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Jonathan D. Wright

University of Kansas, wrightjd.ufl@gmail.com

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Training Issues Related to Touch in Counseling

Abstract

Touch is considered by many to be the most important of the five senses for optimal human development and has been used in healing and medical practices throughout history. Touch also plays a key role in human communication but maintains a position detached from other forms of verbal and nonverbal communication within the field of counseling. Most counselors receive little training in the role of touch in counseling, and there are no ethics codes specific to the use of touch available to guide counselors. The purpose of this article is to provide an overview of historical and current issues related to the practice and training of touch in counseling and to offer recommendations to counselors, researchers, and training programs.

Keywords

counseling, touch, ethics, training

The very first sense that infants develop, while still in utero, is the sense of touch. When they are born, it is how they interact with the world and receive communication from their loved ones. Even as they grow and develop, touch continues to serve as a primary means of communication (Field, 2001). In fact, recent research has shown that adults are able to identify six distinct emotions communicated solely through touch (Hertenstein, Keltner, App, Bulleit, & Jaskolka, 2006). Despite the centrality of touch to development and emotional dialogue across the lifespan, it is a form of communication that is rarely discussed, and even less frequently taught or studied, in the field of psychology (Bonitz, 2008).

Theoretical recommendations regarding the use of touch in counseling have spanned from the banning of all touch in some forms of psychoanalysis to prescriptions for touch as an intervention in Reichian therapy models (Smith, 1998). In family therapy, Virginia Satir is well known for her use of touch, and experiential family therapists use touch in sculpting exercises and as a means of communication (Gladding, 2015). In contemporary models of individual counseling however, the predominant treatment of the topic of touch has been to avoid it altogether. The main practical advice to practicing counselors comes in the form of ethical decision-making models that lay out broad guidelines for when to consider using touch (Calmes, Piazza, & Laux, 2013; Smith, 1998). As the use of touch has largely been ignored in contemporary theories of counseling, researchers have also shied away from the study of touch in psychotherapeutic settings. Consequently, much of the research that serves as the foundation for judgments of the potential effects of touch is 20 to 30 years old.

In order to reintegrate this important form of nonverbal communication into the field as a whole, a multidimensional effort is required. This includes researchers evaluating older findings and further exploring the process effects of touch, theorists including more comprehensive

discussion of nonverbal communication in their models, and practitioners showing heightened awareness of both the therapeutic utility and risks of the use of touch. The reintegration of touch into psychology must begin at the ground level, which entails training programs broadening their discussions of touch to move beyond ethics courses to skills, theory, and research training. This article serves as a brief primer on current practices and future directions for training in the topic of touch in counseling. It reviews the history of touch in counseling; summarizes the primary models of ethical decision-making related to the use of touch; and provides recommendations for training programs, counselors, and researchers to more effectively consider and discuss the role of touch in counseling.

History of Touch in Counseling

Throughout early development and childhood, touch is the sense most critical to positive development (Field, 2001). While children can learn to function adaptively without any of their other senses, a lack of sufficient touch in infancy has been linked to aggressive and antisocial behaviors (Hunter & Struve, 1998), an increased likelihood of the infant displaying a failure to thrive (Polan & Ward, 1994), and reduced weight-gain in preterm neonates (Field et al., 1986). In infants, the positive or negative experience of contact and touch is related to the development of relational patterns that persist into adulthood (Ainsworth, 1989; Bowlby, 1969).

Touch is not only a necessary aspect of healthy development, it also functions as a means of expressing emotion and an important form of nonverbal communication. Hertenstein et al. (2006) demonstrated that people can not only identify distinct emotions through the experience of touch, but also that they can identify communicated emotions simply by watching others communicate through touch. Despite the obvious significance of physical touch in human life and the long history of touch being used in healing practices (Frank, 1973; Hunter & Struve, 1998),

there has been a taboo surrounding the use of touch in many counseling settings since the early 1900s (Bonitz, 2008; Giannone, 2015).

As is true for many contemporary ethics issues, one of the first influential voices on the subject of using touch in counseling was Sigmund Freud. Early in his career, Freud commonly used touch in his work, touching or stroking his patients' necks, or pressing on their foreheads as a way to help them connect with buried memories (Hunter & Struve, 1998; Phelan, 2009). As he began to develop his new psychoanalytic views and techniques, he began vocally advocating against any physical contact with patients in psychotherapy. He believed that the client reenacted past relationships within the therapeutic relationship, transferring the role of the significant other, whether a parent, friend, or partner, onto the psychotherapist. He thus advocated that psychotherapists represent themselves as a blank slate to as great an extent as possible in order to facilitate that transference. This meant that any unnecessary contact, especially physical contact, should be avoided. In addition to believing that touch would deter complete transference, Freud also viewed touch as the gratification of unconscious sexual needs. He believed that by fulfilling these needs, clients would be unable to bring them into consciousness to be processed and worked through, leaving them fixated in undeveloped states (Bonitz, 2008). Freud's perspective, that any touch by the psychotherapist would be fulfilling a sexual need of the client (and possibly the therapist as well), has persisted in many contemporary beliefs and doubts about touch in counseling and continues to present an obstacle for counselors advocating the use of appropriate touch in counseling settings (Durana, 1998).

Despite this barrier, several prominent psychotherapists and counselors have used and written about touch in counseling settings. Even during the early years of psychoanalysis, William Reich, a contemporary of Freud, expressed differing opinions on the use of touch. Reich (1945)

rejected the mind–body dichotomy that Freud and many of his followers espoused, believing instead that the body played a key role in both patients’ resistance and in therapeutic healing. He found that clients not only showed verbal and emotional resistance when dealing with difficult issues but that they also underwent physical changes. Changes included observable symptoms such as stiffening of the face or changes in posture or breathing patterns to sexual dysfunctions and he advocated the use of touch as a specific technique for dealing with such blockages. He devised a number of techniques, including breathing exercises, body movements, massage, and pressure on specific muscles and body areas, which were designed to release stuck resistance and energy, thereby allowing for a more complete resolution of issues (Bonitz, 2008). Reich’s new theories and techniques were not accepted in traditional psychoanalytic circles; however, his work continued to be influential, eventually playing a role in the development of the humanistic movement.

Humanistic therapies entail a greater focus on the relational aspects of counseling and on genuineness of communication. Fritz Perls, an analyst of Reich, used touch and body language as a means of exploring the authenticity of patients’ communication, while other humanistic counselors used touch as a means of communicating their own genuine feelings, thereby strengthening the therapeutic bond (Bonitz, 2008, Hunter & Struve, 1998). Within the field of family therapy, touch has historically been more widely accepted. A number of prominent family therapists are known for their use of touch in the counseling room, including Satir, Carl Whitaker, and Walter Kempler (Gladding, 2015). Minuchin and Fishman (1981) discuss how touch can be used in the context of managing space and intensity when working with families, and Satir has discussed touch as a means to focusing on the present moment and evoking a more sensory level of understanding (Winter & Parker, 1991). Even with touch having a more significant space in the

work of the leaders of the field, Jaison (1991) notes that touch involves a “subjective and personal choice” (p. 161) which is based on personal style and the type of therapy used.

Stenzel and Rupert (2004) conducted a survey of practicing psychologists from a variety of theoretical orientations and found that, despite the overall infrequent use of touch in counseling, humanistic counselors were the most likely to use touch in counseling, whereas psychodynamic therapists were the least likely to do so. These results are similar to those of Holroyd and Brodsky (1977), which suggest that the use of non-erotic touch was endorsed significantly more frequently by humanistic counselors than by psychodynamic therapists. Based on a survey by Milakovich (1992), it is possible to argue that the primary point of contention between touch and no-touch counselors concerns the function of needs gratification in the therapeutic process. Counselors who used touch were likely to believe that gratifying the client’s innate need for touch and contact is therapeutic, whereas those who denied using any touch in counseling were more likely to espouse Freud’s theory of frustration, believing that the gratification of the touch need runs counter to the therapeutic process. With the most recent large-scale survey having been undertaken 15 years ago (Stenzel & Rupert, 2004), it is unclear how frequently contemporary counselors use touch in their work.

In contemporary counseling, touch can take various forms, from socially accepted gestures to therapeutic, communicative touch to touch as a specific technique (Smith, 1998; Zur & Nordmarken, 2011). By far the most commonly used category of touch by counselors is ritualistic or socially accepted gestures, such as handshakes, hugs, and high-fives (Stenzel & Rupert, 2004). Most counselors feel comfortable offering a handshake at the beginning or end of sessions, though only a small portion of these ever discuss or process that touch with clients. Other than handshakes, the most common use of touch in counseling is as a method of communicating with the client.

Counselors frequently aim to convey consolation, reassurance, and empathy in sessions, and touch, in the form of a touch on the client's knee, holding the client's hands, or a comforting hug can support that goal. Touch can also be used as a way of grounding the client or bringing them back from a state of overwhelming emotion or anxiety. This typically involves a gentle touch to the client's hand, arm, or knee, but it also may mean directing clients to focus on their own sense of touch, helping to bring them into the present moment (Zur & Nordmarken, 2011).

While theoretical orientation still plays a role in whether a counselor is likely to use touch (Stenzel & Rupert, 2004), the debate has tended to revolve around the dichotomous question of touch versus no-touch. Farrell (2018) suggested that there is also a tendency to separate touch into good and bad touch. She suggested that a more helpful position is to view it as being similar to verbal communication, which can be used and experienced in many different ways. Early research into touch explored its role within the process of therapy. It was found, for example, that increased physical contact in therapy settings is related to increases in client self-disclosure (Pattinson, 1973) and exploration (Pederson, 1973). In 1981, Hubble, Noble and Robinson found that the use of touch in initial sessions communicated a sense of expertise by the counselor. Despite these seemingly positive findings, discussion of touch in theoretical models has waned and over the past two decades research into the effects of touch has primarily occurred in the social sciences and, more recently, in the field of technological communication (e.g. Eid & Osman, 2015).

The dominant individual counseling interventions in practice today, such as cognitive-behavioral therapy, dialectical behavior therapy, and other evidence-based and manualized approaches tend to spend little or no time discussing the role of touch in therapy. One reason for this gap may be that the medical model on which many evidence-based practices are based tends to place the focus of research and training more squarely in the content, as opposed to the process

of therapy (Wampold, 2001). Even within a contextual model, however, such as the common factors model of counseling, little is written about touch either as an intervention or as a component of nonverbal communication.

Arguments Against Touch

There are two primary lines of reasoning that cite the major risks associated with the use of touch in counseling- the slippery slope argument and the issue of power differentials. The slippery slope argument posits that a boundary crossing, such as the use of touch, will lead to more egregious boundary violations, such as erotic or sexual contact with clients (Calmes, Piazza & Laux, 2013; Williams, 1997). Despite evidence showing that slippery slope incidents are rare (Gottlieb & Younggren, 2009), many practitioners and training programs continue to adhere to its logic. The difficulty in determining the difference between a boundary crossing, which is viewed as a nonthreatening, potentially even therapeutic departure from standard practice, and a boundary violation, which has the potential to harm the client or damage the therapeutic relationship, leads to uncertainty and doubt about what is acceptable in practice (Zur, 2007). Due to this fear, the teaching in many psychology and counseling programs and the accepted practice of many counselors is to simply avoid touch altogether.

The concern about power differentials being reinforced in counseling through the use of touch is discussed in detail by Alyn (1988), and many of her suggestions and considerations have been worked into decision-making models and clinical recommendations regarding touch since that time. Hunter and Struve (1998) mentioned that, in the United States, much of the physical contact that occurs between adults is limited to either the communication of sexual intent or the transmission of power differentials. Status plays a significant role in who is allowed to touch whom in everyday life, and in situations such as counseling, where there are inherent status differentials,

the use of touch can exacerbate such preexisting discrepancies (Henley, 1977). When touch is perceived as a display of power, it may also serve to replicate negative interactions the client has experienced in the past or to reinforce the socially pervasive disempowerment of minority clients (Alyn, 1988). The risk of touch being experienced as a display of power is increased in male counselor - female client dyads. Unfortunately, no recent research has investigated the interaction of touch and power dynamics in counseling. Particularly in today's social and political climate, consideration of the inherent power differentials between the roles of counselor and client should be at the forefront of every decision regarding the use of touch in counseling.

Cultural Perspectives on Touch in Counseling

Starting from birth, the tactile experiences of individuals are intimately linked to the culture into which they are born. Some cultures, such as those of the United States and many other western countries, are defined by a relative lack of touch and contact, starting even immediately after birth, when it is common practice to place the child in a crib rather than with its mother. With newborns, for whom the primary means of communicating with the world around them is through touch, experiences such as this set the stage for how they may perceive touch throughout their lives (Montagu, 1971). Harper, Wiens, and Matarazzo (1978) studied touch across cultures in various contexts, including the frequency of touch in a coffee house. Of the cultures studied, they found that Puerto Ricans touched the most frequently, with 180 touches per hour, whereas Americans recorded only two touches per hour and the English recorded none. Montagu (1986) believes that cultures can be placed on a continuum of tactility, and Durana (1998) notes that almost all contemporary counselors developed in cultures that fall on the very low-to-no touch end of that spectrum.

When considering how culture factors in the use or avoidance of touch in counseling, it is important to consider not only the counselor's and the client's broader cultural heritages, but also their personal touch histories (Eyckmans, 2009). Counselors should begin by examining their own definitions and attitudes around touch, exploring how touch has been used in their family and cultural upbringing. A personal history of physical abuse or neglect or even merely a family history of touch avoidance could lead to a blurring of the motivations for using touch in counseling and should be processed in supervision or in consultation before deciding whether to use touch with clients. While it is acceptable, and even expected, that both the client and counselor may experience the contact as positive and benefit from it, it should be clear that the motivation for using touch is based on the needs of the client rather than on those of the counselor (Durana, 1998). Clarity of motivation cannot be obtained without an exploration and understanding of one's own history and perspectives as a counselor.

Once counselors have explored their own personal touch histories, an examination can begin of both the cultural context within which counseling occurs and the specific cultural and personal touch history of each individual client (Zur, 2007). As a result of the taboo around touch, and a general confusion concerning when or how touch is used in counseling, many clients enter counseling believing that counselors never offer touch in counseling (Harrison, Jones & Huws, 2012). This expectation does not necessarily have to function as a barrier, however, as some models in the communication literature (e.g. Burgoon, 2016) suggest that interpersonal touch is most powerful when it is somewhat unexpected. At the same time, thorough understanding of the broader cultural norms surrounding touch in the specific location a counselor chooses to practice is vital. Counselors are expected to have an awareness of each client's preferred "language" and style of communication as it concerns physical touch as a form of nonverbal communication.

Much of the data gathering that goes into determining whether a client will be receptive to touch in counseling overlaps with the general process of learning about a client's psychological functioning and history. It should include reviewing the client's cultural traditions, as well as their familial experiences and expectations regarding physical contact, affection, and other forms of touch. Instances of abuse or neglect should especially be noted, though they may not necessarily serve as contraindications to the use of touch. In fact, in some instances it has been found that touch has the potential to be a more powerful and positive intervention for those with a history of having been sexually abused than those who have not (Horton, Clance, Sterk-Elifson, & Emshoff, 1995).

In addition, it is important to consider the client's gender and experiences related to power and privilege when gathering information (Alyn, 1988). Totton (2006) noted that many people's touch histories are centered around experiences of powerlessness, such as a child seeking reassurance or an adult seeking treatment from a powered medical professional. Touch has the ability to transmit personal feelings and intentions, yet it can simultaneously evoke memories of past societal oppression or feelings of inferiority associated with power discrepancies or minority status (Alyn, 1988). Consequently, talking with the client about their personal experiences with oppression, whether or not those experiences were directly related to touch, will help the counselor determine the potential consequences of using touch in counseling with that client. Finally, if there is any indication that the client may have sexual feelings toward the counselor or vice versa, touch should be avoided until those feelings are processed or resolved (Eyckmans, 2009).

Decision-Making Models for the Use of Touch in Counseling

One of the challenges counselors face is that there are no specific ethical guidelines in the American Counseling Association or American Psychological Association codes of ethics that

apply directly to the use of touch in counseling. A number of authors have detailed their own decision-making models in an attempt to help counselors determine when touch is appropriate and ethical, two of which are detailed here (Smith, 1998; Calmes, Piazza, & Laux, 2013). To help guide counselors, Smith (1998) created a decision table that includes two dimensions: a theory dimension and an ethics dimension; while Calmes et al. (2013) constructed a model with the flexibility to consider individual cases, basing their model on five core ethical principles (American Counseling Association, 2014; Kitchener, 1984). Both models are geared toward decisions regarding any of the appropriate uses of touch (i.e. socially accepted gestures, communicative, therapeutic, as a specific technique); however, therapies that use touch as a technique frequently have their own decision-making models based on the theories underlying their specific methods and therapies (e.g. Barstow, 2015).

Calmes, Piazza, and Laux's Ethical Principles Model

Ethical principles provide aspirational goals and guidelines to counselors and give support and direction in cases in which more specific ethical standards either do not apply or do not provide clear guidelines, as in the case of touch in counseling. When using aspirational principles to evaluate ethical situations, it is important to consider that at any time only one principle can be applied as the primary principle, though all can be factored into the decision. Thus, having in place a hierarchy that orders the principles for specific situations can aid the decision-making process (Kitchener, 1984). Calmes et al. (2013) proposed that when considering the ethical dilemmas associated with touch in counseling, the hierarchy of principles be: nonmaleficence, beneficence, autonomy, fidelity, and justice.

Nonmaleficence is frequently described as “above all, do no harm” (Kitchener, 1984, p. 47), and serves as a guiding principle in many of the helping and medical fields. Nonmaleficence

dictates that the client's personal touch history, cultural values, and current state be thoroughly explored to ensure that the use of touch is not likely to cause harm. As mentioned above, consideration of a history of abuse or neglect is particularly important when contemplating the client's readiness to receive touch (Durana, 1998). Whereas nonmaleficence serves as the primary defensive principle, beneficence balances it out as the primary action-oriented principle. Beyond simply avoiding harm to clients, it is the responsibility of counselors to promote their well-being and health and to apply their craft to aid in their healing and growth. Calmes et al. (2013) advised that when considering whether touch will benefit a client, reviewing which techniques or components of counseling have worked for the client in the past, both in the current and in previous counseling experiences, can prove highly insightful. They also encourage counselors to critically examine the levels of trust and alliance in the therapeutic relationship, as research has indicated that touch is received more positively when the therapeutic alliance is strong (Horton et al., 1995).

The principle of autonomy, the right of the client to control his or her own decisions and actions, can be applied most directly to the client's right to informed consent to be touched. With touch in everyday life being so intimately connected to power differentials (Henley, 1977), it is crucial that the counselor determine whether the client can comfortably *decline* consent before accepting consent from the client to engage in touch behavior. Many minority clients or clients with low levels of social power may feel that they are mandated by societal or cultural standards to accept the touch of a higher-power clinician; therefore, counselors should be completely comfortable with the client's ability to say no before proceeding. Additionally, it should not be assumed that consent to be touched in one instance can be generalized to other times or conditions (Calmes et al., 2013; Eyckmans, 2009). Closely related to the principle of autonomy is fidelity, the counselor's commitment to honoring commitments and maintaining the trust of the client

(American Counseling Association, 2014). This relates to the counselor's responsibility to inform the client of the potential risks and benefits of the use of touch. When a counselor contracts with a client about a specific use of touch and the how, where, and when thereof, fidelity dictates that the counselor remain within the boundaries established.

The final principle of justice or fairness is expressed as a need for counselors to critically examine their own behavior and to be aware of any biases. Where autonomy focuses on how the client's experience of power differentials and cultural norms relates to consent, justice focuses on how counselors' socialization, experiences, or motivations may affect their choice of treatment. There may be rational, appropriate reasons for using physical contact with some clients and not others; however, counselors who use touch differently based on the client's gender are at greater "risk of obscuring the line between erotic and non-erotic touch" (Alyn, 1988, p. 432). Readers are encouraged to refer to Calmes et al. (2013) for case studies on the application of their ethical principles model.

Smith's 2 x 2 Decision Model

Smith (1998) notes that in discussions of the ethics of touch, the theoretical components and ethical components are combined or conflated; therefore he introduced a decision-making model that distinguishes between the two in order to allow for a more comprehensive decision. The theory dimension of Smith's model refers to the stance of the counselor's personal theoretical orientation. For any counselor, this may be derived from a single theory, from a combination of theories, or from atheoretical research and/or personal experience that shape that counselor's practice and perspectives. A counselor's personal orientation may disallow touch completely, allow touch in certain circumstances, or encourage the use of touch as a specific technique.

Counselors should consider each different type and occurrence of touch and determine whether their theoretical orientation allows for or encourages its use in a particular circumstance.

The ethical dimension comprises three criteria that must be met in order to decide to use touch. The first criterion is whether the counselor has sufficient training and experience in the use of touch. This includes formal didactic training, as well as supervision in the use of touch. The second criterion involves considering whether touch is ego-syntonic or ego-dystonic for the counselor – that is, whether the use of touch resonates with the counselor and whether such behavior feels compatible with who the counselor is as an individual. Smith (1998) advises that when touch does not feel harmonious with the counselor’s identity, its use should be avoided. The third criterion is whether touch will be of therapeutic benefit to the client. If the use of touch were based more on the counselor’s needs or motivations than on the client’s needs, then its use would be inappropriate and unethical. Only when all three criteria are met can the client consider a “yes” response in the decision table, and only when both the ethical and theoretical components for a specific instance indicate that touch would be acceptable should the counselor proceed with its use.

Clinical Guidelines for the Use of Touch in Counseling

Even for the same client, touch has the potential to be a positive, healing intervention or a frightening and confusing experience. This depends on the skill of counselors and the manner in which they approach the use of touch (Eyckmans, 2009). A number of authors have compiled recommendations for clinicians to follow when considering using touch with clients (e.g. Bonitz, 2008; Durana, 1998; Eyckmans, 2009; Westland, 2011). These recommendations serve to add depth and detail to the decision-making models referred to above and to provide guidelines on the actual execution of appropriate touch.

The counselor should talk with their client about the purpose of touch, both short-term, for example, what they intend to communicate through touch, and longer-term, that is, how it may be expected to help the progress of their counseling (Eyckmans, 2009). They should also discuss the specific type of contact they will use – whether that be a hug, a touch on the elbow, a comforting pat on the back, or pressure on specific points of tension. Once the details of the type and duration of touch have been laid out and accepted by the client, it is the counselor’s responsibility to stay within those boundaries until a change is discussed and consented to (Durana, 1998; Westland, 2011). It should be clear that the client always has the right to deny touch, which in and of itself can be incredibly empowering to clients, especially those with histories of oppression or abuse, who have experienced situations where they lacked that control (Alyn, 1988; Eyckmans, 2009). For some clients, the most powerful growth experience comes not from the actual experience of touch but from being able to say “no” to touch, possibly for the first time in their lives (Hunter & Struve, 1998). The challenge lies in being aware of clients’ reactions to touch, something that can only come through adequate training and open discussion.

In many of the body psychotherapies, the tracking of bodily and nonverbal behavior is taught as a core skill for monitoring reactions to interventions (Martin, 2015). These skills are particularly important for counselors using touch as a specific technique, though they would also be valuable to any clinician, whether they intend to use touch or not. Awareness of one’s own body and somatic experiences is the first step in learning tracking skills and is an important precursor to the use of touch in therapy. The focus then moves to noticing various aspects of the client’s bodily expression, including facial expression, posture, movements, and breathing.

Awareness of nonverbal behavior helps the counselor to more effectively assess the impact of touch and sensitively address those impacts with the client. Consent to use touch is merely a

first step. Any touch used in a session should be treated as an intervention and monitored accordingly. For example, a client may give consent for the counselor to place a reassuring hand on their shoulder. The counselor then may proceed to use the discussed touch but should actively track the client's response rather than assuming that the touch will be interpreted as intended. Should the counselor notice a tensing of the shoulder or change in breathing rate following the touch the counselor should then explore those reactions with the client. Even socially accepted gestures should be treated as an intervention. Counselors are taught to be tuned into responses to opening statements such as "how are you doing today," and should similarly be aware of responses to a nonverbal greeting such as a handshake. For further examples, and for exercises to develop tracking skills, readers are referred to Mischke-Reeds (2018) and Martin (2015).

Research has consistently shown that touch is most effective and least likely to be detrimental to the client when there is open and thorough communication regarding its use (Westland, 2011). In spite of this, counselors are frequently hesitant to talk about touch. Stenzel and Rupert (2004) found that when touch occurred in counseling, over 50% of counselors reported never or rarely explaining its use or discussing it with clients. In supervision groups, discussion of touch is frequently avoided, possibly due to feelings of shame or discomfort concerning what is still considered by many to be a taboo subject in counseling (Harrison et al., 2012). Channels of communication need to be opened, and the experiences of both the client and the counselor explored. By pushing for a deeper exploration of the effects of and reactions to touch, counselors will encourage clients to explore and strengthen their own personal boundaries and, at the same time, will help to reinforce the therapeutic relationship (Durana, 1998). Being able to process the use of physical contact with the client immediately after its use is key to therapeutic efficacy (Geib, 1998).

While decision-making models and basic clinical guidelines provide some level of structure, the key problem remains: most clinicians are not trained or comfortable with talking about touch, much less actually using it in a therapeutic setting. Personal discomfort with a topic leads to avoidance of that material in sessions; education, supervision, and self-exploration are key to remediating the gap (Harris & Hayes, 2008; Margolis & Rungta, 1986). In today's culture of increasing visibility of systemic sexual harassment and the #metoo movement, any deficits in a counselor's ability to thoroughly explore clients' attitudes toward and experiences with physical touch must be considered an issue of competence.

Recommendations and Implications

The primary objective of a training program should be to overturn the taboo concerning touch. As is required for learning challenging skills, working with difficult clients, and dealing with countertransference, the program should strive to provide a safe environment to explore feelings around touch, discuss personal theories and their implications, and to practice using and talking about touch. The use of touch in the counseling setting should not be viewed as deviant or unethical behavior, but as another form of communication and intervention. Students should not be judged for either endorsing the use of touch or personally rejecting its use based on individual experiences, theories, or ethics. In order to promote this openness, the discussion of the topic of touch in counseling should not be limited to a brief mention in ethics courses but should be included in the broader curriculum.

Students and researchers interested in studying touch in counseling will find largely fragmented and outdated empirical data within the field of applied psychology. Research coursework can highlight the importance of drawing from a multidisciplinary perspective when developing research ideas and hypotheses. For the topic of touch in counseling, these disciplines

could include social psychology (e.g. Jakubiak & Feeney, 2016), neuroscience (e.g. Gallace & Spence, 2010), communications (e.g. Burgoon, 2016), and nursing (e.g. Bush, 2001).

Despite limited recent research on the process and proximal outcomes of touch in counseling, there are a number of contemporary body psychotherapies that may include touch in work with clients. Therapies such as these can be discussed in coursework on theories of counseling and psychotherapy. Body psychotherapies are based on years of neuroscientific and psychological research that demonstrates the link between body and mind and have been used in the treatment of various disorders, including depression (Röhrich, Papadopoulos & Priebe, 2013), schizophrenia (Galbusera, Finn & Fuchs, 2018), and trauma-related disorders (Langmuir, Kirsh & Classen, 2012; Leitch, Vanslyke & Allen, 2009).

Foundational skills for using touch in counseling can be incorporated into skills coursework. Information about tracking and body awareness can be incorporated into discussions of nonverbal behavior and body language, and touch can be discussed as a form of communication. Counselors can be encouraged to include exploration of clients' touch histories in intakes and case conceptualizations and taught how to discuss touch with their clients as it applies to both informed consent and therapeutic processing. Cultural history as it relates to touch should be considered, particularly how touch was used by attachment figures in the client's life (Duhn, 2010; Takeuchi et al., 2010). Additionally, while touch has great power to elicit feelings of safeness, for many clients touch has most often been paired with experiences of powerlessness. This is most pointedly seen with survivors of abuse, but has likely been experienced to some degree by many clients, particularly women and clients with less privilege. For these clients, providing an opportunity to take control over their own bodies and tactile experiences can be particularly empowering and transformative (Van der Kolk, 2014).

Decision-making models focusing on touch provide a framework for thinking about the use of touch - yet it is important to practice working with such models outside of therapy. Within sessions, a thorough cognitive analysis of the situation may not always be feasible, and counselors are likely to apply touch as an instinctual response rather than because of cognitive rationalizing (Harrison et al., 2012); hence they should be prepared for as many situations as possible *before* encountering them. Finally, the topic of touch should be presented and discussed in a way that allows counselors to be comfortable discussing it in supervision and consultation, whether it is planned and therapeutic, unplanned and conversational, or incidental. The most important step in ensuring the appropriate use of touch in counseling is to lift the taboo on it and bring it back into clinical and training dialogues.

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