that was the body and what my transference and countertransference picked up... so yeah

Interviewer: Apart from the fact that you are a counselling psychologist and very attuned to your body, what is your general view about the future of the use of the body in therapy?

Respondent: I think in terms of counselling psychology there is a tentative pullback. I am thinking of my supervisees... and also I think there is a part of the training dos and don'ts, I mean there are dos and don'ts so...when I think of counselling psychologist trainees, yes there is a slight pullback...when I think of my colleagues I guess.... I am thinking of three of them who I'm very close to in terms of daily contact rather than one that is more at a distance but still very close..

Interviewer: Hmm

Respondent: I think a lot depends on the person... what I've noticed -and now I am being critical – for example, is that she is a counselling psychologist and she is very cognitive oriented... she doesn't pick up a lot of bodily sensations; she is very cognitive in the mind and works on a cognitive level; she does work on an emotion level or I guess that is our engagement as friends if you like; there is touch, hugs with all my friends and it is very much like that but with her it's very much on a thinking level whereas another friend who is a counselling psychologist as well, she is very bodily, she works more cognitively but I know that she is focused on the body as well. I sometimes wonder whether there is a balance between the body and the mind and whether I draw a lot of information through my body... emm... as well as picking it up consciously from the
client... emm... I guess you made me think what is my language in my head

Interviewer:  (smiling)

Respondent:  I think it's very integrative ...Yes I can go down the route cognitively, I can go down the route of psychodynamic, yeah it's very integrative to take the whole...so I guess this is why I am more open..

Interviewer:  So the way you described it, it seems to depend on a lot of different things...

Respondent:  Yeah, person, training, life experience...

Interviewer:  Hmm... I think we are coming towards the end of the interview....are there any feedback, questions from me?

Respondent:  No...I found it very fruitful...it made me think...very interesting topic...good luck!

Interviewer:  Thank you very much for your time.
Quantitative study
Therapists' attachment styles and the use of touch in their clinical practice

Abstract

Aim: Over the years, interest has developed in how factors such as the training, gender, age and cultural background of the therapist may affect the use of touch in therapy. Recently, the therapist's attachment style has been considered an additional influential factor. The aim of this study is to examine the relationships between therapists' attachment styles, personal characteristics, and theoretical orientation; how they affect the types of non-erotic touch (based on Smith's taxonomy) and when, why and how they are used in their practice.

Research Design: A quantitative methodology was appropriate for this study because it required the use of structured questionnaires and a large number of participants.

Method and Procedure: 147 therapists were recruited from the private sector in the United Kingdom. The participants were identified through professional bodies. The survey consisted of 3 questionnaires: a) a demographic questionnaire, b) a questionnaire about the use of touch in their practice, based on Smith's (1998) taxonomy and c) an attachment questionnaire (about their experiences in close relationships) (ECR).

Results: The results showed that securely attached therapists use socially stereotyped touch and touch as an expression of the relationship significantly more often than fearful and preoccupied attached therapists. Securely attached therapists also use touch to provide emotional support and improve their clients' awareness significantly more often than fearful and preoccupied attached therapists. In addition, CBT, humanistic and eclectic therapists seem to offer touch significantly more often than psychoanalysts. Specifically, CBT therapists
were the 'most active' when it came to offering *socially stereotyped touch* and *touch as expression of the relationship* throughout the session.

**Conclusions:** The results of this study could be used to inform for supervision or reading material in psychotherapeutic training, particularly in lectures related to the use of touch. It is also suggested that supervision, training and personal therapy drawn from attachment theory can increase therapists' and trainees' awareness a) of their attachment patterns in their close relationships and especially the strategies they use to seek and maintain physical proximity and b) of how these patterns and strategies might influence their therapeutic work, especially the use of touch in their practice.

**Keywords:** attachment theory, Smith's taxonomy therapist's attachment style, touch
Introduction

Touch is a central aspect of human communication and is essential for physiological and psychological development (Stenzel & Rupert, 2004). Physical contact is especially important between the infant and the caregiver as it signifies comfort, acceptance, protection and a sense of being loved (Hunter & Struve, 1998). However, in the context of psychotherapy, the use of touch has many possibilities for both healing and misinterpretation. Its use is surrounded by controversy and suspicion, which is shaped by a complex interplay of theoretical approaches, cultural taboos, ethical considerations and philosophical influences (Tune, 2001; Stenzel & Rupert 2004).

The misconception and suspicion of using touch in psychotherapy may be rooted in the body-mind dualism of Western thinking and culture (Smith, 1998). As best represented in Descartes' philosophy, Western culture tends to conceptualise things mental (res cogitans) as of a different nature from things physical (res extensa) (Smith, 1998). This philosophical heritage has influenced the dualistic nature of psychotherapy today and there is, therefore, a distinction between body-oriented therapies, where the use of touch is a central aspect of the therapeutic work and talking therapies, where the use of touch seemed to be limited and/or 'inappropriate' (Durana, 1998, Phelan, 2009). Due to its ambiguity, the use of touch remains an ongoing issue for discussion and research. A large body of literature has focused on the ethical considerations and risks concerning the use of touch. Over the years, interest has increased in background factors that may affect the use of touch in therapy. The therapist's training, gender, age and cultural background are some of them. Within one of the most influential theoretical frameworks in contemporary psychology – attachment theory – some authors have started considering the therapist's attachment style as also potentially influencing the use of touch in clinical practice.

The aim of this study is to examine the relationships between therapists' attachment styles, personal characteristics, and theoretical orientation; how they affect the types of non-erotic touch (based on Smith's taxonomy) and when, why and how they are used in their practice.
Theoretical paradigms

Western dualistic thinking with regard to the use of touch is reflected in various theoretical paradigms. For instance, amongst psychoanalysts there has been a concern about, and interest in its potential use in the context of the therapeutic encounter. In the early years of psychoanalysis, Freud’s therapeutic implications relied heavily on the use of touch in therapy. Freud himself occasionally used touch to help patients express their feelings (McLaughlin, 2000). However, as he further developed his work, he gradually replaced touch with the analysis of transference and the technique of free association. He was concerned that the use of touch might raise issues such as the stimulation of sexual feelings in both the analyst and the patient (Phelan, 2009). Some analysts have followed Freud’s path, believing that touching might actually serve to build up a client’s resistance (Kupferman & Smaldino 1987). However, others have continued to use various modes of touch, while differentiating on their level of caution (Smith, 1998). The stance of psychoanalysis with regard to touch has created suspicion and misconceptions about touch and its use.

Touch has been considered as ethically inappropriate for both the client and the therapist. From an ethical point of view, the controversy focuses on the possibility of harm, sexual misconduct or the view that any type of physical contact will blur the therapeutic boundaries. In an attempt to use touch safely, and to minimise the harm and risk of touch application in therapy, Durana (1998) pointed out in his clinical guidelines for touch the need for proper training, whilst raising as ethical considerations the therapist’s understanding of his/her own responses, motivation and attitudes to touch, along with the dynamics of power, gender and boundaries. In a similar way to Durana, Smith (1998) attempted to capture the purposes and motivations of using touch in the context of psychotherapy by proposing a taxonomy that identified seven forms of touch. His aim with this taxonomy was to give a clearer understanding of touch and acceptable types of touch and to encourage professionals to use them. The first two categories he identified were sexual touch and aggressive touch, which are clearly unacceptable in psychotherapeutic work. Yet the remaining five might
be considered as forms of touch acceptable to the client. These are: (a) inadvertent or unintentional touch, i.e. bumping into someone by mistake; (b) touch as a conversational marker, such as placing a hand on a shoulder for emphasis; (c) socially ritualised touch, such as a handshake; (d) touch as an expression of care; and (e) touch as a greeting or a technique of conducting physical contact in a therapeutic context in which the practitioner has received training (Smith, 1998). Smith’s discussion of how to introduce touch into psychotherapy is limited and he therefore suggests that the therapist should explain the reason for touch and ask for the client’s consent in the least coercive manner possible. Consent is best obtained explicitly and early in the therapeutic relationship and whenever a new form of touch is introduced (Smith, 1998).

Historical and philosophical influences, research, as well as clinical developments during the last 40 years have contributed to a shift in thinking about the use of touch in psychotherapy. As described by Fosshage (2000), this has led psychotherapy from a positivistic to a relativistic science and from an exclusively intrapsychic model to a relational and interpersonal one. An example of this shift is the humanistic approach, which suggests a less theoretically complex position on touch (compared to the psychodynamic position). In the humanistic paradigm, touch is simply viewed as a natural and spontaneous expression of a genuine relationship (Milacovich, 1998). Therefore, in clinical work, experimentation with touch is encouraged in combination with other ways of relating and communicating among humanistic therapists (Leijseen, 2006). There is a belief that whatever comes up (when using touch) can be processed as long as there is openness, honesty and genuineness on the part of the therapist. Indeed, based on research, touch has its place in humanistic therapy as 25% to 30% of humanistic-oriented therapists are open to the use of touch, perceiving it as a natural expression of a genuine caring relationship or considering it as a tool which enhances communication (Leijseen, 2006). Similarly, Gestalt therapists encourage the use of touch as long as it can be justified in the therapeutic environment and is tailored to the client’s – and not the therapist’s – needs (Kepner, 2001). In contrast, for CBT and systemic therapists, touch is avoided in favour of other interventions (Stenzel & Rupert, 2004).
**Research evidence**

Despite some the clarifications in the clinical guidelines about which types of touch are appropriate and which are not, touch still creates an atmosphere of suspicion in the psychotherapeutic field (Stenzel & Rupert, 2004). As a result, meaningful conversations around touch as an intervention, as a topic in supervision or even as an aspect of psychotherapeutic training, tend to be suppressed (Caldwell, 2002; Tune, 2001). A large amount of research has focused on sexual misconduct and the risk of erotic touch that may occur between therapist and client, in particular in opposite sex dyads (Stake & Oliver, 1991). Consequently, research about non-erotic touch has been hindered or inadvertently suppressed (Stenzel & Rupert, 2004). The limited research on other forms of touch indicates that therapists do use touch in their clinical work. In a sample of 456 psychologists, 41% reported hugging patients somewhat frequently and 76% accepted and offered a handshake fairly often (Pope, Tabachnick & Keith-Spiegel, 1987) while, in another study, approximately one third of psychotherapists reported using some form of touch with their clients (Holroyd & Brodsky, 1977). In addition, in their survey of over 200 psychologists, Stake & Oliver found that some forms of touch (hand or shoulder) were seldom seen as constituting misconduct and were not always seen as overt sexual behaviours. Milakovich (1992) interviewed 84 therapists to examine how they made decisions about whether to use touch, as well as to evaluate the personal and professional characteristics of those therapists who used touch within the context of their therapeutic relationship. She reported that therapists who used touch were less concerned about the risk and tended to trust their own judgement about the appropriateness of when to use it. This coincides with other studies examining therapists' beliefs about the benefits of the use of touch. Therapists who touch are more likely to consider it to be healing and to believe that it can better facilitate the client's self-disclosure, ground the client in the present moment (Clance & Petras, 1998) and provide the client with an emotionally corrective experience (Durana, 1998; Kupfermann & Smaldino, 1987), along with calming and consoling him/her in times of distress (Torraco, 1998).
In a subsequent study, Milakovich (1998) found that psychotherapists who used touch tended to operate from a belief system that supported the value of physical contact within a clinical setting. More specifically, these therapists had experienced touch from their own therapists (usually body-oriented), undertook training in therapeutic modalities using touch, and had supervisors who validated touch as an intervention or a significant aspect of the therapy (Milakovich 1998; Hunter & Sturve, 1998). According to Kupferman and Smaldino (1987), psychoanalytically trained clinicians are more reluctant to use touch in their clinical work because of their rigid training requirements, tight supervision and ongoing self-analysis. Indeed, the therapist’s fear of talking about the use of touch in supervision and of being criticised by supervisors that using touch was ‘a therapeutic mistake’ seemed to be a factor in preventing therapists from using touch in their work (Daniels, 2000 as cited in: Tune, 2001). These results echo other findings (Geib, 1982; Stenzel & Rupert, 2004) and theory (Durana, 1998), which assert that a therapist’s theoretical orientation and the type of training and supervision encountered professionally have a direct impact on his/her use of touch in the consulting room. Research evidence suggests that therapists with a humanistic, Gestalt and existential background use touch more often than those with psychodynamic training (Stenzel & Rupert, 2004).

Other studies acknowledge the influence of the therapist’s gender in the use of touch in therapy. It seems that therapists who do not touch tend to be male, viewing touch as harmful and not having experienced touch in their own personal therapy and training (Clance & Petras, 1998). In contrast, women often view the use of touch as a feature of communication and a healthy expression of feelings, which according to Pope et al. (1987) explains why it is more prevalent when both the therapist and the client are female.
Therapists' attachment styles

In the last two decades there has been an increased interest in how attachment theory can inform and be applied to interpersonal relationships in clinical work with adults (Holmes, 2001). In his seminal books on attachment theory, Bowlby (1969) proposes that attachment bonds are primarily formed in interactions with primary caregivers but subsequent attachment figures can alter a person's sense of security. A bond is considered as an attachment bond only if it involves four definitional features: a) seeking and maintaining physical proximity, b) seeking comfort and aid when is needed c) experiencing distress during prolonged separations and, d) relying on the attachment figure as a base of security from which the person is able to engage in other exploratory non-attachment activities (Hazan and Diamond, 2000). Taking into account these definitional features, the client-therapist relationship could also be conceptualised as an attachment bond. Indeed, the therapist can become a safe base for the client, increase the client's sense of security and facilitate a healthy emotion regulation. From this perspective, the therapist is considered as an active participant who affects – and is affected by – the client's attachment experience in the therapeutic relationship. This concept was received with great interest by researchers who turned their attention to exploring the therapeutic relationship as an adult attachment bond, and clients' and therapists' attachment styles.

As a result, there has been an increased focus on how a therapist's attachment style may also affect the working alliance and the process of therapy. According to research, secure therapists are more likely to focus on the client's problem, provide compassion and empathy and handle the client's distress more effectively, rather than being overwhelmed by personal distress (Mikulincer & Shaver, 2007). Therapists with higher ratings for a secure attachment style (i.e. comfort in close relationships, the ability to rely on others in times of need, and little fear of abandonment) also have the qualities necessary to form strong working alliances (Dunkle & Friendlander, 1996). In contrast, insecure therapists are less likely to empathise accurately; they keep personal distress and defences
from interfering with compassion and consequently form poorer therapeutic alliances. This echoes research findings on attachment styles which suggest that avoidant therapists may lack the skills needed to provide sensitive care to others. Black, Hardy, Turpin and Parry (2005) found that therapists with an avoidant attachment style were associated with greater client-therapist discrepancies in rating the client's interpersonal problems. Similarly, anxiously attached therapists seem to be very preoccupied with their own distress and less attuned to the clients' needs (Mikulincer & Shaver, 2007).

Although a large number of studies have examined the association between therapists' attachment styles and the working alliance and process of therapy, only limited studies have been conducted on how these styles might relate to and influence the use of touch with clients. Seeking and maintaining physical proximity in relationships, as mentioned above, is considered one of the key features which shapes the attachment style. Taking the above evidence and Smith's (1998) touch behaviours into consideration, it could also be hypothesised that securely attached therapists, who are more comfortable with intimacy, will also be more comfortable with seeking or initiating physical proximity to their clients. It is assumed that securely attached therapists would be 'physically responsive' to their clients' needs, meaning that they will offer touch as an expression of care to their clients. In contrast it is assumed that anxiously attached therapists will be 'physically responsive' not to their clients' needs but to their own. According to the literature, anxiously attached therapists tend to make excessive attempts to seek proximity from their clients in order to meet their own needs and reduce their client's distress more effectively, rather than being overwhelmed by personal distress (Mikulincer & Shaver, 2007). Therefore, this study hypothesises that a therapist's attachment style could be another factor that influences the use of touch in his/her clinical practice. Specifically, this study aims:

a) To further understand the relationships between the therapist's attachment style, personal characteristics and theoretical orientation that affect the type of non-erotic touch used in his/her practice.
b) To further understand whether touch behaviours by therapists support Smith's taxonomy and when, why and how touch is offered.

Clinically, this study can offer therapists a greater understanding of the factors influencing other therapists' decisions to use touch in their therapeutic practice. Taking all the above into consideration, nine hypotheses are made:

**Research Hypotheses**

This study employed a survey methodology to elicit responses to broad questions on the use of touch and to test Smith's conceptual framework of the forms of touch. Therefore, the hypotheses were defined based on Smith's conceptual framework.

**Theoretical orientation**

a) Psychoanalysts are less likely to offer any type of touch than therapists from other modalities.

b) Humanistic therapists offer touch significantly more often than therapists from other modalities.

**Attachment styles**

c) Securely attached therapists are more likely to use any type of touch than anxiously and avoidant attached therapists.

An exploratory analysis will be conducted regarding:

a) Therapists' gender and what types of touch are used.

b) Therapists' years of experience and what types of touch are used.

c) When, how and why touch is used.
Method

Overall 147 therapists working individually with adults were recruited from the private sector in the United Kingdom (therapists in private practice and therapists working in private organisations). Of these, 11 did not fully complete the questionnaire and their data are not included in the following analyses. The following demographic information is for the remaining sample (N=136). The participants were a diverse group regarding sex, age, years of practice, theoretical and professional orientation.
### Table 1 Participants' demographic information

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>91</td>
<td>66.90%</td>
</tr>
<tr>
<td>Male</td>
<td>45</td>
<td>33.10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>26-30</td>
<td>10</td>
<td>7.40%</td>
</tr>
<tr>
<td>31-40</td>
<td>32</td>
<td>23.50%</td>
</tr>
<tr>
<td>41-50</td>
<td>40</td>
<td>29.50%</td>
</tr>
<tr>
<td>51-60</td>
<td>37</td>
<td>27.20%</td>
</tr>
<tr>
<td>60 and over</td>
<td>17</td>
<td>12.50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professional Title</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling Psychologist</td>
<td>46</td>
<td>33.80%</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>17</td>
<td>12.50%</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>73</td>
<td>53.70%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theoretical Orientation</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eclectic/Integrative</td>
<td>66</td>
<td>48.50%</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>21</td>
<td>15.40%</td>
</tr>
<tr>
<td>Existential</td>
<td>10</td>
<td>7.4</td>
</tr>
<tr>
<td>CBT</td>
<td>23</td>
<td>16.90%</td>
</tr>
<tr>
<td>Humanistic</td>
<td>12</td>
<td>8.80%</td>
</tr>
<tr>
<td>Gestalt</td>
<td>2</td>
<td>1.50%</td>
</tr>
<tr>
<td>Systemic</td>
<td>2</td>
<td>1.50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>66</td>
<td>48.50%</td>
</tr>
<tr>
<td>White other</td>
<td>66</td>
<td>48.50%</td>
</tr>
<tr>
<td>Mixed White</td>
<td>1</td>
<td>0.70%</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td>2.20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years of clinical practice</th>
<th>M=12.30</th>
<th>S.D= 8.916</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Range=1- 39 years</td>
<td></td>
</tr>
</tbody>
</table>
Procedure

After being granted a favourable ethical approval by the University of Surrey Ethics Committee (see Appendix A), 200 recruiting e-mails were sent to professional bodies, associations, societies and therapists in private practice across the United Kingdom, describing the aim of the study and asking them to forward the message to their members. Participation was voluntary and anonymous. The inclusion criteria for this study were (a) participants should be qualified counselling, clinical psychologists and/or psychotherapists (Existential, Psychodynamic, Cognitive Behavioural Therapy, Integrative, Gestalt), and (b) they should be working in private practice. Therapists working in the NHS were not allowed to participate. Data was collected through a secure online platform which was created for the purpose of this study by the University of Surrey. It was preserved in accordance with the Data Protection Act (1998) and will be erased a year after collection.

Measures

Demographics questionnaire:

The questionnaire contained nine questions related to the participants' age, gender, ethnicity, professional orientation, theoretical orientation and years of practice.

Use of touch questionnaire (Touch in Individual Psychotherapy, Stenzel & Rupert, 2004):

The researcher gained permission from the authors Stenzel & Rupert to use the questionnaire from their study "Psychologists' use of touch in individual psychotherapy" (2004) which is based on Smith's (1998) taxonomy of touch (See Appendix B). The aim of the study was to examine explicitly non-erotic types of touch by the therapist and the client. The questionnaire (See Appendix C) was therefore adapted for the purpose of the present study. It was expected that the

---

1 The selection of therapists working in private practice was because it is reasonable to assume that their training/orientation would have a bearing on their use of touch rather than the regulations of an institution. This rationale also intends to eliminate confounding variables related to clinical populations as much as possible since one tends to encounter a more diverse range of presentations in private practice (Stenzel & Rupert, 2004).
four clusters for non-erotic touch from Smith's taxonomy - (a) touch as an expression of the relationship, (b) socially stereotyped touch, (c) touch as a technique, and (d) touch as a conversational marker - would be obtained. In Section I, a series of questions refer to the types of touch in their practice, allowing for the inclusion of a recognised and clear categorisation of touch (Stenzel & Rupert, 2004). The participants were asked to rate each touch item twice, to reflect separately their use of touch with female clients and with male clients. In Section II, the participants were asked to rate a series of items with regard to when they use touch (as a greeting at the beginning, during the session, at the end, at the termination), how they use touch (discuss, request permission) and why they use touch (nurture, support, reconnect to reality). Items were scored on a 5-point Likert scale (1= never and 5= very often).

Therapists' attachment dimensions: Experiences in Close Relationships scale (ECR; Brennan, Clark & Shaver, 1998)

The ECR questionnaire consisted of 12 items and was designed to assess a general pattern of adult attachment (Wei, Russell, Mallinckrodt & Vogel, 2007). According to Fraley, Waller and Brennan (2000), the ECR benefits from better psychometric properties than other commonly used adult attachment dimensions.

The ECR is designed to assess two continuous dimensions of adult attachment: Avoidance and Anxiety. Attachment anxiety is defined as involving a fear of interpersonal rejection or abandonment, an excessive need for approval from others and distress when one's partner is unavailable or unresponsive (e.g. 'I worry about being abandoned and rejected by others'). Attachment avoidance is defined as involving a fear of dependence and interpersonal intimacy (e.g. preferring not to be too close to others). People who score high on either or both of these dimensions are assumed to have an insecure adult attachment dimension. In contrast, people with low levels of attachment anxiety and avoidance may be viewed as having a secure adult attachment orientation (Lopez & Brennan, 2000). The statements in the questionnaire concern how individuals generally feel in close relationships (i.e. with romantic partners, family members
and close friends) by indicating how much they agree or disagree (from 1=disagree strongly to 7=agree strongly). The ECR appears to be a highly reliable and valid measure that has been widely used to assess adult attachments. Specifically, the scale has shown a high level of internal consistency with coefficient alphas of 0.91 and 0.94 for the anxiety and avoidance subscales respectively (Brennan et al, 1998).

Results

Before primary analyses were performed the distributions of the variables were examined by using the criterion of skewness and kurtosis, divided by their respective standard errors and it was found that the data did not meet the requirements of normality. The data were both skewed and kurtotic and transformations were not conducted because they would not have repaired kurtosis. Therefore non-parametric statistics were conducted.

Table 2 Descriptive statistics for attachment styles and types of touch

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidant Attachment</td>
<td>136</td>
<td>2.59</td>
<td>0.781</td>
<td>-0.231</td>
<td>-1.175</td>
</tr>
<tr>
<td>Anxiety Attachment</td>
<td>136</td>
<td>2.78</td>
<td>0.984</td>
<td>0.707</td>
<td>-0.139</td>
</tr>
<tr>
<td>Socially stereotyped touch</td>
<td>136</td>
<td>3.49</td>
<td>1.14</td>
<td>-0.231</td>
<td>-1.175</td>
</tr>
<tr>
<td>As expression of the relationship</td>
<td>136</td>
<td>1.36</td>
<td>0.532</td>
<td>1.963</td>
<td>4.085</td>
</tr>
<tr>
<td>Touch technique</td>
<td>136</td>
<td>1.36</td>
<td>0.773</td>
<td>2.778</td>
<td>8.427</td>
</tr>
<tr>
<td>Conversational marker</td>
<td>136</td>
<td>2.13</td>
<td>1.06</td>
<td>0.707</td>
<td>-0.139</td>
</tr>
<tr>
<td>Lap sitting</td>
<td>136</td>
<td>1.07</td>
<td>0.415</td>
<td>7.442</td>
<td>63.273</td>
</tr>
</tbody>
</table>
**Factor Analysis for Smith's Taxonomy of Touch Behaviour**

Ten items on the survey were hypothesised to represent four of the six theoretical dimensions of Smith's taxonomy: touch as a conversational marker, socially stereotyped touch, touch as an expression of the relationship and touch techniques (two dimensions – sexual touch and aggressive touch – were excluded as it was out of the scope of the study). To test whether the data supported the four remaining dimensions of touch in the *a priori* model, the ten touch items for female and male clients (20 variables in total) were subjected to a four-factor solution, stipulated using an oblique principal axis factoring. Despite moderate non-normality it felt important to pursue this analysis to test Smith's assumptions.

The 4-factor solution explained 68.36% of the total common variance. Eigen values for all factors were greater than 1. Touch items were identified with a factor when loading was 0.4 or greater on a single factor and 0.3 or less on all other factors. 14 of the 20 items were loaded on factors 1 and 2. Touch items for female and male clients were loaded on the same factors with no significant differences noted between them. Therefore, in further analysis the participants' responses concerning the clients' gender separately were not examined.

Most of the items were loaded on hypothesised factors with a few exceptions. Factor 1 (*touch as an expression of the relationship*) consisted of "placing your arm around the client, accepting a hug, offering a hug, holding a hand, touching a shoulder". Factor 2 (*socially stereotyped touch*) consisted of "accepting and offering a handshake". Factor 3 (*touch as a technique*) consisted of "the use of touch as relaxation". Factor 4 was not confirmed as a conversational marker as only the two "sitting on the lap" items were loaded on this factor. "Offering a hug and accepting a hug" were loaded on touch as an expression of the relationship (Factor 1) rather than hypothesising on socially stereotyped touch. In addition, touching the client's shoulder was loaded on touch as an expression of the relationship (Factor 1) rather than the proposed conversational marker. No items were loaded to compose the proposed factor *conversational marker*. 
Finally, sitting on the lap was the only item which was loaded on a separate factor which is defined here as a lap sitting.

Table 3 Exploratory Factor Analysis using an oblique principal axis factoring

<table>
<thead>
<tr>
<th>Touch and client gender</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
<th>Factor 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place arm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.821</td>
<td>-0.047</td>
<td>-0.01</td>
<td>-0.048</td>
</tr>
<tr>
<td>M</td>
<td>0.805</td>
<td>0.007</td>
<td>0.038</td>
<td>0.011</td>
</tr>
<tr>
<td>Hold hand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.8</td>
<td>0.008</td>
<td>0.089</td>
<td>0.026</td>
</tr>
<tr>
<td>M</td>
<td>0.749</td>
<td>0.024</td>
<td>0.162</td>
<td>-0.004</td>
</tr>
<tr>
<td>Offer a hug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.75</td>
<td>-0.019</td>
<td>-0.018</td>
<td>-0.08</td>
</tr>
<tr>
<td>M</td>
<td>0.752</td>
<td>-0.007</td>
<td>0.075</td>
<td>-0.039</td>
</tr>
<tr>
<td>Touch shoulder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.654</td>
<td>-0.187</td>
<td>0.094</td>
<td>0.029</td>
</tr>
<tr>
<td>M</td>
<td>0.629</td>
<td>-0.205</td>
<td>0.173</td>
<td>0.032</td>
</tr>
<tr>
<td>Accept a hug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.646</td>
<td>-0.056</td>
<td>-0.209</td>
<td>0.087</td>
</tr>
<tr>
<td>M</td>
<td>0.604</td>
<td>-0.06</td>
<td>-0.124</td>
<td>0.117</td>
</tr>
<tr>
<td>Offer a handshake</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>-0.014</td>
<td>-0.885</td>
<td>0.057</td>
<td>-0.105</td>
</tr>
<tr>
<td>M</td>
<td>0.013</td>
<td>-0.879</td>
<td>0.061</td>
<td>-0.114</td>
</tr>
<tr>
<td>Accept a handshake</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.021</td>
<td>-0.876</td>
<td>-0.087</td>
<td>0.098</td>
</tr>
<tr>
<td>M</td>
<td>0.018</td>
<td>-0.845</td>
<td>-0.033</td>
<td>0.083</td>
</tr>
<tr>
<td>Use touch associated with relaxation training, hypnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.041</td>
<td>0.007</td>
<td>0.948</td>
<td>0.052</td>
</tr>
<tr>
<td>M</td>
<td>0.022</td>
<td>-0.014</td>
<td>0.914</td>
<td>0.09</td>
</tr>
<tr>
<td>Hold client on your lap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0.003</td>
<td>0.031</td>
<td>0.032</td>
<td>0.984</td>
</tr>
<tr>
<td>M</td>
<td>-0.008</td>
<td>0.004</td>
<td>0.078</td>
<td>0.932</td>
</tr>
</tbody>
</table>
Table 4 Factor Correlation Matrix

<table>
<thead>
<tr>
<th>Factor</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1.000</td>
<td>-.398</td>
<td>.181</td>
<td>.240</td>
</tr>
<tr>
<td>2</td>
<td>-.398</td>
<td>1.000</td>
<td>-.093</td>
<td>-.018</td>
</tr>
<tr>
<td>3</td>
<td>.181</td>
<td>-.093</td>
<td>1.000</td>
<td>.192</td>
</tr>
<tr>
<td>4</td>
<td>.240</td>
<td>-.018</td>
<td>.192</td>
<td>1.000</td>
</tr>
</tbody>
</table>

In the table above high coefficient alphas reflect the high correlation loaded within the factors but not across the factors. Therefore factors are relatively independent.

**Reliability analysis**

The items that were loaded on each factor were taken to test whether the scales formed by adding up the items were reliable. All four scales had high reliability. For Factor 1 (*expression of the relationship*) $\alpha=.952$; for Factor 2 (*socially stereotyped touch*) $\alpha=.920$; for Factor 3 (*touch as technique*) $\alpha=.970$; for Factor 4 (*inappropriate touch*) $\alpha=.980$. Therefore, the types of touch were examined through these four factors.

**Correlations**

Due to non-normal data, Spearman’s correlation coefficients indicated that the therapist’s anxiety and avoidant attachment were significantly and negatively correlated with touch as an expression of the relationship and socially stereotyped touch. There was no significant correlation between avoidant attachment, anxiety attachment and touch as technique and lap sitting.
Table 5 Summary of Correlations, Means and Standard Deviations of therapists' dimensions, socially stereotyped touch, lap sitting as inappropriate touch, touch as an expression of the relationship

<table>
<thead>
<tr>
<th>Variable</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Avoidance</td>
<td>3</td>
<td>0.8</td>
<td>-</td>
<td>-.526**</td>
<td>-.174</td>
<td>0.011</td>
<td>-.274**</td>
<td>-0.14</td>
</tr>
<tr>
<td>2 Anxiety</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>- .274**</td>
<td>-0.103</td>
<td>- .248**</td>
<td>-0.068</td>
</tr>
<tr>
<td>3 Socially stereotyped</td>
<td>4</td>
<td>1.2</td>
<td>-</td>
<td>-</td>
<td>- .02</td>
<td>.437**</td>
<td>0.168</td>
<td></td>
</tr>
<tr>
<td>4 Lap sitting</td>
<td>1</td>
<td>0.4</td>
<td>-</td>
<td>-</td>
<td>.218*</td>
<td>0.056</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Relationship</td>
<td>2</td>
<td>0.7</td>
<td>-</td>
<td>-</td>
<td>.253**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Technique</td>
<td>1</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *Correlation is significant at the .01 level (2 tailed)
**Correlation is significant at the .05 level (2 tailed)

Median split for forming the four attachment categories

Since there are no validated cut-off scores for the ECR dimension to give the attachment styles, a median split was conducted in order to group the participants into one of the four attachment styles (secure, fearful, preoccupied, dismissive) deriving from the two-dimensional model of attachment. This procedure revealed four groups: those in the first group where participants who scored low on both avoidance and anxiety (secure 34.6%); those in the second group who scored low on avoidance and high on anxiety (preoccupied, 14.7%); those in the third group who scored high on both anxiety and avoidance (fearful, 35.3%); and, finally, those in the fourth group who scored high on avoidance and low on anxiety (dismissive style 15.4%). However, this categorisation is relative to the present sample and not to all of mankind.
Tests of differences

A number of non-parametric tests were conducted in order to examine if there were any significant differences between age, gender, professional orientation, years of experience and the factors of when, how and why touch is used.

When significant differences were identified in Mann Whitney tests, the size effect was calculated and then a bonferroni correction was conducted in order to minimise the type 1 error. When significant differences were identified in Kruskall Wallis tests, a post hoc Mann Whitney test was conducted to find exactly where the differences lay.

No significant differences were found between age, gender, professional orientation, years of experience and the factors of when, how and why touch is used (See Appendix C).
Table 6 Mann Witney U analysis and medians for therapists’ theoretical orientation and types of touch, when, why and how touch is used

<table>
<thead>
<tr>
<th>Touch Type</th>
<th>Theoretical orientation</th>
<th>U</th>
<th>Mdn</th>
<th>Z</th>
<th>R</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expression of relationship</td>
<td>Eclectic</td>
<td>448</td>
<td>1.6</td>
<td>-2.44</td>
<td>-0.21</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>Psychoanalyst</td>
<td></td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT</td>
<td>133</td>
<td>1.5</td>
<td>-2.56</td>
<td>-0.22</td>
<td>0.01</td>
</tr>
<tr>
<td></td>
<td>Psychoanalyst</td>
<td></td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Humanistic</td>
<td>57.5</td>
<td>1.9</td>
<td>-2.57</td>
<td>-0.22</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Psychoanalyst</td>
<td></td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially stereotyped</td>
<td>CBT</td>
<td>113</td>
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<td>When</td>
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</table>
Therapists' theoretical orientation and when, why and how touch is used

Based on the hypotheses for theoretical orientation, psychoanalysts are less likely to offer any type of touch than therapists from other modalities 2. Indeed, the results confirmed that in the study's sample psychoanalysts offer significantly less often touch as an expression of the relationship and socially stereotyped touch. Specifically, eclectic therapists offer touch as an expression of the relationship significantly more often than psychoanalysts. CBT therapists also offer touch as an expression of the relationship significantly more often than psychoanalysts. The hypothesis that humanistic therapists offer touch as an expression of the relationship significantly more often than therapists from other modalities is partly supported as humanistic therapists offer touch as an expression of the relationship significantly more often than psychoanalysts. However, no significant differences were found with other modalities. With regard to socially stereotyped touch, psychoanalysts again offer significantly less often socially stereotyped touch than CBT therapists.

As noted previously, an exploratory stance was adopted with regard to when, why and how touch is used. Therefore, a series of Mann Whitney tests were conducted. The results showed that CBT therapists are more 'active' in using touch throughout the session compared to psychoanalysts. Specifically, CBT therapists offer touch significantly more often at the beginning of the session than psychoanalysts. CBT therapists also appear to offer touch significantly more often during the session than psychoanalysts. In addition, CBT therapists offer touch at the end of the session significantly more often than psychoanalysts. In relation to how touch is used, results indicated that eclectic therapists request permission from the client before offering touch significantly more often than existential therapists.

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2 There were no significant differences between clinical, counselling psychologists and psychotherapists. As a result this analysis is focused between psychotherapists from different modalities.
Table 7 Mann Whitney U and medians for attachments styles, types of touch, when, how, why touch is used

<table>
<thead>
<tr>
<th>Type</th>
<th>Attachment styles</th>
<th>U</th>
<th>Mdn</th>
<th>Z</th>
<th>R</th>
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Therapists' attachment styles and types of touch (refer to table 6)

The four hypotheses that securely attached therapists are more likely to offer socially stereotyped touch, touch as technique, touch as a conversational marker and touch as an expression of the relationship than anxious and attached therapists were partially supported. Generally, securely attached therapists offer some types of touch significantly more often than therapists with other attachment styles. Specifically, securely attached therapists offer touch as an expression of the relationship significantly more often than fearful attached therapists. In addition, securely attached therapists seem to offer socially stereotyped touch significantly more often than preoccupied attached therapists.
No significant differences were found for other types of touch and dismissive style.

*Therapists' attachment styles and when, why and how touch is used (refer to table 6)*

An exploratory stance was adopted with regard to therapists' attachment styles and when, why and how touch is used. A series of Mann Whitney tests were conducted and significant differences were found. Securely attached therapists offer touch significantly more often to clients when ending the session than fearful therapists. Securely attached therapists explain touch prior to offering it to clients significantly more often than preoccupied attached therapists. Also, securely attached therapists seem to have a clearer rationale as to why they use touch rather than therapists with other attachment styles. For example, securely attached therapists provide touch as emotional support significantly more often than preoccupied therapists and fearful therapists. Lastly, securely attached therapists offer touch to improve clients' awareness significantly more often than preoccupied therapists.

**Discussion**

This study aimed to examine the role of therapist's attachment dimensions in their use of touch in their clinical practice. The findings support that the therapists' attachment style plays a significant role for the use of touch in their practice.

*Smith's touch taxonomy factor analysis*

In the present study, it was hypothesised that the participants' responses would capture the four categories of non-sexual touch defined by Smith (1998). The factor analysis which was conducted offered partial support for this taxonomy of touch behaviours. A possible explanation for the partial support of this taxonomy is that factor analysis aimed to analyse the variability in use of these types of touch; meaning that some of the participants tended to use one kind of touch therapeutically, while some others never used any of them therapeutically at all.
This explanation is reflected in the results. For example, most of the participants considered touch as a technique as it appeared to be reflected in the items regarding touch as body work, relaxation or hypnosis. In the socially stereotyped touch category, offering and accepting a handshake were clustered together and it was the most frequently endorsed type of touch. These findings are consistent with Stenzel and Rupert's study (2004) and with Gutheil and Gabbard's (1993, p. 341) contention that in a therapeutic context, the handshake is "about the limit of social contact". Also, despite the fact that there were no significant differences between male and female therapists, gender stereotypes might nevertheless have influenced the participants' responses. This resonates with references in the literature and previous research (Milakovich, 1992) that male therapists are more likely to exchange a handshake with clients than female therapists with regard to the frequency of use of touch. This gender role appears to influence the use of touch in a therapeutic context as even historically, handshakes have been considered a "male activity" (Stenzel & Rupert, 2004, p.341).

With regard to touch as an expression of the relationship, five items loaded on this factor: placing an arm, holding a hand, accepting a hug, offering a hug, touching a shoulder. Some of these items such as offering and accepting a hug were expected to load on the socially stereotyped touch category. It could be reasonable to assume that these types of touch are rather typical or spontaneous gestures in interpersonal relationships, yet in therapeutic relationships they have an important role: they serve a therapeutic purpose such as offering comfort or nurturing within the context of the therapeutic relationship. Additionally, touching a client's shoulder was expected to load on the conversational marker category. No touch items were loaded on this factor. It seems that although Smith (1998, p.40) outlined his taxonomy of touch based on the therapist's intentions, at the same time he noted that "the message sent is not necessarily the message received". Therefore, due to their ambiguous meanings, these types of touch could be easily misunderstood by clients. As Leijseen (2006) argues a tap on the shoulder can seem like an encouragement for one person whereas for another it might seem like a reprimand. Also the ambiguous meaning of touch could not only be misunderstood by clients but also by therapists. As research suggests, the
use and meaning of touch from therapists are influenced by various factors. In this study, the participants' diverse background (psychotherapy training, cultural background and attachment styles) might have been influential factors in their responses.

No significant differences were found between therapists' age, gender and years and their use of touch and attachment styles. These findings contradict other studies which have indicated that women offer touch more often than male therapists. According to Pope et al. (1987), women often tend to view the use of touch as a feature of communication and a healthy expression of feelings. In contrast, male therapists view touch as harmful or as sexual misconduct, especially with women (Clance & Petras, 1998). The results of this study do not support these differences.

**Therapists' theoretical orientation and the use of touch**

The findings of this study support the view that psychoanalysts are less likely to offer any type of touch at any stage of therapy than eclectic and CBT therapists. This supports the literature which suggests that, in psychoanalysis, physical holding and touch is considered as a taboo and is generally avoided (Kuperfrman & Smaldino, 2009). This could be understandable given that touch is a neglected aspect of training, especially for psychoanalysts (Caldwell, 2002). This is a paradox, though, given that most psychoanalytic concepts use metaphors of touch such as Winnicott's use of the 'holding environment' and Bion's concept of 'containment'. It seems that despite psychoanalysis' relatively recent rapproachement with attachment theory which includes actual touch and physical proximity, these are still disavowed. Further research is needed in the psychoanalytic field on whether holding and containment can be achieved as effectively and efficiently by verbal means only.

In contrast, based on the findings, humanistic therapists offer touch as an expression of the relationship significantly more often than psychoanalysts. These findings are consistent with the literature which suggests that 25% to 30% of
humanistic-oriented therapists are open to the use of touch, perceiving it as a natural expression of a genuine caring relationship (Milakovich, 1998).

According to the findings, CBT therapists seem to offer touch as an expression of the relationship and socially stereotyped touch during all stages in therapy (beginning, during and at the end) significantly more often than therapists from other modalities. These findings support some evidence in the literature which suggest that CBT therapists tend to be more independent and confident, experience less anxiety and form better therapeutic alliances than therapists from other modalities (Arthur, 1999; Agnew-Davies, Stiles, Hardy, Barkman & Shapiro, 1998). Therefore, it could be assumed that CBT therapists feel more confident about initiating socially stereotyped touch and touch as an expression of the relationship.

Also, the study gives an insight into the stance of eclectic therapists with regard to the use of touch. Eclectic therapists reported using touch as an expression of the relationship significantly more often than psychoanalysts. They also reported asking for permission prior to offering touch significantly more often than existential therapists. This could be explained as meaning that eclectic therapists are aware of the risk of misinterpretation and they therefore ask their clients' permission. By asking their clients' permission, they give them the option to decide and therefore feel that they have control over the initiation and sustaining of contact. These findings suggest that therapists with an integrative training may have a more open stance towards touch. They seem to find touch a useful tool to express the therapeutic relationship yet they are aware of its risks and they therefore consider how to use it by asking permission.

**Correlations between therapists' attachment dimensions and the use of touch**

The study aimed to examine whether therapists' attachment styles influence the use of touch in their clinical practice. The findings suggest that the therapists' anxiety and avoidant attachment are significantly and negatively correlated with touch as an expression of the relationship and socially stereotyped touch. However, there is no significant correlation between avoidant attachment,
Research Dossier

anxiety attachment and touch as a technique and lap sitting. These findings contradict what theory suggests, specifically for high anxiety attachment. According to theory, people who score high on attachment anxiety rely on hyperactivating strategies such as excessive attempts to seek proximity (Mikulincer & Shaver, 2007). In this study, it seems that highly anxious attached therapists do not seek proximity to clients by initiating limited socially stereotyped touch or touch as an expression of the relationship. There are indications from previous studies that anxious attached therapists may experience difficulties in responding to their clients' needs (care-giving sensitivity) as they are very preoccupied with their own needs (Black, Hardy, Turpin & Parry, 2005; Dinger, Strack, Sachsee, Schauenburg, 2009). Specifically, studies have found a negative correlation between therapists' attachment anxiety, empathy and care-giving sensitivity (Rubino, Barker, Rorth, & Feearan, 2000). As empathy and care-giving sensitivity may be analogous to offering touch as nurturing and support for the client (an expression of the relationship), it can be argued that the findings confirm these previous studies.

The findings also indicate a negative and significant correlation between highly avoidant therapists and using touch as an expression of the relationship and socially stereotyped touch. These echo the literature, suggesting that people who score high on attachment-related avoidance tend to use deactivating strategies: trying not to seek proximity to others and avoiding closeness and interdependence in close relationships (Mikulincer & Shaver, 2007). It can be assumed that although therapists may want to offer either type (socially stereotyped touch or touch as an expression of the relationship) they will not initiate it.

**Therapists' attachment categories and the use of touch**

The aim of the median split was to group the participants into one of the four attachment styles (secure, fearful, preoccupied, dismissive) deriving from the two-dimensional model of attachment. Interestingly, the findings suggest that securely attached therapists offer some types of touch in therapy significantly more often than fearful and preoccupied therapists. Specifically, securely
attached therapists offer significantly more often socially stereotyped touch and touch as an expression of the relationship than therapists with other attachment styles. These findings are similar with other studies suggesting that securely attached therapists are more comfortable with intimacy and have the ability to create a closer relationship with their clients (Fraley & Davis, 1997; Slade, 2008). It may be assumed that securely attached therapists have internalised a positive sense of self-worth, a positive image of others and a positive personal experience of physical proximity and intimacy. Their secure state of mind within their relationships can affect not only the way they understand but also the way they respond therapeutically to clients. They can be more empathic and more receptive to understanding their clients' needs. Therefore, considering the results, it seems that securely attached therapists may feel more comfortable or express their empathy by initiating touch as an expression of the relationship.

With regard to preoccupied therapists it is not surprising that preoccupied therapists offer touch less often than secure attached therapists. As Diamond and colleagues (2003) discovered, preoccupied therapists believe that their professional reputation depends on the outcome of the treatment and thus they can be preoccupied with the client’s treatment progress. It could be argued that by being so preoccupied with their performance, their clients’ judgment and their reputation, they are less likely to initiate any type of touch, knowing that there is a high risk of misinterpretation of their action. This resonates with the results that they are less likely to ask for permission to offer touch because they might be afraid of being judged if they initiate any conversation around touch with their clients.

Fearful therapists (those who scored high in anxiety and low in avoidance) also reported using touch less often than securely attached therapists, as if emotional or physical closeness is considered intrusive or, as it has been described by Solomon and George (1996), they keep “distanced protection”. Based on this, fearful individuals are scared of any closeness and they therefore use deactivation distancing strategies to deal with those threats.
Furthermore, the results indicate that dismissively attached therapists do not seem to offer any types of touch during therapy. Again, this is not surprising as, based on research, dismissively attached therapists tend to demonstrate cold, countertransferential behaviours towards clients and to exhibit more hostile countertransference behaviours (Wallin, 2007). It could be argued that if therapists experience any hostile countertransference feelings, they are less likely to initiate any type of touch, either socially stereotyped touch, touch as an expression of the relationship or touch as a technique.

**Limitations**

There are a number of limitations that must be considered when interpreting the findings of this study. First and most important, the current study was conducted in the United Kingdom with a majority of white European therapists, which restricts the generalisability of the findings. Also, the sample is of experienced therapists, all of whom have undergone accredited training in psychotherapy or psychology. Therefore, the findings may not be generalised to all psychotherapists since those in the sample are likely to have had more training. Moreover, participation in this study was voluntary so those who participated might have had an increased interest in this area or be more sensitive to the use of touch.

**Methodological limitations**

This study has a number of methodological limitations related to the design of the questionnaires and the statistical analysis. Therefore it is very important to consider all the above interpretations as tentative. The median split method helped with the grouping of participants in one of the four attachment styles but it does not mean that this was the participants’ definitive attachment style. A person’s style was defined relative to others in the sample rather than to national norms or other absolute measures. For example, participants identified as fearfully attached therapists may not really have been that fearful overall but they were, relatively to the others who responded.
With regard to the use of questionnaires, there is an ongoing debate about whether self-reporting can adequately capture the complexity of human behaviour. For instance, in the current study, self-report questionnaires were used to assess the therapists' attachment dimensions but different results might have been obtained if another self-report questionnaire or a different assessment method had been used. Griffin and Bartholomew (1994) suggest that results coming from self-report questionnaires should be validated with an interview—for example, an adult attachment interview. This is significant because there could be discrepancies between how someone views his/her own pattern of attachment and how someone else views it.

In addition, in the touch questionnaire, the use of generalised frequency categories could give limited responses. For example, the Likert-type scale and generally its categories (rarely-very often) seemed to be vague quantifiers as one participant's 'very often' is not as regular as another participant's 'very often'.

In addition, an optimal factor analysis was conducted to examine whether Smith's (1998b) four types of touch were supported by the data. Optimal factor analysis could be very useful in finding underlying structures when all variables are normally distributed. It is based on product moment correlations which assess the strength of a linear relationship between two variables. In this study, the non-normal distributed data gave a sub-optimal factor analysis, meaning that there is non-linearity hiding between the variables.

Another important issue that should be noted by researchers, especially when conducting studies on adult attachment, is how adult attachment organisation should be assessed and conceptualised. In the analysis, attachment avoidance and anxiety were initially examined in relation to the use of touch and it was found that they were negatively and significantly correlated. In addition, given that attachment dimensions did not have cut-off scores, further attachment styles were examined to group into one of the four attachment styles (secure, fearful, preoccupied, dismissive) deriving from the two-dimensional model of attachment. Therefore, the results include both dimensional and categorical models of attachment. However, there is an ongoing debate about how to
conceptualise and assess attachment organisation. It is suggested that researchers should be aware of the different psychometric properties and limitations of each method of assessing an individual's attachment organisation before employing it for research purposes.

**Implications for practice and future research**

The results of this study on types of touch (when, why and how it is used) and attachment styles could offer some implications for practice. Firstly, this study offers an insight into when, why and how various types of non-sexual touch are used in current clinical practice. Based on the results, non-sexual touch is used in therapeutic work either simply as socially stereotyped touch or as an expression of the relationship. These results could be used as guidelines in supervision, or as points of reference in psychology and psychotherapeutic training, particularly in lectures or class discussions related to the use of touch. They could enhance clinicians' and students' awareness on when, why and how they might use touch in their practice. To the best of the researcher's knowledge, this study is the first to give an insight into how therapists' attachment styles — which have been informed by a close relationship — could possibly influence therapeutic work. Supervision, training and personal therapy drawn from attachment theory can increase therapists' and trainees' awareness a) of their attachment patterns in their close relationships and especially the strategies they use for seeking and maintaining physical proximity and b) of how these patterns and strategies might influence their therapeutic work, especially their use of touch.

In addition, the results and limitations of this study offer some suggestions for future research. For example, an investigation on how clients' attachment style could influence their need to seek physical proximity — in other words, to initiate physical contact with their therapists — could offer some useful insight into clients' attachment styles as an influential factor in the use of touch in therapy.
Conclusion

The limited research into how therapists’ attachment styles influence their need to seek physical proximity – in particular in the form of touch – to their clients was the inspiration for conducting this study. The results offer a tentative interpretation that the therapist’s attachment style could influence the use of touch with clients. This study attempted to examine the association between two rich yet controversial theoretical concepts in the literature: attachment styles and use of touch. Attachment theory and the use of touch have sparked numerous debates and discussions about the purpose, meaning and use in psychotherapy. Interestingly, both concepts seemed to add something extra (Harris, 2004, p.204) to psychotherapy; an emphasis back to the body. For example the ethological/evolutionary perspective of attachment theory implies that attachment behaviours and styles are instinctive, based on the explanation that our behaviours (i.e. seeking proximity) remain tied to our bodies. Therefore, this study suggests that, based on their attachment styles, therapists bring their own evolutionary past and bodies and their need for seeking proximity to clients. In addition, the use of touch and the taxonomy of non-sexualised touch behaviours bring back, to ‘dominant talking oriented’ psychotherapy a neglected aspect of therapy: physical contact and its healing benefits between therapist and client.

In addition, it is worth questioning the purpose of clustering attachment styles and touch. Clearly, taxonomies of attachment styles and touch behaviours could inform therapists’ work as a ‘diagnostic tool’ or a ‘guide’, offering an understanding and evaluation of attachment styles and guidance on what touch behaviours could be used in therapy. However, it needs to be acknowledged that attachment styles and touch behaviours are not fixed. Firstly, therapists’ attachment patterns can be influenced and can change in time because of life experiences, relationships, therapy and supervision. Secondly, touch behaviours and the reasons behind how and when to use them in clinical practice seem to have more of an ambiguous than a universal meaning because they are influenced by a number of significant factors such as personality traits and
cultural backgrounds. It is suggested that, rather than using them as a cluster of behaviours, grouping therapists or clients into an attachment style, it might be better to use them as theoretical entities which can inform and increase our understanding, our personal experience as individuals and our clinical work as therapists.

**Reflections on the use of self**

As with all my research projects, the present study is motivated by a personal interest as well as an academic one. My personal experience of the 'inappropriate touch' as an intervention by my first therapist in Greece was one of the main reasons behind my curiosity and general interest in the role of the body and touch in psychotherapy. I can still remember having quite strong negative feelings about my therapist's intervention which led to the rupture of the relationship and my sudden decision to give up therapy. The experience left me with many questions: When is touch appropriate in a therapeutic encounter? How can it be used in a therapeutic way? As therapists, do we initiate touch to meet our clients' needs or our own needs? Starting this training and having the opportunity to conduct some research into areas of personal interest was the best way to find some answers to my questions.

Initially I conducted a literature review on the role of the body in psychotherapy. On reflection, it feels like an attempt to familiarise myself with the role of the body, its value, ethical risks and various factors that need to be considered before using it (theoretical training, client group, cultural background). In other words, it was my attempt to understand my therapist's intention behind his inappropriate touch. My first contact as a researcher into this topic left me with mixed feelings of confusion and excitement as I came across sharply contradictory views among theoretical paradigms. In some of them, touch is considered as an inseparable part of therapy whereas in others it is a neglected aspect. As a counselling psychologist trainee, I was somewhat disappointed to realise that among the literature there was limited reference to counselling psychology's stance with regard to the body. Hoping to offer a greater insight to the counselling psychology discipline, my second piece of research aimed to
explore counselling psychologists' perceptions of the role of body in the therapeutic encounter. Interestingly, from this qualitative study, a number of interesting themes emerged, such as a) how therapists' personal experiences and personal relationships with their bodies might influence how much they value and consider the body in therapy, and b) the use of touch as a powerful tool of communication in therapy and the importance of therapist's awareness of when, why and how to use it.

Moving ahead to my third year of training and, sadly, having a difficult time at placement had an impact on my personal style as a therapist. Having a difficult and challenging supervisory relationship made me doubt my capacities as a therapist. I can still remember being in the room with clients and feeling anxious about my skills and interventions, especially when the clients were distressed. There were times, when my clients were distressed that I was tempted to offer them a tap on the shoulder or hold their hand. However, on those occasions, I was also wondering whether such physical contact would be helpful to my clients or myself. I was aware that, on a personal level, I was very comfortable to seek and maintain physical proximity whenever I was stressed, sad or happy from my significant others but I was also aware that, being a client myself, I had experienced the 'inappropriate touch' too. My interest in, and readings on, attachment theory became my guide to understanding my need to seek physical contact when I was feeling distressed. Attachment theory concepts helped me to understand a) the importance of the attachment bond with caregivers especially when the individual is distressed, and b) that the therapist's attachment style could be an influential factor in the therapeutic outcome and the quality of the therapeutic alliance. The limited research into how therapists' attachment styles influence their need to seek or maintain physical proximity with clients meant that I could combine my interest in attachment theory and use of touch. As I had already conducted a qualitative study in which I carried out an in-depth analysis of the experience of three participants, I felt that a quantitative research design would allow me to test specific hypotheses, while allowing me to include a larger number of participants. Advertising and circulating my survey was a fascinating process as it received a great interest on the part of academics, researchers and
therapists from different modalities. Having conversations with these people helped me to engage on a deeper level with my topic.

However, I have to confess that it was more difficult than I had initially expected. Specifically, it was very challenging for me to create a quantitative design, as I was aware of the complexity and richness of the experience I wanted to explore. I found it difficult to become more specific about what I wanted to investigate, to form specific hypotheses and to remain focused on analysing my data in relation to these hypotheses. I was constantly thinking of other factors and variables that I would like to have included in the study and I often felt frustrated. However, I soon started enjoying the process and I grew excited about analysing the data and, more specifically, about interpreting the results. As the study comes to an end, it leaves me with mixed feelings because it also signifies the end of my training. I feel both relieved and sad to have finished both this study and my training.
References


Appendix A: Research Ethical approval

RE: Final approval of ethics proposal 729-PSY-12
j.earl@surrey.ac.uk
Sent: Thursday, February 14, 2013 11:45 AM
To: Kouloumbri M Miss (PG/R - Psychology)
Cc: Fife-Schaw CR Prof (Psychology); Draghi-Lorenz R Dr (Psychology)

Dear Maria

Thank you for your email and sending the relevant amended documents for your proposal. I can now confirm that you have adhered to the conditions stipulated after ethical review and can now proceed with your research.

Kind regards and good luck with your project!

Julie

Julie Earl
Secretary and Administrator FAHS Ethics Committee
Faculty Administrative Assistant
Administrative Assistant to Professor Marie Breen-Smyth, Associate Dean International
Faculty of Arts and Human Sciences
University of Surrey
Tel: 01483 689175
Faculty Office: 04 AD 04
Appendix B: permission for touch questionnaire

**Touch survey permission**

Stenzel, Dr. Cheryl [CStenzel@allendale4kids.org]

*Sent:* Thursday, February 02, 2012 4:13 PM  
*To:*  Kouloumbri M Miss (PG/R - Psychology)  
*Cc:* PRUPERT@luc.edu

Dear Maria Kouloubri:

Thank you for your interest in the questionnaire on touch in psychotherapy. I support your use and appropriate reference of the material. Please let us know what you find from your research.

Cheryl L. Stenzel, Ph.D.  
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Allendale Association/Bradley Counseling Center  
P O Box 1088  
Lake Villa, IL 60046  
847-356-3322  
fax 847-356-2360

>>> <M.Kouloumbri@surrey.ac.uk> 1/29/2012 3:31 PM >>>

Dear Professor Rupert,

My name is Maria Kouloumbri and I am a counselling psychologist trainee in PsychD Psychotherapeutic & Counselling Psychology at the University of Surrey in the UK. My research interests concern the use of touch and its various forms within the therapeutic encounter.

Currently, I am using an experimental design to investigate how professional psychologists use touch during therapy. I came across a questionnaire that one of your supervisees designed (Cheryl Stenzel) and used in a paper Stenzel, & Rupert, (2004)"Psychologists' use of touch in individual psychotherapy". The instrument is based on Smith's taxonomy of touch and I would like to use it for my own study. Unfortunately, I can't find Cheryl Stenzel's contact details so I would be grateful if you could advise me on how to proceed regarding seeking permission to utilise this scale.

Best regards,  
Maria Kouloumbri  
Counselling Psychologist in training
Appendix C: Information sheet/ questionnaires

Information Sheet for participants

Title of the study
Therapists' attachment styles and their use of touch in therapy

Description of the study
My name is Maria Kouloumbri and a 3rd year Counselling Psychologist trainee at University of Surrey. As a part of my research project I am interested to explore how clinicians' attachment styles are associated with their use of touch in therapy. Use of touch here is defined broadly as explicitly non-erotic types of touch from therapist to client such as hugging, holding touching hands/shoulder etc. My research supervisors are Dr Riccardo Draghi- Lorenz and Prof Chris Fife-Schaw. The study has received a favourable ethical opinion from Ethics Committee of the Faculty of Arts and Human Sciences of the University of Surrey.

Research and clinical practice suggest that therapist's theoretical orientation; personal variables (age, gender, social background) influence the use of touch in their practice. However, there is a lack of research on how therapist's attachment styles related with their use of touch in therapy. The current study aims to offer insight in this area.

What would participation involve?
In order to participate in this study, you must be a qualified clinical/counselling psychologists or psychotherapist. In addition you must be above 25 years old and to work in private practice.

If you are interested in participating in this study, I will send you a link to an online survey that will include questions about some demographic details and questions exploring your attachment style and eventually questions about various applications and types of touch and in your practice.

Anonymity is guaranteed in order to protect your privacy. The survey is anonymous and you will not be asked to provide information that would identify you personally. The survey is brief and should not take more than 15-20 minutes of your time.

I hope to incorporate your anonymous contributions into my study. Your responses will help to fill a gap on how clinicians' attachment styles influence the use of touch in their practice as well as contribute to the ongoing dialogue about both modalities and use of touch in our profession. Please feel free to contact with me with questions or concerns you may have at the following email address or phone number.

Thank you for taking time to read this.
Demographic questionnaire

Please provide the following information:

1) Gender

Male ---------- Female ---------------

2) What is your age?

26-30
31-40
41-50
51-60
61 or over

3) What is your ethnicity?

White British
White (other background) specify -------------------------
Mixed White
Black

4) What is your professional title?

Counselling psychologist
Clinical psychologist
Psychotherapist
5) What is your primary theoretical orientation? (please choose only one)

<table>
<thead>
<tr>
<th>Eclectic/integrative</th>
<th>Cognitive-behavioural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic/psychoanalytic</td>
<td>Humanistic</td>
</tr>
<tr>
<td>Existential</td>
<td>Gestalt</td>
</tr>
</tbody>
</table>

6) Years of clinical practice --------------------------
Research Dossier

Experiences in Close Relationships Scale (ECR)

(Brennan, K.A., Clark., C.L., & Shaver,P.R., 1998)

The following statements concern how you generally feel in close relationships (e.g., with romantic partners, close friends or family members). Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree strongly</td>
<td>Disagree slightly</td>
<td>Disagree</td>
<td>Neutral / mixed</td>
<td>Agree</td>
<td>Agree slightly</td>
<td>Agree strongly</td>
</tr>
</tbody>
</table>

1. I prefer not to show others how I feel deep down.

   1 2 3 4 5 6 7

2. I worry about being rejected or abandoned.

   1 2 3 4 5 6 7

3. I am very comfortable being close to other people.

   1 2 3 4 5 6 7

4. I worry a lot about my relationships.

   1 2 3 4 5 6 7

5. Just when someone starts to get close to me I find myself pulling away.

   1 2 3 4 5 6 7

6. I worry that others won’t care about me as much as I care about them.

   1 2 3 4 5 6 7
7. I get uncomfortable when someone wants to be very close to me.

1 2 3 4 5 6 7

8. I worry a fair amount about losing my close others.

1 2 3 4 5 6 7

9. I don’t feel comfortable opening up to others.

1 2 3 4 5 6 7

10. I often wish that close others’ feelings for me were as strong as my feelings for them.

1 2 3 4 5 6 7

11. I want to get close to others, but I keep pulling back.

1 2 3 4 5 6 7

12. I want to get very close to others, and this sometimes scares them away.

1 2 3 4 5 6 7

13. I am nervous when another person gets too close to me.

1 2 3 4 5 6 7


1 2 3 4 5 6 7

15. I feel comfortable sharing my private thoughts and feelings with others.
16. My desire to be very close sometimes scares people away.

17. I try to avoid getting too close to others.

18. I need a lot of reassurance that close others really care about me.

19. I find it relatively easy to get close to others.

20. Sometimes I feel that I try to force others to show more feeling, more commitment to our relationship than they otherwise would.

21. I find it difficult to allow myself to depend on close others.

22. I do not often worry about being abandoned.

23. I prefer not to be too close to others.
24. If I can’t get a close other to show interest in me, I get upset or angry.

1 2 3 4 5 6 7

25. I tell my close others just about everything.

1 2 3 4 5 6 7

26. I find that my close others don’t want to get as close as I would like.

1 2 3 4 5 6 7

27. I usually discuss my problems and concern with my close others.

1 2 3 4 5 6 7

28. When I don’t have close others around, I feel somewhat anxious and insecure.

1 2 3 4 5 6 7

29. I feel comfortable depending on others.

1 2 3 4 5 6 7

30. I get frustrated when my close others are not around as much as I would like.

1 2 3 4 5 6 7

31. I don’t mind asking close others for comfort, advice, or help.

1 2 3 4 5 6 7

32. I get frustrated if close others are not available when I need them.

1 2 3 4 5 6 7
33. It helps to turn to close others in times of need.

1 2 3 4 5 6 7

34. When other people disapprove of me, I feel really bad about myself.

1 2 3 4 5 6 7

35. I turn to close others for many things, including comfort and reassurance.

1 2 3 4 5 6 7

36. I resent it when my close others spend time away from me.

1 2 3 4 5 6 7
PSYCHOLOGISTS' USE OF TOUCH IN INDIVIDUAL PSYCHOTHERAPY

(Stenzel & Rupert, 2004)

Section A:

Please consider how you have typically interacted with adult clients (over 18 years) in your practice. Reflect on the physical contact between you and your client when you greet, say good-bye and during the work of psychotherapy. With this in mind, use the scale below to rate the following behaviors. Please circle the appropriate number to indicate separate responses for female and male clients.

1 = never  2 = rarely  3 = sometimes  4 = fairly often  5 = very often

<table>
<thead>
<tr>
<th>How often do you</th>
<th>Male clients</th>
<th>Female clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place your arm around a client</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Physically restrain a client</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Hold a client on your lap</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Use touch associated with relaxation training, or hypnosis</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Accept a hug from a client</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Offer a hug to a client</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Accept a handshake from a client</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Offer a handshake to a client</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Hold a client's hand</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Kiss a client on the cheek</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Touch a client's shoulder, arm</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
Section B:

Please use the scale to rate the following in your practice. Please consider all forms of touch and indicate your responses separately for female and male clients.

1 = never   2 = rarely   3 = sometimes   4 = fairly open   5 = very often

<table>
<thead>
<tr>
<th>How often do you</th>
<th>Male clients</th>
<th>Female clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Touch a client when greeting at the beginning of the session</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>2 Touch a client when parting at the end of a session</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>3 Touch a client when parting psychotherapy</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>4 Touch a client during a session</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>5 Discuss the client’s experience of the therapist’s touch in session with the client.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>6 Request permission from the client prior offering touch.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>7 Explain the use of touch to the client prior to offering touch.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>8 Offer touch as nurturance, emotional support, empathy, comfort.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>9 Offer touch to reconnect a client with external reality.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>10 Offer touch to enhance emotional expression.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>11 Offer touch to improve client’s awareness.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>12 Offer touch as part of a reparenting process.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>13 Offer touch to unblock energy.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>14 Offer touch to provide the experience of safe touching.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
<tr>
<td>15 Offer touch to enhance self-esteem.</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

If you do not use any types touch in your work why is this? Are there any particular reasons for this?
Appendix D: Tests of differences

Table 4 Kruskall Wallis test for types of touch, when, how, why it is used and years of clinical practice

<table>
<thead>
<tr>
<th>Touch</th>
<th>Years of clinical practice</th>
<th>H</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>expression of the relationship</td>
<td>1-34</td>
<td>19.1</td>
<td>27</td>
<td>0.866</td>
</tr>
<tr>
<td>social stereotyped</td>
<td>1-34</td>
<td>33.636</td>
<td>27</td>
<td>0.117</td>
</tr>
<tr>
<td>touch technique</td>
<td>1-34</td>
<td>34.756</td>
<td>27</td>
<td>0.145</td>
</tr>
<tr>
<td>lap sitting</td>
<td>1-34</td>
<td>40.3</td>
<td>27</td>
<td>0.048</td>
</tr>
<tr>
<td>beginning session</td>
<td>1-34</td>
<td>21.186</td>
<td>27</td>
<td>0.778</td>
</tr>
<tr>
<td>when</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>during session</td>
<td>1-34</td>
<td>26.612</td>
<td>27</td>
<td>0.485</td>
</tr>
<tr>
<td>end session</td>
<td>1-34</td>
<td>20.633</td>
<td>27</td>
<td>0.803</td>
</tr>
<tr>
<td>increase awareness</td>
<td>1-34</td>
<td>24.597</td>
<td>27</td>
<td>0.597</td>
</tr>
<tr>
<td>provide support</td>
<td>1-34</td>
<td>20.312</td>
<td>27</td>
<td>0.817</td>
</tr>
<tr>
<td>reconnect</td>
<td>1-34</td>
<td>27.87</td>
<td>27</td>
<td>0.418</td>
</tr>
<tr>
<td>why</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reparenting process</td>
<td>1-34</td>
<td>21.712</td>
<td>27</td>
<td>0.752</td>
</tr>
<tr>
<td>connect external reality</td>
<td>1-34</td>
<td>27.31</td>
<td>27</td>
<td>0.447</td>
</tr>
<tr>
<td>unblock energy</td>
<td>1-34</td>
<td>34.817</td>
<td>27</td>
<td>0.144</td>
</tr>
<tr>
<td>enhance self esteem</td>
<td>1-34</td>
<td>24.299</td>
<td>27</td>
<td>0.614</td>
</tr>
<tr>
<td>how</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>explain prior offering</td>
<td>1-34</td>
<td>24.327</td>
<td>27</td>
<td>0.612</td>
</tr>
<tr>
<td>discuss client's experience</td>
<td>1-34</td>
<td>25.142</td>
<td>27</td>
<td>0.567</td>
</tr>
</tbody>
</table>
### Table 5: Kruskall Wallis test for types of touch, when, how, why it is used and therapists’ gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean Rank</th>
<th>H</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>expression of the relationship</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>68.22</td>
<td>0.004</td>
<td>1</td>
<td>0.951</td>
</tr>
<tr>
<td>female</td>
<td>68.64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>social stereotyped touch</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>71.28</td>
<td>0.336</td>
<td>1</td>
<td>0.562</td>
</tr>
<tr>
<td>female</td>
<td>66.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>conversational marker</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>69.69</td>
<td>0.065</td>
<td>1</td>
<td>0.799</td>
</tr>
<tr>
<td>female</td>
<td>67.91</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>touch technique</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>71.84</td>
<td>0.825</td>
<td>1</td>
<td>0.364</td>
</tr>
<tr>
<td>female</td>
<td>66.85</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>lap sitting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>71.46</td>
<td>2.989</td>
<td>1</td>
<td>0.084</td>
</tr>
<tr>
<td>female</td>
<td>67.04</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>beginning of session</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>77.66</td>
<td>4.104</td>
<td>1</td>
<td>0.043</td>
</tr>
<tr>
<td>female</td>
<td>63.97</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>during session</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>67.12</td>
<td>.099</td>
<td>1</td>
<td>0.753</td>
</tr>
<tr>
<td>female</td>
<td>69.18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>end of session</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>72.42</td>
<td>0.709</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>female</td>
<td>66.56</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>provide support</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>65.98</td>
<td>0.299</td>
<td>1</td>
<td>0.585</td>
</tr>
<tr>
<td>female</td>
<td>69.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>reconnect</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>67.27</td>
<td>0.082</td>
<td>1</td>
<td>0.775</td>
</tr>
<tr>
<td>female</td>
<td>69.11</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>reparenting process</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>65.83</td>
<td>0.547</td>
<td>1</td>
<td>.460</td>
</tr>
<tr>
<td>female</td>
<td>65.83</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>connect with external reality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>67.00</td>
<td>0.121</td>
<td>1</td>
<td>0.728</td>
</tr>
<tr>
<td>female</td>
<td>69.24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>enhance self esteem</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>66.71</td>
<td>0.222</td>
<td>1</td>
<td>0.637</td>
</tr>
<tr>
<td>female</td>
<td>69.38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>unblock energy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>70.66</td>
<td>0.473</td>
<td>1</td>
<td>0.492</td>
</tr>
<tr>
<td>female</td>
<td>67.43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>explain prior offering</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td></td>
<td>3.423</td>
<td>1</td>
<td>0.064</td>
</tr>
<tr>
<td>female</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6 Table 7 Kruskall Wallis test for types of touch, when, how, why it is used and therapists' age

<table>
<thead>
<tr>
<th>Type</th>
<th>Age</th>
<th>Mean Rank</th>
<th>H</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>expression of relationship</td>
<td>26-30</td>
<td>51.45</td>
<td>10.93</td>
<td>4</td>
<td>0.027</td>
</tr>
<tr>
<td></td>
<td>31-40</td>
<td>60.59</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>41-50</td>
<td>65.69</td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>51-60</td>
<td>72.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>61 and over</td>
<td>91.79</td>
<td></td>
<td></td>
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**Research Dossier**
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Poster presentation

Annual Conference of Division of Counselling Psychology,
Cardiff, 2013
Mind the body: Exploring counseling psychologists' perceptions about the meaning and the role of the body in clinical practice

M. S. Kouloumbri, D. Brown
School of Psychology, Faculty of Arts and Human Sciences, University of Surrey, Guildford, GU2 7XH

Introduction
In the early ages of psychotherapy the use of body and touch were considered as a central aspect of the therapeutic work and a channel of communication between clients and therapists. However, throughout the years a misconception of using body and touch in psychotherapy has been developed in western cultures due to ethical considerations and cultural taboos. Due to this, psychotherapy has been divided into body-oriented therapies where touch is a central aspect of the therapeutic work and talking therapies where the use of touch seemed to be limited and/or inappropriate. In most talking therapies there is a clear rationale on why body is not used in clinical practice. However, in counselling psychology there is an inconsistent view and limited reference with regard to the meaning and use of body and touch.

Aim
This study aims to explore and add further knowledge to the ignored but significant area of the body and its aspects and their application in counselling psychology.

Method
Semi-structured interviews were conducted with 5 qualified Counselling Psychologists working in private practice. Interviews were audio taped, transcribed and analysed using Interpretative Phenomenological Analysis (IPA). Detailed analysis of the transcripts was conducted to elicit key themes based on the experiences of the participants.

Results

"I value the body a lot in my life and I think in terms of therapy it plays a significant role if you allow it to...

"Touch releases something to people that is quite powerful if it works for them."

"We are constrained about our title as 'talking therapists'."

"I work with young people and I may sometimes sit next to them and touch them when they are upset, tap them on the shoulder."

"We are forced to describe that a counselling psychologist is a person who does 'this and that' and moving out from 'that' means you move from your area of expertise...it's more risky."

"There is a split (body-mind) and I don't see an improvement...it gets worse."

"There is a split and I would like to think the body would an adjustment in counselling psychology."

"There is a split and I would like to think the body would an adjustment in counselling psychology but I don't see an improvement...in fact I see the body towards the opposite direction."

Conclusions
• The body is valuable, a source of information and an attractive tool of communication within therapy offering a holistic approach in the work of the therapist.
• Touch is viewed as powerful, healing, genuine and is sometimes characterised as more appropriate than other verbal interpretations or interventions.
• There are doubts in the use of touch with certain clients in fear of violation of therapeutic boundaries, possible sexual arousal and allegations.
• The clients' cultural background could influence the therapist's decision to involve the body or use touch. This is in line with the British Psychological Society's (BPS) Code of Conduct which stresses that therapists should consider when they use bodily techniques with clients of different culture, religion, gender, and developmental history, previous experience with touch or sexual abuse history.
• The training of the participants was revealed as an important element. Their training as counselling psychologists had not necessarily provided them with sufficient knowledge about the use of the body and touch in therapy. They interpreted this as an attempt by the discipline of counselling psychology to distinguish itself and establish its own boundaries as 'talking therapy'.
• Visualising the future of counselling psychology, participants either expressed mixed feelings or were pessimistic about greater involvement of the body, but hoped for further research in this area.

Implications
The results of this qualitative study could:
1. Enrich counselling psychology literature and textbooks and be used as reference material in lectures related with body in counselling psychology courses.
2. Provide a better, more clear understanding of how counselling psychologists' training, cultural and ethical considerations, combine to formulate a meaning of the body in therapy.

References