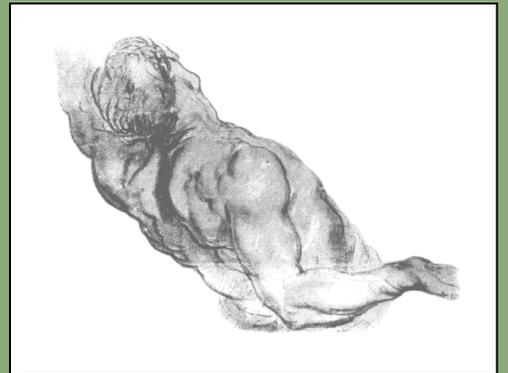


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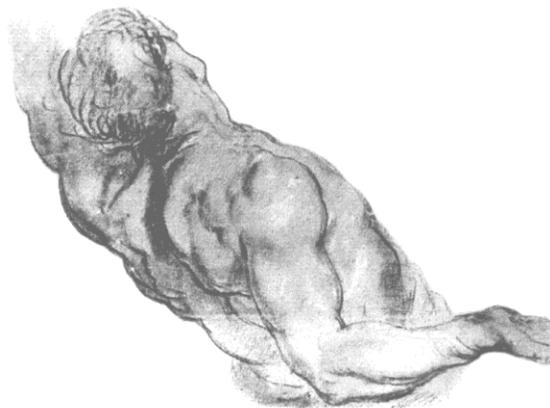


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USABP Mission Statement

The USABP believes that integration of the body and the mind is essential to effective psychotherapy, and to that end its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity.

Clinicians' Use of Touch and Body Awareness in Psychotherapy: Trained vs. Untrained

Anastasia D. McRae, MSW

Abstract

A national purposive expert convenience sample of 164 licensed, practicing mental health professionals responded to an anonymous online survey regarding their use of touch and body awareness in their treatment with clients. The findings show that while training in the use of touch or body awareness does influence positive attitudes toward both, clinicians without training incorporate body awareness at about the same rate as do those with training. In fact, the major difference between those with training and those without surfaced sharply only in the area of actual use of touch. Attitudes and beliefs about the importance of the body, both the therapist and the client's, and of their use as therapeutic tools were very similar.

Keywords

Touch – Psychotherapy – Body awareness

Just as a controversy existed many years ago regarding whether it would ever be clinically appropriate for the psychotherapist to use self-disclosure in therapy (Jourard & Friedman, 1970) a controversy continues among clinicians as to whether the use of touch is or ever can be appropriate in psychotherapy. Touch is perhaps the most powerful way animals communicate. It is only logical that humans have used it for centuries as a way to help each other heal.

Though it is still thought of by many as a taboo, use of touch is a branch of psychotherapy with roots going back to and beyond Freud. Unfortunately, the power of touch brings with it both positive and negative possibilities. As one writer notes, the body and the touching of it are difficult and confusing subjects culture-wide:

Many of the difficulties in integrating bodymind psychotherapy into psychotherapy as a whole are reflecting of general cultural problems around bodies and touch. Body-centered therapy rubs—literally—on some of society's sorest spots. It brings to light all the ways in which themes and experiences of embodiment become traumatizing aspects of individual history, through our culture's deep sickness in relation to sexuality.... Working through the body, and with and through the feeling and thoughts that this work mobilizes, necessarily uncovers our trauma of socialization: a trauma which cannot fully be repaired or undone. To fantasize such an undoing is to fantasize a state outside culture (Totton, 2003, p. 147).

Although Freud once wrote that “the ego is first and foremost a body-ego,” (as cited in Smith, 1998b, p. 5), the person existing with bodily deprivations and needs is something of a pink elephant in the treatment room since Freud ceased touching his own clients and insisted all other analysts in his early psychoanalytic circle do the same (Totton, 2003). Much, if not all, training of psychotherapists is curiously lacking in knowledge relative to seeing the person living within and as a body, other than, perhaps, courses on pharmacological issues and physical trauma.

The field of neurobiology has, however, expanded contemporary conversations concerning the nature of the body in relation to mental and emotional processes. This is especially the case in the area of trauma where it is argued that the brain and physical development of a person are greatly impacted by emotional distress and that the body in turn remembers that emotional distress as physical symptoms that may have no obviously physical antecedents (van der Kolk, 1994; Ogden, 2000; Solomon & Siegel, 2003).

In recent years studies also show the increased use of complementary and alternative therapies by populations engaged in psychotherapy, including touch therapies like massage, acupuncture, and Reiki, Bioenergetics, etc. (Elkins, G., Marcus, J., Rajab, M. H., & Durgam, S., 2005; Field, 1998a, 1998b; Mamtani, R. & Cimino, A., 2002). Many clinicians in the mental and physical health arenas, often users of alternative modalities themselves, have turned to what is today termed *holistic medicine* in an effort to span what had become the chasm between treatment of the *bodymind*. Some of these clinicians have sought out formal training in or dialogue on the use of touch or body awareness and use one or both in their psychotherapy practice. Even still, most psychotherapists continue to think of touch in the treatment room as contraindicated for their patients, and legally and ethically risky, if not outright dangerous for the patient and therapist.

The purpose of this study was to answer the following question: “Do clinicians with training regarding the use of touch and body awareness report using these modalities more often and report more positive attitudes towards them than do clinicians who report no training in the area?” This research question incorporates two hypotheses of difference: 1) that training in the use of touch and body awareness engenders more use of both among mental health professionals; and 2) that training is also a significant predictor of a clinician's attitudes and beliefs about the use of touch and body awareness. The sample includes clinicians with and without training in the use of touch and body awareness. The term *bodywork* refers to the intentional use of systematic touch to therapeutically assist clients in the integration of body awareness and the release of

stored habitual tension patterns. *Body awareness* is defined as a means of perception as experienced through movement, gesture, illness, or sensation. While these were the main hypotheses, the results of the study revealed a number of avenues for future related research.

METHODOLOGY

Formulation

This study was conducted using a mixed method, relational design, in an effort, as Anastas writes, "...to describe whether or not a phenomenon or a characteristic of it is systematically associated with another phenomenon and, if so, how" (Anastas, 1993, p. 150). The study used primarily quantitative survey questions with a limited number of qualitative questions. The participants were comprised of mental health professionals, including clinical social workers, psychoanalysts, and otherwise licensed professional counselors.

The mixed method design was appropriate for this study in two ways: it allowed for the quantification of responses as well as some possibility for deeper narrative response. One weakness of the quantitative portion of the study is that during data analysis it is difficult to ask all the necessary questions to account for the multitude of variables present thereby forcing the researcher to ask and answer only a small selection of questions that will undoubtedly leave many more questions unanswered. A weakness of the qualitative sections is again during data analysis, as the complete richness of the coded data may not come through due to the difficulty in finding similarities in every answer. "No study can presume to isolate, measure, and discuss every variable of possible interest" (Anastas, 1993, p. 157). With that in mind, the vision of this study is to serve as a preliminary effort that may lead to future research.

Sample

A purposive expert convenience sample of one hundred sixty-four mental health professionals took part in this study. Clinicians were able to participate if they were licensed mental health professionals—either as psychotherapist, psychoanalyst, professional counselor, or clinical social worker—with at least five years clinical experience. If the clinicians currently used a specific touch modality, they needed licensure or certification to practice that particular modality to participate in the study.

Data Collection

Participants were asked to complete a fifteen-minute thirty-six question anonymous online survey about their use of body awareness and touch in sessions with clients, about their training and familiarity with touch and body awareness as a component of their practice, as well as about their attitudes about touch and body awareness. There was also a series of demographic questions for participants to answer.

Quantitative data was collected because of its concreteness and the opportunity of doing correlational analyses, while qualitative data was collected for the richness of more individualized, in-depth and personal responses that numbered responses to survey items might not capture. The design of one question in the survey instrument (#17) replicates Smith's taxonomy of touch (Smith, 1998a). Smith's taxonomy allowed for the inclusion of a recognized, accepted, and clear categorization of touch (Durana, 1998; Stenzel & Rupert, 2004).

Licensed mental health professionals were recruited through the Smith College School for Social Work alumni association (graduates from 2005 or earlier to ensure at least five years in practice), the National Association of Social Workers, the American Psychological Association—Divisions 29 and 39, and the Illinois Association of Clinical Social Workers. Clinicians who might have more formal training in the use of touch and body awareness were recruited through national organizations, schools, and training facilities including the California Institute of Integral Studies, the Naropa School, the United States Body Psychotherapy Association, and the training institutes for Hakomi, the Rosen Method, and the Rubenfeld Synergy Method. Participants were also identified through association or a snowball sampling method by which participants were encouraged to pass along the survey to colleagues they identified as having interest in the study.

Recruitment began with phone calls and emails to the above listed organizations after receipt of approval from the Smith College School for Social Work's Human Subjects Review. Once initial contact was complete, a recruitment letter was sent electronically to the identified person who had agreed to send it along to the organization's list-serve. The recruitment email included information about the intent and description of my study, participation requirements, and the risks involved in participation.

Once possible participants received the letter and agreed to take part in the study, they received instruction, in the body of the letter, to click on a link that took them to the online survey. The first page available to participants was the informed consent to which they answered YES or NO prior to proceeding to the instrument. If they answered YES, they went to the first question of the survey. If they answered NO, they went to a "thank-you" page and directed out of the survey.

Participants were also asked to supply demographic information pertaining to age; sex; years in practice; state of licensure; type of mental health licensure; theoretical framework from which they work; type of arena in which they practice; and how they identify racially or ethnically.

Data Analysis

Once the data were collected, statistical tests were run to ascertain any relationships among variables using descriptive statistics, including frequencies and cross-tabulations. Descriptive statistics were further utilized to view the data based on which respondents reported some level of training and which did not and to ascertain whether chi-square tests for difference were possible. Chi-square tests were run for gender; use of touch and body awareness, and training variables on a series of questions highlighted as those most salient in regard to use of touch and body awareness and the therapist attitude toward both.

FINDINGS

The absence of training and dialogue about the use of touch and body awareness in psychotherapy has been cited as one plausible reason for ethical misconduct vis-à-vis physical contact in the treatment room. This research project focused on a small facet of this debate by asking whether training in the use of body awareness and the use of touch among licensed mental health professionals was a predictor of more and different, non-erotic, use of physical contact. The major finding of this research is that training does have an effect on both use of and attitudes about touch and body awareness in the psychotherapy practice of those surveyed. The results also revealed continued ambivalence about the use of touch, even among those reporting training in a body-oriented modality.

Characteristics of Respondents

164 respondents between November 2007 and February 2008 started online surveys. 103 surveys were complete and useable. Surveys were eliminated due to missing consent or demographic information; out of country mental health licensure; and listing a non-recognized mental health licensure or theoretical background. The following demographic information is for the remaining sample (N=103). Respondents to the survey were a diverse group across sex, age, practice setting, years in practice, and location (see Table 1).

Overall Sample Characteristics

The median age of the respondents in the sample was 51 with the maximum age at 86 and the minimum at 29. Ninety-one (88.3%) of the respondents were female and twelve (11.7%) were male. Respondents answered variously to an open-ended question about race or ethnicity with 79.6% answering "Caucasian or White;" 8.7% "Jewish;" 2.9% "Arab-American or Lebanese American;" 1.9% each for "African American or Black," "Latina or Hispanic," and "Native American;" and 2.9% answered "Other" (see Table 1).

The median number of years in practice among the respondents is 17. More than half of the respondents (54%) reported working in private practice settings (see Table 1). Twenty-six states are represented in the sample as counted by licensure, including Arizona, Connecticut, California, Illinois, Massachusetts, Washington, and West Virginia (see Table 1). The bulk of the sample (73.8%) reported having mental health licensure as clinical social workers though there was others represented (see Table 1).

The reported theoretical framework of responding clinicians varied a great deal. The largest grouping was of psychodynamic therapists (N=37), followed by those claiming an eclectic background (N=19). Other frameworks reported were psychoanalytic (N=6), Body Oriented or Centered Psychotherapy (N=7), Jungian (N=5), CBT (N=5), Somatic Psychotherapy and Integrative (N=4, each), Gestalt, Object Relations, and Narrative (N=2, each), and Other (N=10).

TABLE 1

Demographic Characteristics of Respondents

	Frequency	Percent			
Sex					
Female	91	88.3			
Male	12	11.7			
Race or Ethnicity					
Caucasian or White	82	79.6			
African American or Black	2	1.9			
Jewish	9	8.7			
Latina or Hispanic	2	1.9			
Arab or Lebanese American	3	2.9			
Native American	2	1.9			
Other	3	2.9			
Mental Health Licensure					
Clinical Social Worker	76	73.8			
Marriage and Family Therapist	8	7.8			
Professional Counselor	10	9.7			
Psychiatrist	2	1.9			
Psychologist	6	5.8			
Other	1	1.0			
Practice Settings					
Private Practice	56	54.4			
Community Mental Health	21	20.4			
Adult or Child Inpatient	2	1.9			
Hospital Adult or Child Outpatient	3	2.9			
Other	21	20.4			
States Represented by Licensure and Distribution of Respondents					
Arkansas	1	Massachusetts	21	Oregon	2
California	12	Maine	4	Pennsylvania	3
Colorado	6	Maryland	4	Rhode Island	1
Connecticut	10	Minnesota	1	South Carolina	1
Delaware	1	North Carolina	2	Texas	1
Florida	1	New Hampshire	1	Virginia	1
Georgia	2	New Mexico	4	Washington	2
Hawaii	2	New York	10	West Virginia	1
Illinois	4	Ohio	1		

Characteristics of Those Reporting Some Level of Training in the Use of Touch or Body Awareness

The sample was further broken down according to those who reported some level of training in the use of touch or body awareness. Of the total sample, 59.2% reported having some training in touch and body awareness and their use in the treatment room either through coursework, in supervision, or for a bodywork modality (see Table 2). Fifty-three women (58.2%) reported some training in the use of touch or body awareness and eight men (66.7%) had some training. By mental health licensure, the majority (83.3%) of the psychologists, half of the psychiatrists, 47.4% of the clinical social workers, and 100% of both the marriage and family therapists and the professional counselors reported some level of training in this area. The mean age for this group was 51.70 and the mean number of years in practice was 18.97 (see Table 2).

Clinicians involved in a particular body centered psychotherapy reported training that had lasted, for most (77.4%), more than one academic term, included personal treatment as part of the training (82.1%), involved information on professional ethics (86%), and included methods to help in the integration of the modality into their mental health practice (71.9%). Clinicians trained in a formal bodywork modality or particular branch of body centered psychotherapy reported practicing from many schools of thought including Reichian therapy, Somatic Experiencing, Radix, Rubenfeld Synergy Method, the WaveWork, Hakomi, Cranial Sacral therapy, Bodydynamics, Polarity therapy, Reiki, Sensorimotor Experiencing, and Rosen Method Bodywork.

General Findings

The findings are grouped below in two primary areas: attitudes and beliefs about and the actual use of touch and body awareness in mental health practice with a focus on the differences between those who reported some training in the use of touch or body awareness and those who did not.

Attitudes and Beliefs

Attitudes and beliefs were assessed through a subset of questions designed to get an impression of how clinicians in this study thought about the physical body as a clinical component of the psychotherapy process. Likert scaled questions and an open-ended question focused on the respondents' emotions, thoughts, or concerns about their participation in the study.

A majority (91.8%) of those reporting some level of training said they view tending to the physical as equally important as tending to the emotional while over half (65.9%) of those who reported no specific training in the use of touch or body awareness agreed that the physical is equally important. A similar trend is apparent in ideas about memories stored in the body and a clinician's use of both her and the client's physical reactions during treatment. Some part of the work of many clinicians (91.8% of those with training, 85.7% of those without) in this study is informed by a belief that memories are stored in the body and have an effect on the health and well being of the client.

Two respondents, both reporting some level of training, voiced their opinion about the importance of training in these areas:

My... training was NEVER to touch clients. I do a lot of supervision of interns and discuss touch with my students regularly. I do believe therapists should think before using touch and should understand why they do it. It should never be for the therapist's comfort or benefit. Body awareness and discussion of body experiences are a critical part of my work in a family trauma clinic. It is helpful for me that touch is openly discussed in my workplace and a topic of clinical team meetings as well as trainings. [Respondent reported training in the form of classroom discussions, seminars, and supervision.]

I've worked in the mental health field for many years and the profession has given me mixed messages when it comes to "touch," "feel" so I have had to rely on my own personal professional opinion. The majority of cases that I carry are either latino/a or african-american ethnic/culture. I try to accommodate & respect the individual's culture and rituals. [Respondent reported training in the form of seminars.]

Another respondent who reported no training in the use of touch or body awareness stated his or her concern a little differently: "[I] now have a fuller appreciation of what use of touch can mean, and I now see that I use it and think about it more often than I realized." [Respondent reported no training.]

A respondent who reported formal training in a bodywork modality wrote in: "For me in general touch belongs to human being. We all learned in an essential way through being touched, so using touch in psychotherapy is an important tool for learning about oneself and for communication."

Respondents saw the bodily reactions of the clinician along with those of the client as important indicators in the course of treatment. Ninety-five percent of those with training and 73.8% of those without training strongly agreed or agreed

that their bodily reactions and those of the client are important information. It is salient in each of the three instances mentioned that even those without training, more than half from that group, think of the body, both theirs and the client's, as important and are influenced by their awareness of physicality in the room. Some, however, voiced concerns about scope of practice:

I think that touch is not really the role of a psychotherapist, unless one wants to pursue a specialization, such as Reiki, and offer services concurrently. I see this as both a therapeutic and legal issue. We should be professionally qualified for the things we do. That said, I think that discussion of sensations in the body, body memory, and physical experience should occur more. This allows a clinician to reach more clinical topics with quiet individuals, cultures who may be more likely to experience feelings somatically, and of course, people experiencing illnesses. I think that clinicians are sometimes concerned that they are not qualified to discuss physical or medical experiences not having gone to medical school. I think that this is a shame. We are not providing medical interventions. We are opening new dialogues. Mind and body do not stand juxtaposed to each other. [Respondent reported no training on the use of touch or body awareness.]

There are basic ethical principles that must be followed whether one uses touch or not. Therapists must be educated in the modality and experience total comfort when employing touch in therapy. [Respondent reported formal training in a bodywork modality.]

TABLE 2

Characteristics of Those Reporting Training in Body Awareness or Use of Touch

	Frequency	Mean	Percent
Female	53	--	58.2
Male	8	--	66.7
Years in Practice	--	18.97	--
Age	--	51.70	--
Mental Health Licensure			
	Frequency	Percent	
Clinical Social Workers	36	47.4	
Marriage and Family Therapists	8	100	
Professional Counselors	10	100	
Psychiatrists	1	50	
Psychologists	5	83.3	
Type of Training in Body Awareness Or Use of Touch			
	Frequency	Percent	
Classroom Discussion	27	26.2	
Seminar or course	41	39.8	
Supervision	42	40.8	
Formal Training	41	39.8	

In terms of their clarity about the validity and use of touch in the psychotherapy there was a sharp divide between the groups. While eighty-five percent of those with training strongly disagreed or disagreed that they were unclear about the use of touch and its validity, 42.9% of those without training strongly agreed or agreed that they were unclear on this point, and 38.1% of those without training were not sure or neutral about touch's use and validity. Some respondents explained it in the following manner:

Taking this survey reminds me of how split I am about touch. I believe it can be helpful, but I'm also committed to practicing w/in the limits of my professional license. [Respondent reported formal training in a bodywork modality.]

When I consider touch, and we in Hakomi do a lot, I am again aware of my own ambivalence of using it and not because I think there is anything wrong with it, but I always worry about how it is interpreted by a client. [Respondent reported formal training in a bodywork modality.]

I tend to have a negative response to the use of touch in therapy, except occasionally with older people, so I felt a little old fashioned/rigid in my responses. However, I do believe that, with the exception of people trained in specific body-based techniques, one has to be very cautious about the impact that touch can have on a client and the therapists' needs that may be involved. [Respondent reported no training in the use of touch or body awareness.]

Though participants from neither group said they always or almost always had a sense of doing something wrong or feared facing ethical or legal ramifications for using touch, 16.7% (N=16) did sometimes have this concern, 36.5% (N=35) had it rarely, and a little less than half (46.9%, N=45) never had a sense of ethical or legal repercussions. The majority of those with training, 60.7%, never had the sense of wrong doing while the majority of those without training, 47.5%, rarely had that sense.

Comparison of Attitudes and Beliefs of Therapists by Report of Training in the Use of Touch or Body Awareness in Psychotherapy
Table 3

1- Tending to the physical in psychotherapy is as important as tending to the emotional and mental processes ?

	Frequency (N)	% With Training	% Without Training
<i>Yes</i>	83	91.8	65.9
<i>No</i>	19	8.2	34.1

2- A belief that memories are stored in the body and affect the health and well being of clients informs some part of my work.

	Frequency (N)	% With Training	% Without Training
<i>Strongly Agree</i>	53	75.4	16.7
<i>Agree</i>	39	16.4	69.0
<i>Neutral/Not Sure</i>	7	4.9	9.5
<i>Disagree</i>	3	1.6	4.8
<i>Strongly Disagree</i>	1	1.6	0

3- My bodily reactions and those of the client are important indicators for me in the course of clinical treatment.

	Frequency (N)	% With Training	% Without Training
<i>Strongly Agree</i>	50	71.7	16.7
<i>Agree</i>	38	23.3	57.1
<i>Neutral/Not Sure</i>	11	3.3	21.4
<i>Disagree</i>	2	0	4.8
<i>Strongly Disagree</i>	1	1.7	0

4- I am unclear about the validity and use of touch in therapy.

	Frequency (N)	% With Training	% Without Training
<i>Strongly Agree</i>	5	0	11.9
<i>Agree</i>	17	6.7	31.0
<i>Neutral/Not Sure</i>	21	8.3	38.1
<i>Disagree</i>	26	31.7	16.7
<i>Strongly Disagree</i>	33	53.3	2.4

5- When I have used touch I have a sense that I am doing something wrong or will face ethical or legal repercussions.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	0	0	0
<i>Almost always</i>	0	0	0
<i>Sometimes</i>	16	10.7	25
<i>Rarely</i>	35	28.6	47.5
<i>Never</i>	45	60.7	27.5

Table 3 shows a larger percent of clinicians who had received training in use of touch or body awareness answered positively when asked about their attitudes and beliefs. Chi-square analyses were run to determine if these differences were significant. There was a significant difference in "Tending," "Body Reactions," and "Touch as Valid" (see Table 4). There was no significant difference in the variables "Body Memory" and training. The results of this analysis partially support the hypothesis that there is a significant relationship between training and attitudes and beliefs.

TABLE 4

Chi-Square Results 1: Training and Attitude

Variable	df	N	Value	p
Tending	1	102	9.248	.002
Body memory	-	---	----	-----
Body reactions	1	102	7.664	.006
Touch as Valid	1	102	17.049	.000

Use

Just over half (51.4%) of the entire sample reported rarely or never using touch in their psychotherapy practice. The other 48.6% reported using it at least some of the time. A portion (22.1%) of those respondents without training experienced using touch almost always or sometimes. Though many (70.5%) of those with training in the use of touch and body awareness reported using touch in their psychotherapy practice almost always or sometimes, some reported rarely (11.5%) or never (13.1%) doing so (see Table 5).

Respondents shared a range of opinions about their clinical experiences in specific instances with the use of touch: One long-time client, not particularly psychologically sophisticated and very sensitive, used to ask me regularly for a hug at the end of her session. For a long time, I acquiesced. Eventually, I began to feel less and less comfortable with the "routine" and tried to talk with her about ceasing the practice, mumbling something inchoate about "feelings need to be talked about, not acted on..." She was understandably devastated, had little comprehension of what I was talking about, and felt primarily rejected and confused. Today, I'd have done the whole thing quite differently, but I wouldn't have necessarily ceased the practice -- just processed it better! [Respondent reported no training in body awareness or the use of touch.]

I practice both psychotherapy and Rosen Method Bodywork. Touch is never used in psychotherapy. Touch is only used when the client has contracted to participate in Rosen Method Bodywork with this practitioner. [Respondent reported formal training in body awareness or the use of touch.]

There are times in a client's process that I use touch to support an already happening process. Ie: a client in a fetal position, touching (with permission), a foot so she knows she is not alone in her deep process. I rarely use touch, even though I was trained to, and always ask permission. I use touch less with men and gay women in my practice. [Respondent reported formal training in body awareness or the use of touch.]

My theoretical stance is that touch IS appropriate in some cases, and I have used touch with some of my clients. Social work ethics (NASW) include the use of appropriate touch. [Respondent reported no training in body awareness or the use of touch.]

I have only used touch w/ clients in a setting that structures the use of touch in the therapy, such as Hakomi training. In my "office" practice as an LPC I do NOT use touch. [Respondent reported formal training in body awareness or the use of touch.]

One client who was pregnant and emotionally rejecting. The client was able to realize her emotional conflict through the use of touch. As she became aware she was completely numb to the sensations of the baby inside her, she was able to access her fears and sadness about being pregnant. By the following session she was letting her husband feel the baby move and genuinely bonding with the baby. [Respondent reported no training in body awareness or the use of touch.]

A majority (85.2%) of respondents reporting some level of training always or almost always incorporated body awareness into their clinical practice while three-quarters (78.6%) of the respondents without training reported doing so almost always or sometimes. Of those respondents without training, 21.4% rarely or never incorporated body awareness into their psychotherapy treatment (see Table 5).

Examples from respondents of their use of body awareness in treatment with clients:

I was meeting with a 9 year old girl who was very angry about her foster care situation and had started having anger outbursts in school, which were very uncharacteristic of her. She expressed frustration at not being able to feel the anger coming on. We acted out feeling angry and once she was able to recognize the feeling of anger in her body she could address it before it became an outburst. [Respondent reported no training in body awareness or the use of touch.]

I have a counter dependent client who uses a certain gesture to indicate that she is fine, and I pointed out this gesture to her, so that she can be aware of moments of pushing away feelings of need. [Respondent reported no training in body awareness or the use of touch.]

Therapists surveyed about use of their body sensations to inform their approach with clients showed similar results, with 83.6% of those with training almost always or always doing so, 73.8% without training almost always or sometimes doing so, and 14.3% of those without training doing so rarely or never (see Table 5).

Comparison of Use Tendencies of Therapists by Report of Training in the Use of Touch or Body Awareness in Psychotherapy
Table 5

1- I incorporate body awareness into my clinical practice.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	25.9	45.9	0
<i>Almost always</i>	34	39.3	23.8
<i>Sometimes</i>	31	13.1	54.8
<i>Rarely</i>	6	1.6	11.9
<i>Never</i>	4	0	9.5

2- In my clinical practice, I am aware of and utilize my own body sensations to inform my approach with clients.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	36	50.8	11.9
<i>Almost always</i>	32	32.8	28.6
<i>Sometimes</i>	28	14.8	45.2
<i>Rarely</i>	6	1.6	11.9

<i>Never</i>	1	0	2.4
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3- In my clinical work I notice and talk with clients about their physical realities---

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	16	23	4.8
<i>Almost always</i>	40	49.2	23.8
<i>Sometimes</i>	38	23	57.1
<i>Rarely</i>	8	4.9	11.9
<i>Never</i>	1	0	2.4

4- I have had the experience of using touch as an element in my clinical practice.

	Frequency (N)	% With Training	% Without Training
<i>Always</i>	3	3	0
<i>Almost always</i>	13	21.3	12.6
<i>Sometimes</i>	34	49.2	23.8
<i>Rarely</i>	8	4.9	11.9
<i>Never</i>	1	0	2.4

Helping clients to examine their physical reactions in the treatment room was reported by 72.2% of those with training always or almost always with the largest percent (49.2%) reporting almost always doing so. A majority (80.9%) of therapists without training reported incorporating client physical responses almost always or sometimes with the highest number (57.1%) reporting sometimes. Only 7.8% of the entire sample reported rarely doing this and 1% never doing so (see Table 5). One therapist who reported some training in body awareness and use of touch wrote:

I have worked in inpatient and outpatient settings with trauma survivors. I encourage my clients to find the place in their bodies where they feel a particular feeling the most and, when appropriate or requested, I will sit next to a client and, with their permission, put my hand on their hand that holds the feelings to help them feel like they are sharing the feelings with me.

Table 7 shows the type of touch used by therapists in the sample, according to gender and training. Socially ritualized touch, as in handshakes, is the most used type of touch by both therapists with training in use of touch and body awareness and those therapists without training. Those with training chose touch as technique as the second most used form of touch. Therapists without training were much more likely to touch inadvertently (54.7%) than were those with training (14.7%). Interestingly, only 57.3% of those with training said they use touch as technique (see Table 7).

Table 6 displays results of when sample respondents offered touch. Reports of when touch occurred during treatment were similar for both groups in all but three areas. Therapists with training were more likely to use touch when they thought it would help with client self-disclosure (41.1%) than those without training (0%). Therapists without training indicated that they used touch most often at the end of treatment (71.4%) than those with training (42.6%). Therapists with training rated using touch with clients at the clients' request higher (54.1%) than those without training. Both groups were just as likely to use touch at the end or beginning of a session and when a client is sad or anxious.

Some clinicians expressed their positions on when they offer touch as follows:

I never use touch other than a greeting handshake, or termination handshake or hug. Physical sensations are more a conversation topic. I believe strongly in discussion of physical sensations as being relevant to psychiatric state. I just do not believe that touch is my role. [Respondent reported no training in the use of body awareness or touch.]

I do NOT use touch as regular part of my clinical work. For me, touch is part of the "social framework" such as handshakes, guiding people down a hallway (holding child's hand), etc. My theoretical framework does not incorporate touch so when I do touch a client, I do have to consider if it is clinically appropriate - most of the time, I don't feel it is clinically appropriate. [Respondent reported no training in the use of body awareness or touch.]

Working a lot with female traumatized clients I have often used touch with the outcome that clients became more relaxed and in some cases could speak about difficult experiences why they were touched. At the same time they were able to put their body awareness into words. [Respondent reported formal training in the use of body awareness or touch.]

Table 4 shows a larger percent of clinicians who had received training in use of touch or body awareness answered positively when asked about their use of touch and body awareness. Chi-square analyses were run to determine if these differences were significant. There was a significant difference in "Body Awareness," "Use of Client Body," and "Actual Touch" (see Table 8). A chi-square analysis could not be run to determine if there was a difference in "Use of Own Body" since more than 20% of cells had expected value of less than 5, which violates an assumption necessary for the use of chi square. The second major hypothesis, that training in the use of touch and body awareness engenders more use of both among mental health professionals, was partially supported by the results of this analysis.

TABLE 6
When Touch Offered by Training and Gender

	Female		Male	With Training	Without Training
	N=91	N=12	N=61	Total Checked (%)	N=42
End or beginning of session	44.0%	50.0%		27 (44.3%)	19 (45.2%)
End of treatment, at termination	56.0	41.7		26 (42.6%)	30 (71.4%)
When client sad/anxious	30.8	8.3		17 (27.9%)	12 (28.6%)
For client self-disclosure	24.2	25.0		25 (41%)	0 (0%)
When client requests	50.5	41.7		33 (54.1%)	18 (42.9%)

TABLE 7
Touch Category by Training and Gender

	Female		Male	With Training	Without Training
	N=91	N=12	N=61	Total Checked (%)	N=42
Inadvertent-- not intentional	31.9%	25%		9 (14.7%)	23 (54.7%)
Conversation marker	38.5	33.3		22 (36%)	17 (40.4%)
Socially ritualized	75.8	83.3		48 (78.6%)	31 (73.8%)
As an expression of comfort	42.9	33.3		28 (75.9%)	15 (35.7%)
Touch as technique	31.9	50.0		35 (57.3%)	0 (0%)

Gender Differences

Women (N=91) and men (N=12) reported mostly comparable answers in attitude and actual use of body awareness and touch except in three broad areas. The subset of questions on attitude revealed no major differences between men and women in the sample. Women were more likely to use body awareness (61.5%). Fifty percent of the male respondents reported using touch as technique as opposed to the 31.9% of female respondents. The time at which touch was offered showed the most contrast between women and men. Women reported offering touch more during termination (F=56%, M=41.7%), and when client is sad or anxious (F=30.8%, M=8.3%) than their male counterparts.

TABLE 8

Chi-Square Results 2: Training and Use

Variable	df	N	Value	p
Body awareness		103	39.96	.000
Use of own body	---	---	---	----
Use of client body		103	19.06	.000
Actual Touch		103	43.85	.000

Narrative Data

The general narrative themes that surfaced in the answers from clinicians in the study when asked in what kind of situation did touch occur are as follows: when offering specific bodywork, in situations of trauma and grieving, at termination, when client asked for a hug, with young children, at the beginning of a session, in culturally specific context. Some answered that they do not touch or that touch is not appropriate. Most answering this question stated that they used touch in their general practice. Some who do use touch reported not doing so in a psychotherapy context and some acknowledged that touch is feasible under certain conditions according to NASW guidelines. Some of these comments are distributed throughout this chapter.

For the particular touch incident described in earlier statements, therapists were asked to describe what they attributed to either the negative or positive outcome of the incident. General themes were: unsure if the incident were positive, that clients felt connected; it was a planned touch; clients connected to a physiological sense of themselves; it was a corrective emotional experience; it enhanced and clarified the client’s self-awareness; and the healing intention of the incident. Others described their experiences this way:

Negative outcomes

I believe I was too rule-bound in how I explained not wanting to hug. I wish I had been more reflective about my own personal comfort or discomfort and then disclosed a version of that. The clinical moment might have been useful had I been able to do so. [Reported no training.]

The negative outcome (her hurt and confusion) was directly attributable to my inept processing, largely, in turn, due to the rather doctrinaire nature of my psychodynamic training conflicting with my own better instincts and preventing my effective internalization of the role of physical contact in an authentic treatment moment. [Reported no training.]

The first client laughed about the gesture, and felt more comfortable admitting to certain needs. When I did hold the second client's hand for a moment, she became calmer because she felt more accepted, and we talked about it during her next appointment, as well as discussion of her waiting for me, etc. The whole thing was a crisis in the therapy. [Reported no training.]

Positive outcomes

People become aware of their body as having memory and history and are able to connect, heal, and release traumatic events and/or patterns that are no longer working with them in their highest good. [Reported no training.]

Clear patient therapist boundaries, clear exploration re: potential meaning of hug. Ability to process effects of hug in next treatment session. [Reported formal training.]

Every traumatic experience seems to involve mental, emotional, spiritual, "energetic" and physical components and memories, and to the extent that all are released, the healing is more or less thorough and permanent. [Reported formal training.]

Only a few therapists (26.6%) who reported using touch also reported using outcome measures to assess the effectiveness of their use of touch. Of those still fewer elaborated on the type of measure used. The general themes from the narrative data of this question focus on changes in client self-perception, changes in the therapeutic alliance, client feedback, and checking in with the client.

Overview of Results

The results of this study reveal a relationship between training in the use of touch and body awareness and attitudes and use among mental health professionals surveyed. It was found that those with training were more likely than those reporting no training in this area to have more affirming beliefs about the use of touch and body awareness and to use both more often in their psychotherapy practice. These results surfaced even though the majority of those without training used body awareness at least some of the time and held mostly similar attitudes about the use of touch and body awareness. Distinct divisions emerged concerning actual use of touch and clarity about touch's validity in the treatment room.

Overall, more respondents used body awareness than touch. Most (51.4%) answered that they rarely or never used touch in their psychotherapy practice. The most used type of touch was socially ritualized touch, as in handshakes or pats on the back. The majority of respondents offered touch at the end of treatment, during termination. These results are congruent with previous studies on the use of touch in psychotherapy.

DISCUSSION

A review of the literature revealed that the use of touch in psychotherapy is still very much addressed in terms of stark contrasts of positives and negatives and often met with ambivalence. Yet the literature also reflects a change over time in attitude among mental health professionals about the body and body awareness -- a change that may have led some mental health professionals to seek out training in or dialogue about the use of touch and body awareness in psychotherapy. Although literature is beginning to appear that stresses training as an important element when incorporating touch or body awareness in psychotherapy, there is a lack of empirical data concerning those mental health professionals who do have training in the use of touch or body awareness.

The question guiding the current research investigated the effects of training in the use of touch and body awareness on clinicians' attitudes toward, and use of, both touch and body awareness in psychotherapy treatment. This question incorporated two hypotheses: 1) that training in the use of touch and body awareness engenders more use of both among mental health professionals; and 2) that training is also a significant predictor of a clinician's attitudes and beliefs about the use of touch and body awareness. This mixed-method study sought to understand any relationship between training in the use of touch and body awareness and the attitudes and behavior among those mental health professionals surveyed.

Current Findings and Previous Literature

The findings show that training in the use of touch and body awareness does affect how mental health professionals think about and use body awareness and touch in psychotherapy. The results of this research show a relationship between training in the use of touch and body awareness and positive attitudes about touch and body awareness as well as increased use of both in psychotherapy. Chi-square analyses found significant difference in three of the four questions in both subsets targeting actual use of touch and body awareness ($p > 0.00$ for each question) and attitudes and beliefs ($p > 0.00$, $p > 0.02$, $p > 0.06$) about both, thereby partially supporting both of this study's hypotheses.

Those mental health professionals surveyed who reported some level of training in the use of touch and body awareness were more likely to have used both body awareness and touch in psychotherapy, have more comfort and clarity about the validity of touch in psychotherapy, and less worry that the use of touch and body awareness is inappropriate. Training seems to produce a more thoughtful consideration of use of touch and body awareness and an allowance for touch as part of a treatment continuum as echoed by a number of writers on this topic (Greene, 2001; Leijssen, 2006; Milakovich, 1998; Petrucelli, 2007; Shaw, 1996; Smith, 1998a; Totton, 2003).

It is not surprising, then, that a larger percentage of clinicians who had received training in use of touch or body awareness answered positively when asked about their attitudes and beliefs and were also more likely to use touch and body awareness in their psychotherapy practice. Several authors and researchers (Durana, 1998; Kertay & Reviere, 1993; Smith, 1998a; Stenzel & Rupert, 2004) link training in some type of body-oriented modality, access to other mental health professionals with whom to process touch related incidents, or involvement in a theoretical framework that allows for touch or body awareness as valid treatment modalities leading to more informed and less ethically questionable usages of touch.

Interestingly, with over half (59.2%) of the sample reporting some level of training in the use of touch and body awareness, a little less than half (48.6%) of the sample reported using touch in their psychotherapy practice. Of the remaining 51.4% who reported never or rarely using touch, 14.6% of that number reported receiving some form of training in touch and body awareness. The original hypothesis that training would tend to make therapists more likely to use actual touch was only partially supported. It may be that anxiety about risks still constrains many from use of the modality that they have sought

training in. Some of the narrative comments seem to suggest that being able to dialogue about touch and body awareness may increase the self-reflection that could lead to ambivalence and wariness due to more focused consideration of the issues related to the body in psychotherapy. The ambivalence among therapists who reported training in a formal body work modality was also salient in the narrative data, and is consistent with clinicians who are very keen on the use of body awareness treatment, but who do not advocate touch (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006; Rothschild, 2000).

Those who reported no training in use of touch or body awareness were slightly less likely to use body awareness, much less likely to use touch, and when they did use touch seemed unclear about why they used it, were unsure if it had been a positive experience for the patient, and did not know whether touch could be a valid intervention. These clinicians do use touch but with higher levels of ambivalence and added confusion about why and whether it is appropriate. The results of this study partially support the thinking that body awareness is a murky reality for most therapists not trained in a body-oriented modality and who have not had the opportunity to discuss these issues in a professional setting (Orbach, 2003b; Totton, 2003) and that therapists are not as comfortable with their own bodies as they are with the client's body as informational tools in treatment (Leijssen, 2006; Ventling, 2002). Strozier, Krizek, and Sale (2003) report similar findings on touch use among clinical social workers in terms of their sample's inability to clarify why they chose to use touch as well as their overall lack of exposure, through formal training or supervision, to the use of touch or body awareness concerns.

While training is a powerful influence on the use of and attitude about touch and body awareness in psychotherapy, it is not a predictor of whether or not touch will be used. In her study of the differences between therapists who touch and those who do not, Milakovich pointed to other aspects that influence therapists' use of touch, in addition to training in a body-oriented modality. Most notably, she highlighted the significance of therapists' personal and professional experience with touch (Milakovich, 1998). Though the current research did not ask about personal and professional experiences of touch and body awareness directly as did other research (Clance & Petras, 1998; Milakovich, 1998; Strozier, Krizek, & Sale, 2003), this researcher is aware that factors other than training affect how mental health professionals will work with touch and body awareness. In fact, it is reasonable to assume that there was possibly a predisposition among those who chose to participate in this study towards more positive interest in body awareness, the body, and the use of touch by the very fact that they volunteered to take part.

Self-awareness and professional dialogue are both thought to be crucial components in the ethical use of touch and body awareness (Durana, 1998; Kertay & Reviere, 1993; Smith, 1998a; Wilson, 1992). The current research found that 86% of those with training in a formal body-oriented modality answered that they had received ethics information as part of their training and were less likely to fear legal repercussions due to use of touch in their practice. It is encouraging that those with formal bodywork training do feel ethically prepared to make use of that training in practice, even if some of them, as seen in the narrative statements, choose not to use touch for reasons related to ethics and the currently received wisdom about the proper scope of practice boundaries.

The type of touch most often offered is indicative of the influence of training in the use of touch and body awareness. Even with the noted ambivalence of those with training toward touch in practice, they did not report using inadvertent touch as a method, where clinicians without training choose it as the second most used form of touch.

Use of an online survey significantly increased the number of respondents for the sample, much more so than a mailing to the same organizations would have produced. The ease of making contact with organization representatives by telephone, sending them a request letter with a live email link that they could then forward to their list-serves made this process tremendously successful. If time had permitted, the sample could have been far greater. Being able to assure anonymity through SurveyMonkey.com's encrypted software was a very helpful asset, especially when working with a classically controversial topic. Lastly, an online survey was a cost-effective tool to gather data over such a short period from so many different places.

The strength of the sample was in its number, diversity of training, and variety of locations. Though the response rate versus rejection rate is impossible to calculate because once the request letter left this researcher there was no way of knowing how many people may have simply deleted the email, 164 people started the survey and from that group, 103 were used in the research analysis. As discussed earlier, some respondents left out crucial information or failed to answer questions, so that 61 of the 164 responses could not be used. The inability to cue or prompt participants about missing data is one disadvantage to a quantitative survey that might not have been problematic in a qualitative, face-to-face interview.

Apparently, based on the number of respondents in the short time that the survey was available online, there is enough interest in the topic to warrant further research. This study may have only tapped a very small vein possible of informants who may be accessible using online survey instruments. With this in mind, the sample seems to adequately represent the sought after groups: mental health professionals and mental health professionals who have training in the use of touch or body awareness. Due in part to the recruitment process, these numbers included an even range of diverse levels of training in use of touch and body awareness. That twenty-six out of fifty states -- including Washington, Georgia, California, Massachusetts, and Texas -- were represented is another strength of the sample. Though heavily weighted on the east coast, the geographic diversity of the sample offers some sense that results could apply nationally.

Although minimized in this study, researcher bias was an interesting component of note. On the one hand, it was clear because of full disclosure and researcher accountability that this researcher has a strong interest in the incorporation of body awareness, including touch, into the psychotherapy treatment room. It is also of note because some of the write-in comments suggested that an actual positive researcher bias was perceived in a contrary way, for example, one respondent wrote: "[I] wondered how questions seemed biased towards touch being considered a negative while I've always seen it as a useful therapeutic tool." Perhaps this response is also a positive -- in that the instrument was mistaken for leaning in the opposite direction from the one in which the researcher positions herself.

Limitations of Study

Even though there are many strengths of the study, it is also limited. Most notable is the sample's imbalance in ethnicity and gender. Caucasian women were by far the majority of the sample. This is due in part to the researcher's focus on the recruitment of therapists trained in the use of touch and body awareness for the sample. It was assumed that recruitment of general therapists would produce some level of ethnic diversity; unfortunately, this was a faulty assumption. Only 19 out of the 103 participants did not report being Caucasian. Similarly, only twelve out of the 103 respondents were male.

Additionally, the use of the internet survey offered some drawbacks, the major one being the limitation addressed above with regard to unanswered questions. An internet survey question can only be asked once, and if it is not clear or acceptably phrased, there is a risk that the respondent will not answer it or will provide an answer the question did not intend. Unlike the situation in qualitative research, the researcher does not have the freedom of explaining the question or of clarifying an answer, or simply reminding a respondent that an answer is still needed. Another drawback is that some recipients possibly dismissed the survey without attending to it because it was an electronic transmission without a researcher to give it a human appeal.

Another limitation of the survey is possible researcher bias. Prior interest in the subject matter and training and licensure as a massage therapist may have influenced the way in which the research reported here was conducted. A core assumption, based on personal and professional knowledge, was that there existed psychotherapists who have received training in use of touch and body awareness to make up a portion of the sample. To that end, sampling methods sought to contact those clinicians as well as general practitioners.

Implications for Future Research

The results of this research support Strozier, Krizek, and Sale's (2003) observation that: "given the potential of touch in psychodynamic treatment, it would seem wise to address the intervention of touch in open dialogue within the educational, supervisory and/or training setting" (p. 58). Training in the use of touch and body awareness, whether in classroom discussions, in supervision during placement, in seminars, or through formal training in a body-oriented modality, is the best line of defense against ethical violations concerning touch. It allows students as well as practicing clinicians to, at the very least, become clear on why they do or do not incorporate touch or body awareness into their practice protocol.

The findings of this study suggest two perspectives of interest: that of clients of clinicians experienced and trained in the use of touch and body awareness and that of the mental health professional student in training. It could prove interesting to investigate the experience and outcome of clients diagnosed with Post-Traumatic Stress Disorder or Generalized Anxiety Disorder through the course of a yearlong treatment with clinicians trained in the use of body awareness and touch. The clients would be split into two groups: one receiving talk therapy only and the other body-oriented psychotherapy. Pre- and post-treatment measurements would be made of changes in brain structure and function, cardiovascular indicators such as cortisol levels and blood pressure measurements by way of neuro-imaging or stress level tests. The measurements could compare symptom and health indicator changes as a function of each type condition's treatment.

Another fruitful study revolves around the needs of mental health professionals in training regarding touch and body awareness. This study could involve an assessment of attitudes and behaviors of students prior to any training in the use of touch and body awareness and after a year-long period wherein students were afforded the opportunity to experience personal treatment in a body-oriented modality, whether primarily hands-on or a body-oriented psychotherapy, and professional training in the form of lectures and seminars taught from a variety of perspectives in the area of mind-body-spirit. The sample would be split into three groups: one receiving regular training and only personal treatment; another receiving regular training and only professional training in touch and body awareness; and the last receiving regular training along with personal treatment and professional training in touch and body awareness. This research could compare the affects of training in the use of body awareness and touch on self-awareness, clinical sophistication, ethics, as well as offer an idea of whether including some level of training in this area would prove beneficial to new generations of mental health professionals.

The use of touch and body awareness in psychotherapy is not an easily dismissed topic. In fact, as the public continues to influence the profession with ideas from other cultures and disciplines, as it demands more from us as a profession each day, it is only self-awareness on the part of clinicians and knowledge of the needs of clients that will afford

us the tools for professional discretion, ethical conduct, and healing of the whole person in this highly technological age of disembodied reality.

APPENDIX

SURVEY TOOL

Use of touch in psychotherapy

Consent Form

Dear Participant,

My name is Anastasia McRae and I am a master's level student at the Smith College School for Social Work. I am conducting a research study to gather data for my master's thesis and for possible presentations and publications. I am investigating clinical attitudes and activities involving body awareness and touch in psychotherapy treatment.

I am interested in the use of touch and the use of body awareness as therapeutic techniques by mental health professionals. In order to participate in this study, you must be a licensed mental health professional—either a psychotherapist, psychoanalyst, professional counselor, or clinical social worker and have at least five years clinical experience. If you currently use a touch modality (ex. Hakomi, Rosen, Alexander Technique, Polarity, Healing Touch, the Rubenfeld Synergy Method, or a body psychotherapy method not mentioned here) in your practice, you must also be licensed and/or certified in that modality. The survey takes approximately 15-20 minutes to complete and includes demographic questions such as your age, race or ethnicity, gender and education level. The survey requires that participants read and write in English. The bulk of the survey asks questions about your clinical experiences using touch and body awareness as an element of your practice.

While there is no foreseeable emotional risk to you from participating in this study, it is possible that you will find certain questions in the survey thought provoking. It is assumed that as a seasoned mental health professional you probably have access to resources should you find the need to process your participation in this study.

You may benefit from being part of a study that offers the possibility to influence other clinicians' ideas about the nature of integrating body awareness into psychotherapy; suggesting ways of embracing a new way of working in the mental health field; and contributing to an area of clinical research that has been neglected. Compensation will not be provided for participation in this study. As this survey is being conducted completely online with encrypted software designed to protect the identity of the participants, your participation is completely anonymous and no specific answer can be traced back to any particular respondent. The link to the survey does not retain email addresses or ask that you give your name. The software program collects and initially compiles the data for further research and the researcher is given this compiled data in aggregate form. Only my research advisor, the Smith College School of Social Work statistical analyst and this researcher will have access to these materials. All research data will be kept secure in a locked location for three years, as mandated by federal law. After three years, I will continue to keep the materials secure and destroy them when they are no longer needed.

Your participation in this study is voluntary and you may decline to be involved in this study without repercussion. You may withdraw from the survey at any time simply by exiting the survey or closing the browser. I can be reached by email at amcrae@email.smith.edu. I welcome your questions and comments. If you have any concerns about your rights or any aspect of this study, please contact me at the above email or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. I hope you will decide to participate in this study.

You must read and electronically sign this informed consent form by clicking on the "yes" option below before being able to proceed with the survey. If you choose to consent, please print off this page and keep it in your records. If you click on the "no" option below, you will immediately be exited from the survey. During the survey, you may decline to answer any questions you do not feel comfortable answering. You have the right to exit this study at anytime prior to pressing the "DONE" option at the end of the survey. Once you have submitted your completed questionnaire, you will not be able to withdraw from this study since there is no identifying information on the surveys that would connect a particular survey to your responses and permit the information to be selectively deleted.

YOUR CLICKING THE "YES" BUTTON INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy of this page for your records by going to FILE at the top of this browser page then selecting the PRINT option so you can contact me later or use the referral numbers.

1. I consent to participation in this survey

- Yes
 No

Use of touch in psychotherapy

2. Tending to the physical in psychotherapy is as important as tending to the emotional and mental processes.

- Yes
 No

3. A belief that memories are stored in the body and affect the health and well being of clients informs some part of my work.

- Strongly agree
 Agree
 Neutral/Not sure
 Disagree
 Strongly disagree

4. I incorporate body awareness into my clinical practice.

- Always
 Almost Always
 Sometimes
 Rarely
 Never

5. In my clinical practice, I am aware of and utilize my own body sensations to inform my approach with clients.

- Always
 Almost Always
 Sometimes
 Rarely
 Never

6. My bodily reactions and those of the client are important indicators for me in the course of clinical treatment.

- Strongly agree
 Agree
 Neutral/Not sure
 Disagree
 Strongly disagree

Use of touch in psychotherapy

7. In my clinical work I notice and talk with clients about their physical realities--for example, the way they may hold their bodies; an irregular gait not due to illness or accident; particular gestures when any one subject is mentioned.

- Always
- Almost always
- Sometimes
- Rarely
- Never

8. I have received training in body awareness and its use in the treatment room either through coursework for my degree as a mental health professional, in supervision, or formal training in a bodywork modality.

- Yes
- No

9. What kind of training did you receive? (choose all that apply)

- Classroom discussions
- Seminar or course
- Supervision
- Formal training in a bodywork modality

10. If formal training in a bodywork modality, please name it in the space below.

11. How long was the training?

- 1 day or part of a day
- 2 or more days
- 1 week
- 2 or more weeks
- 1 academic term (quarter, semester)
- more than 1 academic term

12. Did the training involve personal treatment as part of your completion?

- Yes
- No

13. Did the training include information on professional ethics?

- Yes
- No

Use of touch in psychotherapy

14. Did the training include methods to help you integrate the modality into your psychotherapy practice?

- Yes
- No

15. I have had the experience of using touch as an element in my clinical practice.

- Always
- Almost always
- Sometimes
- Rarely
- Never

16. I am unclear about the validity and use of touch in therapy.

- Strongly agree
- Agree
- Neutral/Not sure
- Disagree
- Strongly disagree

17. I have or currently use the following types of touch with clients (choose all that apply):

- Inadvertent or not intentional, as in brushing against someone by mistake
- Conversational marker, as in a touch on hand or shoulder for emphasis
- Socially ritualized, as in handshakes or greeting hug
- As an expression of comfort or care, as in holding a client's hand, embracing with a hug, or rocking
- Touch as technique, as in a formal bodywork centered technique, i.e. Reichian

18. I use touch mostly with clients who are (choose all that apply)

- Under 5 years old
- 5-10 years old
- 10-15 years old
- 15-30 years old
- 30-50 years old
- 50-70 years old
- 70+ years old

19. I am more likely to touch a client, with their permission (choose all that apply):

- At the end or beginning of a session
- At the end of treatment, during termination
- When a client is sad or anxious
- When I think it will help clients with self-disclosure
- When the client requests (if it is clinically appropriate)

Use of touch in psychotherapy

20. I have used touch with clients and was able to process it with colleagues or supervisors.

- Yes
- No
- Sometimes

21. When I have used touch I have a sense that I am doing something wrong or will face ethical or legal repercussions.

- Always
- Almost Always
- Sometimes
- Rarely
- Never

22. Though I am clear about my theoretical framework's stance that touch in the context of therapy is inadvisable, I have used touch in my clinical practice.

- Yes
- No

23. In what kind of situation did this touch occur? Please describe in space below.

24. Based on your clinical experiences, can you describe a particularly notable therapeutic intervention, either positive or negative, that occurred as a result of touch as therapy between you and a client?

25. To what would you attribute either the negative or positive outcome of the above interaction?

26. Do you use particular measures to assess the effectiveness of your use of touch?

- Yes
- No

27. If so, please name them below.

28. How was it for you to take part in this survey? Did any particular emotions, thoughts, or concerns occur to you?

Demographic Information

29. Your Age

30. Your Sex

31. How you self-identify your race or ethnicity

32. Mental Health Licensure

33. Years in Clinical Practice

34. Theoretical framework or orientation

35. State of licensure

36. In which of the following settings do you practice

- Private Practice
- Community Mental Health Agency
- Hospice
- In-Patient Treatment, Adult
- In-Patient Treatment, Child and Adolescent
- Hospital Outpatient, Adult
- Hospital Outpatient, Child
- Other

End of Survey

Thank you for your interest and participation in this research study.

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Biography

Anastasia McRae, M.Div, MSW, is a recent graduate of Smith College School for Social Work, August 2008 (at which she won the Alumnae Persons of Color Grant for her thesis), and of Chicago Theological Seminary, 2006. Her clinical interests include psychodynamic and narrative therapy, relational psychoanalysis, Jungian analysis, and body-centered psychotherapy. Prior to going into private practice, she hopes to have the opportunity to complete a post-graduate fellowship with a focus on family and couple therapy; to work with various adolescent and young adult populations; and to begin training in a specific body-centered modality. Ms. McRae has also trained as a clinical massage therapist and personal trainer.

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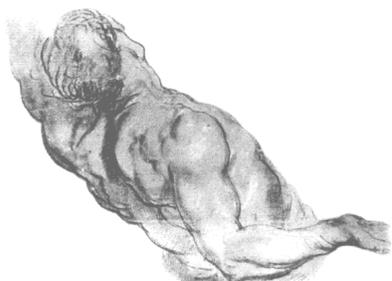
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