

Saint Paul University
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Teaching Touch: A phenomenological study of how touch is addressed in clinical supervision

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Abstract

The literature suggests that touch between a therapist and client is a relatively frequent occurrence. Touch, however, entails important ethical and legal implications. As such it is surprising to conclude that little to no training on the safe and effective use of touch is provided in counselor training programs (Strozier, Krizek, & Sale, 2003). Indeed, one study with social workers found that 82% of those that used touch with therapeutic intent indicated that they did not receive adequate training on how to use touch and often based their decisions on instinct, or unspoken cues from clients (Strozier, Krizek, & Sale, 2003). Furthermore, faculty members have reported being unclear, themselves, about the use of touch and consequently have reported anxiety about addressing this topic with their own students (Burkholder, Toth, Feisthamel, & Britton, 2010). Without clear guidelines and training, professionals who practice and those who teach are left without solid knowledge to inform their touch interventions, leaving them vulnerable to making mistakes and ultimately being at risk of harming their clients (Stenzel & Rupert, 2004). It is therefore important that we begin to look more closely at how touch is taught to begin to establish a knowledge base area that will help guide practice and ultimately to ensure safe and effective use of touch. While research suggests touch is a topic often left out of formal training, little is known regarding how touch is addressed in other training contexts such as supervision. Some studies have begun to explore the ethical issues surrounding touch and the implications for teaching and the practice of supervision (Bilodeau, in press; Hunter & Struve, 1995; Robinson, 2006). However, there is no research exploring the supervisor's own reported experiences regarding touch in a supervisory context. This phenomenological study aimed to explore the experiences of supervisors regarding the issue of touch in the context of supervision. Specifically, we were interested in understanding whether or not touch was addressed in the

context of supervision and how the supervisors made sense of their experiences. Four themes emerged from this research that can aide in the understanding of how touch can be taught in supervision. The first theme formed from the results was how supervisors viewed the use of touch in therapy. The second and third theme discussed the roles of the supervisee and supervisor when addressing the use of touch in supervision. The fourth and final theme discussed how the supervisors processed the use of touch in supervision.

Overview

This chapter will review the literature on supervision, as well as the use of touch in psychotherapy. This chapter demonstrates that supervision is the primary method used by counselors to develop competencies, as such, touch in psychotherapy needs to be taught in supervision. The chapter begins by defining supervision and discusses the difference between supervision and counseling. This chapter then discusses supervision models, the supervisory relationship, and the main learning mechanism that supervisors use to develop competencies. The chapter then details four aspects on the use of touch in psychotherapy. The first aspect is the history of touch in psychotherapy, which provides a brief description on the development of touch formed in psychotherapy. The second is the debate, which describes the arguments for whether the use of touch in psychotherapy should be used. The third discusses the advantages and disadvantages of using touch in psychotherapy. The fourth, and final aspect provides guidelines on the appropriateness of using touch. The final section of the chapter focuses on the lack of literature addressing the use of touch in supervision.

Clinical Supervision

Clinical Supervision is essential to the development of counselors and is assumed to be a career long process (Barnett, 2007). Supervision is necessary to develop supervisees' knowledge and skills around counselling. Supervisees' knowledge and skills obtained during clinical supervision are essential to support the continual maintenance necessary during the professional practice of counseling (Barnett, 2007). Supervision is the main learning model for training counselors and is mandatory for new counselors (Bernard & Goodyear, 2014). Typically, goals of supervision focus on the counselor's learning and developmental outcomes, while assuring client safety (Overholser, 2004). Supervision promotes the acquisitions of knowledge, skills and

attitudes important to the profession (Lichtenburg, 2007). Moreover, experienced counselors also seek supervision to develop new skills and techniques, assistance with challenging clients, and developing expertise while working with a new population (Barnett, 2007). The most widely accepted definition of supervision is (Milne, 2007),

An intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of the same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter (Bernard & Goodyear, 2014, pp. 8).

Bernard and Goodyear's definition of supervision highlights the aspect that supervision is hierarchical and evaluative in nature. They also include that supervisors are not always from the same professional body, therefore, supervisors and supervisees may be working from two different ethic codes and the supervisor may have limited knowledge of the professional body (Crocket, Cahill, Flanagan, Franklin, McGill, Stewart, Whalan & Mulach, 2009).

Milne (2007) believed that Bernard and Goodyear's definition lacked the criteria for an empirical definition. Therefore, Milne (2007) produced an empirically researched definition of supervision and defines it as, "The formal provision, by approved supervisors, of a relationship-based education and training that is work-focused and which manages, supports, develops and evaluates the work of colleague's" (pp. 439). In Milne's definition, supervisees obtain skills and knowledge through goal setting, teaching and feedback. Milne emphasized the objectives of supervision that are "normative (e.g. quality control), restorative (e.g. encourage emotional

processing) and formative (e.g. maintaining and facilitating supervisees' competence, capability and general effectiveness)" (pp.439). Similar to the other two definitions, Milne's definition of supervision includes the aspect of supervision being an evaluative relationship. Milne's definition is unique, due to the fact it includes the main objectives or tasks for supervision.

Compared to Bernard and Goodyear (2014) and Milne (2007) Falendar and Shafranske (2004) place a greater emphasis on the collaborative nature on supervision. Falendar and Shafranske (2004) describe supervision in the following manner, "Distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process"(pp. 3). Supervision promotes self-efficacy through evaluation and feedback. In supervision, competencies are acquired through "instruction, modeling and mutual problem –solving" (pp.3). Competent supervision adheres to the ethical standards of the profession and ensures client safety.

The definitions of supervision provided are the ones most often seen and used in literature. These definitions differ in quantity of details, and highlight different methods involved in supervision. However, each definition shares the common understanding that supervision is a relational learning process aimed at developing professional competence, while ensuring the protection and safety of the client and public.

Supervision benefits from being distinguished from psychotherapy. The definition of counseling as stated by the CCPA is also a relational process which aims to facilitate human change (Canadian Counselling and Psychotherapy Association [CCPA]). This differs from supervision, as it aims at developing competence. Counseling addresses "wellness, relationships, personal growth, career development, mental health, and psychological illness or distress. The counseling process is characterized by the application of recognized cognitive, affective,

expressive, somatic, spiritual, developmental, behavioural, learning, and systemic principles” (CCPA). While both supervision and counselling are aimed at helping the supervisees and the clients, there are still many differences.

The differences between supervision and counseling can be separated into three categories: goals, process, and nature of the relationship (Bernard & Goodyear, 2014; Page & Woskett, 2001). In counseling the goal is to obtain a more satisfying life, whereas in supervision the goal is to develop the supervisee’s skills and techniques (Page & Woskett, 2001). Counseling and supervision both address the “recipient’s problematic behaviours, thoughts, or feelings” however, supervision should only address these areas to increase supervisee’s effectiveness with clients (Bernard & Goodyear, 2014, pp. 10). Furthermore, they differentiate by process. Clients present material verbally, whereas supervisees may use various communication methods (e.g videotape or audiotape). Clients also choose the pace of their sessions, whereas in supervision, supervisors set the pace and ensure that supervisees have learned a new skill or gained understanding by their next session (Page & Woskett, 2001). Not only does supervision have an evaluative aspect, but also, the supervisee has no choice in who their supervisor will be, in contrast to counseling, where the client chooses their therapist. (Bernard & Goodyear, 2014). Clients often choose to enter therapy, whereas in supervision it is often not a choice for new therapists. Therapists must be in supervision due to the many training programs and professional colleges with mandatory requirements. The last difference is the relationship between supervision and counselling. They differ as a fluctuating level of dependency is encouraged in counselling, whereas supervision tolerates a beginning level of dependency with a linear development of independency. In addition, “the supervisee is in an inextricably vulnerable relationship- an evaluative, hierarchical relationship where the supervisor holds the supervisee’s

professionals career in his or her hands” (Ellis, Berger, Hanus, Ayala, Swords & Siembor, 2014 pp. 435). These differences have the potential to elicit anxiety and shame with the supervisee (Bernard & Goodyear, 2014). To summarize, supervision and counselling differ in three ways: goals (learning vs. wellbeing), process (clients often have a choice in pace and therapist, supervisees do not), and nature of the relationship (supervision is evaluative) (Bernard & Goodyear, 2014; Page & Woskett, 2001).

Supervision Models

Many different models of supervision are presented in literature. Bernard and Goodyear (2014) separate the models into three broad categories: models grounded in psychotherapy, developmental models, and process models. Psychotherapy models focus on applying their theoretical framework of working with clients to working with their own supervisees. The goal of the psychotherapeutic model is for the supervisee to learn how to deliver the specific treatment theory. One example of a psychotherapy-based model of supervision is Cognitive-Behavioural Supervision. Liese and Beck (1997) developed a template for CBT supervisors to follow which includes a step-by-step process. For example, models of supervision developed by a CBT framework adopt a formal structured approach as typically found in the CBT model. The agenda is set and supervisors are responsible to manage the supervision session. Similarly to a CBT therapy session, homework can be assigned and the supervisees’ negative thought patterns can be assessed. Assessing the thought pattern includes looking at the stress and emotions that arise with the thought pattern and how it impacts the supervisee’s goals (Liese & Beck, 1997). There is strong research evidence that illustrates the link between specific interventions and client outcomes; as a result CBT supervision tends to place a larger emphasis on assessing and

monitoring than any other supervision approach (Bernard & Goodyear, 2014). For example, it is recommended that supervisors view or listen to the entire recorded session (Liese & Beck, 1997).

An advantage of psychotherapy-based models is that supervisees are directly and continually exposed to the psychotherapy theory their supervisor subscribes to, allowing them to develop a rich and deep understanding of the theoretical underpinnings and develop related skills. In contrast, these approaches have been criticized for being too narrow in terms of learning and may be limiting to supervisees whose personal values may not fit with the supervisor's chosen approach (Bernard & Goodyear, 2014).

The second category is developmental supervision models, these models emerged in 1960 from the field of education rather than psychotherapy and focus on the "needs of the supervisee" based on the supervisee's level of skill (Bernard & Goodyear 2014, pp.33; Page & Woskett, 2001). Developmental models emerged from the understanding that supervisors need to develop various styles and approaches when working with supervisees (Page & Woskett, 2001). Developmental models include either psychosocial developmental theory, cognitive learning theory, social learning, motivation theory, and human development theories, or a combination (Bernard and Goodyear, 2014). An example of a developmental model is the Integrated Developmental Model (IDM). The IDM model is a favourite among the literature as it is more fully conceptualized and is clearly described (Page & Woskett, 2001). This model includes four stages of development that include three "overriding structures that provide markers in assessing professional growth" (Stoltenberg & McNeill, 2010, pp. 23). The first growth marker includes *self and other-awareness: cognitive and affective*, this assesses a supervisee's knowledge and accesses if they can apply that knowledge in clinical situations. The second growth marker is *motivation*, which includes a supervisee's level of interest and effort towards their training and

practice. The third growth marker is *autonomy*, which includes a supervisee's level of dependency on the supervisor. These three markers are assessed in the four stages of supervisee development. The supervisee being new to the field characterizes level 1 of development; this is the initial phase of training, and the supervisee's have limited knowledge, experience and skills. In level 2 supervisees have acquired basic skills and have more confidence in making their own decisions. Supervisees in level 3 are starting to have a personalized approach to their practice and begin to understand the use of self in therapy. Level 3i (integrated) supervisees have a strong level of self-awareness and personalized approach to all domains of practice, including treatment assessment and conceptualization.

A benefit to developmental models is that they are designed to align with the supervisee's professional and personal needs. Developmental models respond to supervisee's needs by incorporating theories, such as learning theory and motivation theory. Furthermore, developmental models typically take a stage approach when describing supervisee development, which can have a normalizing affect for supervisors (Watkins, 2012). These models have been criticized for having a lack of understanding regarding the supervisee's unique learning style and it can be inadequate for understanding cultural differences (Bernard & Goodyear, 2014).

The last category is the process models, which focuses on the educational and the relational process of supervision. These models can be simple or complex and can be used with any psychotherapy theory or developmental model. One process model is the Discrimination Model (DM), this model is typically the first model learned by new supervisors (Bernard & Goodyear, 2014). This model focuses on three supervisee skills and three roles of the supervisor. The three supervisee skills that supervisors assume focus on are interventions (skills used in sessions with clients), conceptualization (supervisee's understanding of what is happening in

session), and personalization (supervisee's personal style). The three supervisor roles include teacher (includes giving direct feedback), counselor (used to enhance supervisee's reflective abilities), and consultant (a role that allows for a more equal relationship). In this process model, a supervisor can move between the roles of a teacher, counselor and consultant to help the supervisee develop in the three areas of intervention, conceptualization and personalization. The process model alone can lack attention in theory and developmental models (Bernard & Goodyear, 2014).

In summary, there are a variety of different approaches to supervision. While some approaches focus more on the transmission of theoretically oriented knowledge, others focus on professional competence milestones to be attained, while another may focus on understanding the dynamics of the relational process. Bernard and Goodyear (2014) recommend that supervisors should include all three of these categories when providing supervision. They also note that recently the second generation of supervision models have been developed to help combine and advance these supervision models. Second and third generation models are typically more integrative and research based than the three major models. The fundamental focus of supervision models is to guide supervisors in developing supervisee skill and competency, for example touch.

Supervisory Relationship

As mentioned above in the various definitions the supervisory relationship is central to how supervision is defined and practiced. Although not always explicitly mentioned in the supervision models, research has found the supervisory relationship to be a crucial component in all approaches to supervision. The supervisory relationship is essential for the learning and development of the supervisee. The supervisory relationship has been described as the

“quintessential variable”, the “heart and soul” of supervision and “highly powerful and the most influential factor” (Watkins, 2014, pp. 20). The supervisory relationship is a complex system with many factors that can influence the experience for either party. The nature of this relationship is the greatest predictor of supervisee evaluation of the quality of supervision. Worthen and McNeill (1996), in their qualitative study investigating the experience of good supervision found that every one of their participants described the quality of the relationship to be “crucial and pivotal” (pp. 26). They concluded that the supervisory relationship is the fundamental element that nurtures the acquisition of professional skills, without this element the development of the supervisees may be negatively impacted. Furthermore, it is both the quality of this relationship and the level of trust within it that has shown to be a predictor of supervisee disclosure. One study found that 44% of supervisees did not report clinical mistakes to their supervisors and two of the reasons were poor alliance (50%) and supervisor incompetence (21%) (Ladany, Hill, Corbett & Nutt, 1996).

Research has found that personal characteristics of both the supervisor and the supervisee can significantly impact the quality of the supervisory relationship. For example research has found supervisee shame proneness (Bilodeau, Savard, & Lecomte, 2010), anxiety (Skovholt & Rønnestad, 1992) and feelings of incompetency (Rabinowitz, Heppner, Roehlke, 1986) greatly influence the supervisory relationship and outcomes of supervision. The factors the supervisors bring that can impact the quality of the relationship include unclear goals (Nelson, Barnes, Evans, & Triggiano, 2008) and counter-transference (Ladany, Constantine, Miller, Erickson, & Muse-Burke, 2000). Factors including supervisee shame, the power difference and the evaluative nature of the relationship have been found to have an impact on supervisee disclosure in supervision (Farber, 2006; Spence, Fox, Golding, & Daiches, 2014).

Learning Mechanisms

The supervisory relationship plays a crucial role in the outcome of effective supervision. In the main definitions the supervisory relationship was a primary mechanism through which knowledge is transferred. The supervisory relationship has the ability to maximize supervisee education because the supervisory relationship impacts the level of supervisee disclosure, and the lack of disclosure can impact supervisee learning (Johnston & Milne, 2012). Various learning mechanisms have been identified in the literature that supervisors rely on to transfer knowledge. These learning mechanisms include modeling, feedback, direct instruction and reflective practice (Goodyear, 2014; Watkins & Scaturro, 2013). These learning mechanisms are transtheoretical, and stimulate learning in both the personal and professional domains of the supervisee (Watkins & Scaturro, 2013). Learning mechanisms are the main tools that supervisors use to aide in the development of supervisee competencies.

Modeling. Modeling happens when one internalizes another person's attitudes and perspectives. In supervision modeling happens when a supervisee observes the supervisor's attitudes and behaviours and incorporates them into their own practice. Modeling results from two types of identifications: similarity identification and wishful identification. Similarity identification refers to modeling someone who shares important similarities. Wishful identification refers to modeling someone who has behaviours that one would like to acquire (Von Feilitzen & Linne, 1975). Both of these identifications must be present in the supervisory relationship. Specifically to the supervisory relationship, modeling happens when a supervisee observes the supervisors counselling skills by watching them live or co-counselling, and when supervisors share their thinking about clients and relationship dynamics. Modeling in supervision affects the supervisee's professionalism and ethical behaviour.

Feedback. Feedback is “information intended to reduce discrepancies between what the person currently knows and is able to do and what is desirable for him or her to be able to know or do” (Goodyear, 2014, pp. 87). Although the role of feedback is indispensable for supervisee’s learning, supervisors fail to use feedback effectively, often not using it at all (Milne & Westerman, 2001). Effective feedback should include three specific dimensions that include specificity, valence and formality (Goodyear, 2014). Specificity refers to the feedback being clear, direct and based on specific criteria. In order to provide specific feedback, supervisors need to directly observe the work of the supervisee and not just rely on self-report. Corrective feedback or feedback about how the supervisee is not meeting expectations, which can demoralize and even shame a supervisee, while valence feedback refers to feedback given to the supervisee about exceeding expectations. (Goodyear, 2014; Watkins, 2012). Also, effective feedback should be formal. Formality feedback essentially means that feedback should be intentional. To assist supervisors in giving the best well-rounded feedback possible, Chur-Hansen and Mclean (2006) suggested that feedback be given in a “positive-negative-positive approach... 1. Say something about the student’s strengths; 2. Identify the specific problem; 3. Finish with a motivating or positively enhancing statement” (pp. 67). Therefore, feedback can help supervisees understand which competencies that they are doing well with and which competencies that they may need to improve.

Direct Instruction. Direct instruction is the most used intervention in the supervisory relationship (Milne, Aylott, Fitzpatrick, & Ellis, 2008). Direct instruction includes some form of modeling and then direct and immediate feedback. Essentially the supervisor explains and demonstrates a skill to a supervisee and then provides feedback as the supervisee practices that skill. As a supervisee gains more knowledge and skill a supervisor should be able to step back

and gradually remove support in order to start to transfer responsibility to the supervisee. This component of feedback is a stepping-stone for the next component of supervision, which is to encourage supervisees to become a “self- regulating learner” (Goodyear, 2014). When a supervisee becomes a “self- regulating learner” they have the ability to self supervise. Furthermore, this ability to reflect has been found to be a strong characteristic in the best therapists (Miller, Hubble & Duncan, 2008). Direct instruction allows for a refinement and a personalization of competencies learned.

Reflective Practice. Self- regulation learning is a skill that includes “assessing a situation and making decisions about what to do or not do based on that assessment; and the ability to evaluate and modify one’s decisions as appropriate” (Kaslow 2004, pp. 775). Self-regulated learning is done through reflective practice. Supervisees learn how to engage in reflective practice when modeled by the supervisor and also through Socratic questioning (Orchowski, Evangelista & Probst, 2010; Overholser, 1991).

Supervision is the main method used in counselling for developing competencies. The supervisory relationship serves as the foundational base from which supervisee learn and develop. In addition, supervisors use learning mechanisms such as modeling, feedback, direct instruction and reflective practice to develop and enhance supervisee competencies. The next section will demonstrate how the use of touch in psychotherapy is one such competency that counselors need to develop.

Touch in Psychotherapy

History of Touch in Psychotherapy

From the beginning of psychotherapy the body was a central component. Dr. Pierre Janet preceded Freud by three years and is often referred to as the first body psychotherapist. Janet

often incorporated the body in his work with hysteria. Freud's work developed out of this body-oriented work but turned into the "talking cured" which ignored Janet's work (Young, 2006).

Psychoanalysis. The history of psychoanalysis and the use of touch in psychotherapy have a complex history that has been fraught with anxiety and prohibition. Freud originally used hypnosis techniques to treat patients, often using touch by placing his hands on the patient's head. The intended goal of this treatment technique was to unblock the patient's mind and thus permit memories to emerge through the pressure of Freud's hands (Breckenridge, 2000). With Freud's development of psychoanalysis and the ensuing abandonment of hypnosis as a treatment, Freud ceased using touch as an intervention. With the development of psychoanalysis Freud theorized that the analyst should act as a blank screen for the patient. Therefore, analysts do not indulge in any of the patient's wishes and desires; hence analysts have internalized the practice of abstinence where touch is concerned (Ruderman, 2000; Schlesinger & Appelbaum, 2000).

Regardless of the rule of abstinence select analysts would use touch with their patients and expressed this use in the analytic literature. Case examples by Ferenczi, Fromm-Reichman and Winnicott raised the debate over the use of touch within psychoanalysis. Ferenczi would kiss his patients on the cheek after each session, Fromm-Reichman would provide reassuring touch to severely disturbed patients and Winnicott would hold his patients to help with containment and facilitate regressive work (Breckenridge, 2000; Toronto, 2002). Outraged by the continued use of touch, Freud "excluded" these analysts from his community. This created a sense of fear throughout the psychoanalytic community, propelling analysts to silence their use of touch within the analytic relationship (Fosshage, 2000).

Body oriented psychotherapies. Subsequent to Freud's excommunication a new community of body-oriented psychotherapists emerged. The body-oriented movement started with Wilhelm Reich who was experimenting with uses of touch in psychoanalysis. Body-oriented psychotherapies include various models that share an ideology, which shifts the attention of resolving psychological distress from a cognitive approach to a physical approach (Hunter & Struve, 1998). All body-oriented psychotherapies share the understanding that the body is as important as the mind, that it is a source of information about a client's state and can hold memories, can be the place for change as it can bypass intellectual defenses, and can be used as an intervention (Young, 2006).

Humanism. In response to psychoanalytic theory, Rogers emphasized the capacity of the therapist to be spontaneous. The use of touch from the humanism perspective is less complex and less formalized (Smith, 1998) and touch is viewed as an important and natural way of relating and facilitating healing (Hunter & Struve, 1998; Leung, 2015).

In summary, the history of touch in psychotherapy has been complex. Psychotherapy has seen the rise and fall of the popularity of using touch. The next section will discuss the types of touch that have been included in psychotherapy since the start.

Types of Touch

There are various types of touch that can be used in psychotherapy, ranging from social touch, to intentional or therapeutic touch, to inappropriate touch. Zur (2007) presents an extensive list of the many forms of touch in psychotherapy. The list includes the type of touch and the intention behind using this type of touch in therapy. Five distinct categories emerge; incidental touch, intentional touch, protective touch, touch used by body psychotherapists, and inappropriate touch. The first category would include engaging in social touch with a client, such

as a handshake when leaving the session, or a hug at Christmas time. Social touch is typically culturally informed, and includes greetings or departure gestures. The other type of touch in this category is touching the client accidentally, for example brushing shoulders as you pass each other, or a quick touch when exchanging receipts. Task-oriented touch could be included in this category, as it includes touch that has a functional aspect to it, including helping someone stand up. These incidental forms of touch tend to be either socially acceptable forms of touch or accidental.

The second category of touch is intentional touch, which conveys a message to the client. Zur (2007) stated that the most important type of touch in this category is the consolatory or comforting form of touch, which is the “most likely to enhance the therapeutic alliance” (pp. 173). Other messages that touch can convey are celebration and encouragement. This category also includes touch used to help ground the client and touch between client and therapist that can be instructional or modeling, for example demonstrating a firm handshake.

The third category of touch is forms of touch that have a protective intention. These forms of touch include touching or restraining to protect the client from hurting themselves, someone else or the therapist. This type of touch can be used through self-defense using minimal force. The fourth category is touch used by body psychotherapists, which is a different form than touch used in addition to talk therapy. Body oriented psychotherapists use touch as part of their theoretical orientation and as a specific intervention.

The last category includes the forms of touch that are inappropriate for a therapist to engage in with a client. These forms of touch include sexual, violent or punishing forms of touch. This category is highly unethical for a therapist to use and is never appropriate.

In conclusion, there are five categories of touch; incidental touch, intentional touch, protective touch, touch used by body psychotherapists, and inappropriate touch. Except for the inappropriate forms of touch all other forms could potentially be used in therapy. The use of the other four forms of touch is widely debated topic as to whether or not these forms should be used in therapy.

The Debate

The use of touch in psychotherapy has been a widely debated topic, with some therapists stating that it is beneficial while others argue that it is detrimental to both the client and the therapist. Initial research divided this debate between the different theoretical orientations concluding that psychoanalytic schools believe that touch in psychotherapy is a wish from the patient and it would be detrimental to give in to a wish, whereas humanistic therapists believe that touch is an inherent need that must be satisfied (Milakovich, 1998). That is, Milakovich (1998) found that one of the important differences between therapists who touch and therapists who do not, is the therapist theoretical orientation. Specifically, he found that 30% of humanistic therapists and 6% of psychodynamic therapists answering that they used touch (Milakovich, 1998). However, new literature has emerged from the psychoanalytic area discussing the use of touch in this type of therapy. They explained that fear and taboo are the reasons that touch is not discussed in this literature. (Breckenridge, 2000; Fosshage, 2000; Ruderman, 2000; Tune, 2001; Toronto, 2002).

Despite the lack of clear guidelines on the appropriateness of touch in the context of psychotherapy current research suggests that touch occurs in psychotherapy quite regularly. A recent study has found that 15.8% therapists sometimes offer a hug and 30.65% sometimes accept a hug (Stenzel & Rupert, 2004). This study also found that 22.9 % of therapists sometimes

offer a hand and 18.75 % accept a hand. Furthermore, this study asked therapists to assess when the touch took place, whether it was a greeting (16.2%), parting (25.25%), terminating (34.6%) or during the session (9.25%), which could suggest that most of the touch taking place is a social form of touch. However, this study did not differentiate the type of touch being used, consequently one cannot know whether they are referring to social, inadvertent, or touch with intention. One could assume that all forms of touch could take place at the timings stated; for example, celebratory or encouraging touch could take place at the end of a session.

Furthermore, Westland (2011) argues that touch is an intrinsic part of communication and that a relationship without touch is only a partial one. In this regard, touch in psychotherapy could be viewed as a natural result of the relationship. Hunter and Struve (1998) deem this debate as irrelevant when they state, “the question is not ‘does touch hurt or heal?’ we know empirically that it can do both. Rather the question ought to be ‘what forms of touch are most effective and efficient when treating what type of problems with which type of clients at what phase of the therapeutic relationship by which therapists” (pp. 70). They state that practitioners need to be educated on the various aspects of how, when, and who should use touch. The next sections will address some of these aspects.

Factors for the Use of Touch

Whether to engage and how to engage in touch is not a simple process and should not be used without considering many different factors (Horton, Clance, Sterk-Elifson, & Emshoff, 1995; Hunter & Struve, 1998). Research suggests that there are benefits for including the use of touch in psychotherapy. One such benefit is that it creates a stronger bond with feelings of closeness and/or a sense that the therapist cares, which increases trust and openness (Horton et al, 1995). Within that same study, the researchers found that 47% of clients reported that touch

communicated acceptance and enhanced self-esteem (Horton et al, 1995). Touch can also facilitate a transformation in the physical and emotional states of the clients. Hunter and Struve (1998) describe the power of this shift when they state, “physical contact generally bypasses the internal mechanisms for cognitive processing and is experienced at a more emotional, and sometimes preverbal, level” (Hunter & Struve, pp. 128). Touch has encouraged clients to focus their attention on the body and to notice and feel emotions that might have otherwise gone unnoticed (Horton et al., 1995; Leung, 2015). In this way, touch allows clients to move from a cognitive level to focus their attention to their body.

Factors Against the Use of Touch

When using touch in psychotherapy there is also a potential for harm. The main argument for avoiding touch is that touch will lead to sexual exploitation between therapist and client (Hunter & Struve, 1998). Other reasons for avoiding touch include the fear that touch will lead to aggressive behaviours in clients or that it may be manipulative (Fosshage, 2000; Westland, 2011). Finally, psychotherapist fear false accusations and litigations from clients who have misinterpreted well intentioned touch in psychotherapy (Westland, 2011).

As discussed, there are possible negative impacts for using touch, however, there are also possible negative impacts for not using touch. Although there has been minimal research in this area a negative impact of not using touch in psychotherapy is that it may create transference distortions, such as the client viewing the therapist as cold or withholding (Willison & Masson, 1986). Being seen as cold and withholding can be increasingly true if a client has requested some form of touch by the therapist. Taking into consideration all of the potential impacts touch can have, it is important that psychotherapists receive proper training for the use of touch to prevent them from using touch from an uninformed perspective.

Guidelines for Using Touch

After considering the potential benefits and risk factors it is important to note that researchers have found components or guidelines for how to incorporate touch in psychotherapy. By researching client's perceptions and understanding of touch, researchers have found factors that influence the perception of touch. Three significant factors that influence the perception of touch: the event is congruent with the client's experience in therapy, the client's perception of the therapist's sensitivity, and the client's ability to communicate feelings about the therapist (Geib, 1982; Horton et al., 1995; Hunter & Struve, 1998). Another study found several other factors including verbal transitions, pacing, timing, and tracking of clients responses to be an important component of using touch in psychotherapy (Leung, 2015).

Hunter and Struve (1998) have provided an extensive list of guidelines of when it is appropriate to use touch in psychotherapy and when it is inappropriate to use touch in psychotherapy. The first involves the client wanting or agreeing to touch and is educated about the use of touch. The therapist is both clear of the intention for using touch and is using touch for the client's benefit. The boundaries between therapist and client are clear and touch is available to all clients. Touch can be used when touch matches the level intimacy in the relationship and there is enough time left in the session to debrief the touch. The therapist must have a solid knowledge base of the use of touch, is comfortable with touch and uses consultation.

Hunter and Struve's (1998) guidelines for when it is clinically advisable not to use touch in psychotherapy include that the focus of the therapy has had sexual content, there is a risk of violence, and the client does not want to touch or be touched. The use of touch should not be used if the therapist doubts the client's ability to say no and occurs in secret. Touch should not be used if it is not clinically appropriate or if it is being used to replace verbal therapy. Finally touch

should not be used if the therapist has been manipulated into touch and if the therapist is not comfortable with touch.

The common thread throughout the guidelines for whether or not touch is appropriate to use is the assessment of the client including their comfort level (the client wants to touch or be touched), request (client has requested or accepted the touch offer) and history (past experiences of touch). Secondly, any touch in therapy must be client centered, meaning that clients have been educated about touch and are choosing touch every step of the way. Finally, the therapist needs to be comfortable with accepting or offering touch, should have knowledge on the use of touch and the therapist should seek consultation when using touch.

Touch in Supervision

Although touch is occurring frequently in the psychotherapy relationship, and there are some guidelines in the literature on how to safely and effectively incorporate the use of touch, research has found that there is often little or no training is provided (Burkholder, Toth, Feisthamel, & Britton, 2010). One study found that 82% of social workers that use touch said they did not receive adequate training on how to use it and often base their decision on instinct, or unspoken cues from clients (Strozier, Krizek, & Sale, 2003). Having few tentative guidelines and little training leaves new professionals in the dark on how to use touch, and they are left to make decisions based on instinct rather than formal knowledge and training. Consequently, this leaves new professionals vulnerable to making mistakes or forgoing important steps when faced with an issue of touch with clients (Stenzel & Rupert, 2004). It is therefore important that we begin to look closer at how touch is addressed in training and supervision to gain greater understanding of the current practices and lacunas in an effort to increase knowledge and reduce the potential harm to clients.

Many of the studies on the use of touch in psychotherapy have concluded that more research in how touch is taught or addressed in educational programs is necessary (Phelan, 2009; Leung, 2015). Leung (2015) concluded her study stating that the components and the effectiveness of including touch in psychotherapy have been researched, and what needs further examination is the discussion among practicing psychotherapists and students. A few studies researching the topics of touch or supervision have hypothesized how touch or other ethical issues could be included in supervision (Bilodeau, in press; Hunter & Struve, 1995; Robinson, 2006). Hunter & Struve (1995) provided three experiential exercises that trainers could use with students to capture the experience of touch. Robinson (2006) suggested multiple questions supervisors could ask supervisees, to assess the supervisees' reasons for the touch, and the potential impacts. Yet there is little research on whether or not touch is even being addressed in supervision. One study that conducted a focus group with faculty members from counselling educational programs found that the faculty members are unclear about the use of touch and become anxious about teaching the use of touch to students (Burkholder et al., 2010). This anxiety and confusion in the educators was transmitted to the students who in turn, described feeling insecurity regarding touch in therapy. The models of supervision and learning mechanisms provide a guide of how competencies such as the use of touch could be developed. However, they lack a structured format on how to transfer the information to supervisee's to ensure the safe and effective use of touch in therapy. More research is needed in this area to better understand the experience supervisors have with addressing touch in supervision. This research will be the first step in understanding how to address touch in supervision.

The Present Study

As highlighted above, faculty members in training institutes have struggled to incorporate training on the use of touch in psychotherapy as the decision to include touch can be situational and contextual (Burkholder et al, 2010). We are therefore left with the question of where touch is actually addressed or can be addressed? The twofold purpose for supervision is to develop supervisee competency all the while safeguarding clients. This implies that supervision may be an important place where supervisee's develop knowledge and skills regarding the use of touch in therapy. However, the current lack of clarity in the literature on how the competency of touch could be learned by supervisees leaves supervisors ill equipped and at risk for avoiding the topic altogether. The purpose of this study is to explore the experiences of supervisors regarding the issue of touch in the context of supervision. Specifically, we were interested in understanding whether or not touch was addressed in the context of supervision and how the supervisors made sense of their experiences.

Role of the Researcher

I am conducting this research because I became interested in the topic of touch in psychoanalysis. I was fascinated with the idea that two people could spend three or five hours a week together for five years and never physically touch. I became interested in why this desire never emerged in a patient and if it did why it was never discussed in the literature. The personal vignettes and complexity of the topic in the psychoanalysis and general psychotherapy literature created even more excitement and interest in me. After reading through many research articles I discovered that many called for more research in the area of training and supervision of touch and psychotherapy.

Overall, I feel that touch is an important part of human experience; it is something that is necessary for development. I understand and feel that it is a healthy desire when it appears in the

counselling relationship. I think that touch is inevitable in the therapeutic relationship and yet from my experience touch is taught as a “don’t” aspect in training programs. I think that not addressing touch leaves new therapist vulnerable to unintentional mistakes. When done properly and with good intentions I think it can be more powerful and impactful than any other intervention. However, I also understand that when touch is done without informed knowledge the effects can be harmful to both client and therapist. Therefore, it is important to me that supervisors and training institutes start to include education on the use of touch.

Method

Saint Paul University’s Office of Research and Ethics approved the design and procedures used in this study prior to beginning the recruitment process (See Appendix A- Ethics Certificate, Research Ethics Board). After receiving the certificate the researcher had to seek another approval for the use of Skype to conduct interviews. This request was approved and documented.

Design

This Phenomenological study aims to understand supervisor’s experiences of how touch is addressed within supervision. A phenomenological approach was selected for this study as it allows supervisors to use their own language when describing and explaining the meaning of their work. Phenomenological research samples are typically small in order to provide an in-depth analysis of individual experiences and to compare similarities and differences (Smith, Flowers and Larkin, 2009).

Interviews were conducted individually with each participant and each interview was between 45 to 60 minutes in duration. Interviews were audio recorded and then were transcribed. Once all of the interviews had been transcribed verbatim the researcher analyzed each interview

using Interpretive Phenomenological Analysis (IPA). Various themes and subthemes emerged from the IPA. After the analysis was completed, an independent colleague verified the themes found by analyzing 10% of the data.

Participants

Participants were eligible to participate if they were currently supervising. Experience with touch or supervising touch was not a criterion for participation as the exploratory nature of this study aimed to understand the role of touch in supervision and not having addressed it would give insight into understanding the reasons it is not being addressed.

The final sample consisted of five supervisors, three males and two females, who had varying years of supervisory experience ranging from 10- 40 years. The participants varied in theoretical backgrounds including psychoanalysis, Neo- Reichian and Somatic experiencing. Four of the participants had extensive training on the use of touch in psychotherapy and one participant did not have any training on the use of touch in psychotherapy. All of the participants had experience with addressing the topic of touch in supervision, four of the participants discuss touch in supervision regularly, the other participate rarely discusses touch in supervision but has had the occasional experience of addressing touch in supervision. Each participate gave their consent and participated in a 45 to 60 minute interview via Skype or telephone.

Procedure

Participants were recruited through advertisements posted in the Saint Paul University Counselling Centre, emailed to members of The Canadian Counselling and Psychotherapy Association (CCPA) and emailed to the members of the International Association for Relational Psychoanalysis and Psychotherapy (IARPP). The advertisements included information about the study and its intent. The recruitment advertisement also included information about the interview

process, explained how participation is voluntary and confidential and included contact information of the main researcher and her supervisor (See Appendix C & D) From the advertisements one participant was recruited through the CCPA, this participant recruited two colleagues, and two participants were recruited from IARPP.

All of the participants were emailed the consent form once they agreed to participate in the study. Each participant signed and emailed the consent form back to the main researcher before the interviews. Participants were made aware that their participation is completely optional and that all information collected is confidential. However, because of the importance of providing the readers with a rich description, the participants were asked if direct quotes from interviews could be used for the research paper.

The main researcher conducted individual semi-structured interviews, which were 45 to 60 minutes in duration. All of the participants were located outside of the research area and thus interviews needed to be conducted via telephone or Skype. Two interviews were conducted via Skype and three interviews were conducted over the telephone. An interview guide was developed prior to the start of the interviews and was used for all of the interviews conducted (See interview guide in Appendix B). All questions in the interview guide were open-ended questions so as to avoid leading the participant's answers. The use of semi-structured interviews provided structure for the interviews. Probing questions were also used to encourage the participants to expand on their answers. The interviews all started with the researcher thanking the participants for their involvement in the study. The researcher then explained the purpose of the study and explained the difference between incidental and intentional touch. At the start of the interviews basic personal information, for example, theoretical background, and number of years or supervisory experience, etc., of the participants was collected. At the end of the

interviews participants were asked if they would like to add any information that they thought was important or that was not asked about. The participants were then asked if they had any questions before stating that they could contact the main researcher or the researcher's supervisor at any time with any questions or concerns. The participants were again thanked for their participation in the study.

Analysis

The main researcher used Interpretative Phenomenological Analysis (IPA) to analyze all of the data collected. The first step of IPA requires the researcher to closely read over each interview several times. Following this, the researcher makes marginal notes that reflect content (Pietkiewicz & Smith, 2012). After the close examination of the transcripts and making marginal notes the researcher then focuses mainly on their notes. In this stage, the researcher aims to take their notes and transform them into themes. The researcher finds themes by trying to find a word or phrase that captures the essence of the note. After the researcher has identified several themes from their notes the researcher seeks to identify relationships and connections between themes. This stage often includes clustering similar themes together (Pietkiewicz & Smith, 2012). Six major themes emerged from this data set and twenty- two subthemes. The tables explaining these themes and subthemes can be found in the results section of this paper.

Validity Measures

Multiple measures were used in attempt to preserve the validity and reliability of the data. The first validity measure used was researcher reflexivity, which entailed the researcher writing a description of their beliefs and values of the phenomenon being studied (Creswell & Miller, 2000). Researcher reflexivity allows for the reader to understand the position and biases the researcher has toward the phenomenon being studied. Having the researcher write their

position and biases before beginning the research allows the researcher to authentically emerge themselves into the lived experience of the participants (Finlay, 2002). This validity measure was done by the researcher before beginning the analysis, and can be found in the section titled role of the researcher.

The second measure employed was attention to thick and rich description of the themes identified. Thick and rich description essentially means providing as much detail about the phenomenon and themes as possible (Creswell, 2013) Providing a detailed description allows the readers to experience themselves the phenomenon being described, enabling the reader to make a decision about the credibility and applicability of the results (Smith, Flowers, & Larkin, 2009). The researcher also used feedback from her thesis supervisor and thesis committee to provide, review and debriefing of methods, meanings and interpretations made by the researcher.

Reliability Measures

The reliability measure used by the researcher was an inter rater reliability; this is used to test trustworthiness of the results. The researcher selected a colleague who had never seen the data and is unfamiliar with the phenomenon being studied. The researcher provided this colleague with a description of the IPA and half of the first interview to analyze and code without any influence. The purpose of this inter rater reliability was to show that an outside source would develop similar themes from the same passages. After each coder had finished analyzing and theming the data, they met to review their findings. Each coder stated their theme and explained what meaning that specific theme held. The coders were able to come to an agreement on the majority of the themes discussed. After the process of both intercoder reliability and intercoder agreement the intercoder rate was 85%.

Limitations of Study

One limitation of this present study is that interviews were unable to be conducted in person and needed to be conducted via telephone or Skype. In person interviews allow for the researcher to observe non-verbal cues used by the participants. Non-verbal cues can carry certain messages or emphasis when describing lived experiences. Conducting interviews via Skype and telephone would have meant that the researcher would have missed potentially important non-verbal cues.

Results

Participant Descriptions

Supervisor 1 has been a clinical supervisor for 10 years; his theoretical orientation is Somatic Experiencing. This supervisor engages in touch with his clients when he has the “opportunity”. Supervisor 1 has had extensive training on the use of touch in therapy, mostly through the somatic experiencing training which was 2-3 years of training. Additionally, he completed a more extensive touch training. This supervisor resides in Canada.

Supervisor 2 has been a clinical supervisor for 30 years and her theoretical orientation is psychoanalytic mainly relational and British object relations. This supervisor only engages in touch at termination of the therapeutic relationship. She has received no formal training on the use of touch in therapy. This supervisor resides in Australia.

Supervisor 3 has been a clinical supervisor for 10 years and her theoretical orientation is Somatic Experiencing. She engages in touch with her clients and has received formal training on the use of touch in therapy. In addition to the somatic experiencing training, which includes modules on touch, this supervisor has received training on touch in trauma work. This supervisor resides in Canada.

Supervisor 4 has been supervising for 40 years and his theoretical orientation is neo-Reichian body psychotherapy and psychoanalysis. This supervisor regularly engages in touch with his clients and has received formal training on the use of touch in therapy. His training included training as a body psychotherapist, which he describes as being a “systematic training” in the use of touch and different kinds of touch. This supervisor resides in the United States of America.

Supervisor 5 has been supervising for 20-25 years and his theoretical orientation is Somatic Experiencing. This supervisor engages in touch with his clients. His formal training in touch has included the Somatic Experiencing training and a post advanced course. This supervisor is a retired professor at a university. This supervisor resides in Canada.

Table 1. Participant Descriptions

| Participant | Number of Years Supervising | Theoretical Approach | Training on the Use of Touch | Use of touch in own practice | Country of Origin | Gender |
|--------------------|------------------------------------|---|--|-------------------------------------|--------------------------|---------------|
| 1 | 10 years | Somatic Experiencing (SE) | SE training, 2-3 years and a more extensive touch training | Yes | Canada | Male |
| 2 | 30 years | Psychoanalytic, relational and British Object Relations | None | Only at termination | Australia | Female |
| 3 | 10 years | Somatic Experiencing and Eclectic | SE training and training on touch in trauma work | Yes | Canada | Female |
| 4 | 40 years | Neo- Reichian and psychoanalysis | Training as a body psychotherapist | Yes | U.S.A. | Male |
| 5 | 20 to 25 years | Somatic Experiencing | Somatic Experiencing training and a post advanced course | Yes | Canada | Male |

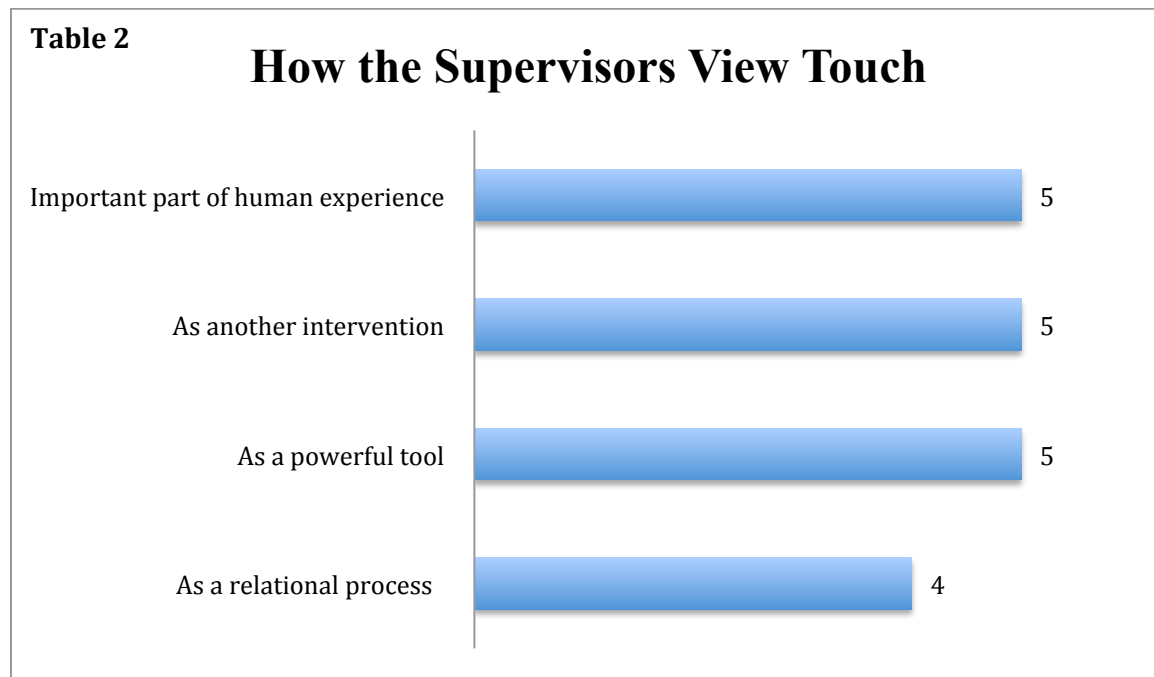
Emerging Themes

The Interpretative Phenomenological Analysis (IPA) process of all five interviews revealed four emerging themes that are shown in the graphs below. Within each of the four major themes, several sub-themes are included. Each sub-theme is marked with a number; the number represents how many participants mentioned that particular sub-theme in their interview. An explanation and details about each sub-theme can be found below each graph.

In general, all of the supervisors reported or discussed positive experiences when addressing touch in supervision. Most of the supervisors interviewed (4/5) came from a body-oriented theoretical framework (Somatic Experiencing and neo-Reichian). Thus, it is important to keep in mind that these supervisors were extensively trained in the use of touch, and most of their supervision was focused on the use of touch. The second supervisor's theoretical framework was psychoanalytic and she had no training on the use of touch. In regards to the supervisors with a body-oriented theoretical framework, they may have had the topic of touch arise a great deal in supervision. For example, supervisor number three, one of the somatic experiencing supervisors, stated that "touch is a regular part of consultation." In contrast, supervisor two, the psychoanalytic supervisor, stated that it does not come up very often in supervision. When it does, she feels that she does not have much knowledge to contribute to the topic. All of the supervisors interviewed reflected how touch is an important topic of discussion in supervision, and should be discussed if it is happening in the therapeutic relationship. One supervisor stated that supervision can serve as the middle ground for discussion and education. Additionally, in supervision, touch does not have to be discussed in a yes or no manner but can be a topic for exploration. The fourth supervisor (neo-Reichian) highlighted this when he discussed how, in theoretical orientations like psychoanalysis and CBT, there is no formal

training. Thus, there are “no grounds at all to begin thinking about the clinical relevance of touch... so to have that as part of the supervisory process I think is really important”. In contrast, he discussed how in training in body psychotherapies or humanistic therapies, “touch is taken for granted... and there is not enough thoughtfulness about it.” Supervision can allow for the opposite of the yes or no; it can allow for the exploration of the clinical relevance of touch. Therefore, supervision can allow the space for a therapist to process their feelings and ideas around the use of touch in therapy with a particular client.

Supervisors View of Touch



The theme depicted in the graph above has implications for how the supervisors view touch in psychotherapy. All of the supervisors viewed touch as an important component of human experience; with the exception of supervisor two. She stated, “it is important but I’m frightened of it.” To expand on participant two’s comment of being frightened of touch, it is based on her personal experience of growing up where touch was a dangerous thing. It can also

be based on her experience later in formal training in a “very inhibited culture... in the analytic world” where she was “encouraged to be as invisible as possible.” In contrast, the fifth supervisor self identified as an advocate for touch and stated that he uses some form of touch with about 30% of his clients. Supervisor one emphasized the importance of touch when he stated that touch “is something we crave, and it is something that we need.” Although, this sub-theme had some differing opinions between the participants all of the participants saw touch as an important component.

Touch was viewed by all of the supervisors as simply another intervention in the practitioner’s toolbox. Supervisor four emphasized this when he stated that touch is “part of the therapist’s potential repertoire.” Furthermore, supervisor three stated, “in the right realm, its as useful as any other treatment, any other strategy that we might use in psychotherapy”. These examples highlight the sub-theme that four out of five of the participants discussed how touch is just another intervention or strategy to use in psychotherapy.

Supervisors three and four linked the two above sub-themes, of viewing touch as just another intervention in psychotherapy and as important component of human experience, together. Supervisor three explained that touch can be particularly helpful when working with clients whose trauma occurred at a preverbal time because essentially at that time touch would have been their language not words. Supervisor four explained that touch can be helpful in facilitating the deepening of self-experience and the experience between client and therapist. These two participants highlighted that touch can be used to facilitate new experiences similarly to any other intervention could. They also expressed how important touch is as it can provide access to places that talking might not be able to acquire. Supervisor three summarizes that she believes “that the benefits of good touch outweigh the risks.” Therefore, there are many reasons

that supervisors feel that touch is important. So important, in fact, that when done properly it can outweigh the risks.

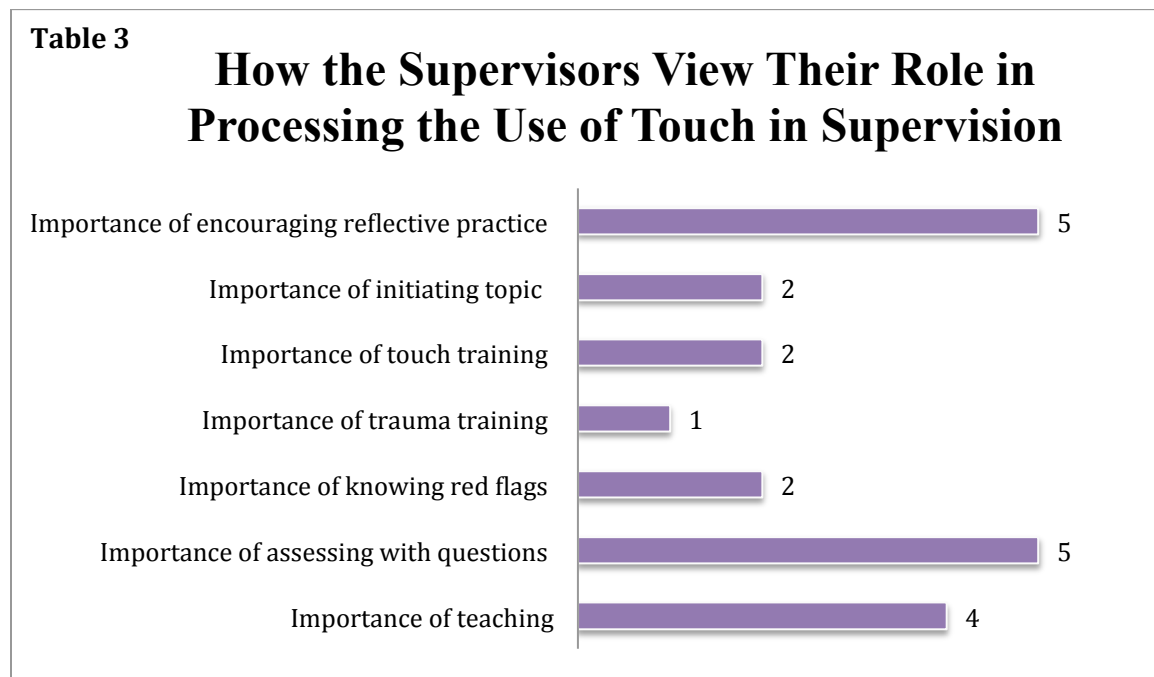
With this idea in mind, that touch can access places that talking cannot, we move to the next sub-theme. This is the idea that touch is a powerful tool. The supervisors view touch as a powerful tool that can be used to promote deep experiences and self-awareness. Supervisor one emphasized this sub-theme when he said that when we use touch “things happen at a very deep level that we don’t necessarily see or know.” Supervisor five discussed how the nervous system is activated just with incidental touch. Supervisor one took this notion a step further and explained that just talking about touch can activate the nervous system. These examples highlight how the supervisors view touch in psychotherapy as a powerful tool that, can as supervisor four said, “facilitate body awareness, body process... self experience, self awareness that are not as easy to access verbally.” Therefore, all of the supervisors viewed touch as a powerful tool in psychotherapy because it can promote a deepening of experiences and awareness and because touch can activate things within the body that are not always visible.

The last sub-theme discussed by the participants was the idea that touch is a relational process. Supervisor one stated that “ the client and practitioner are engaging in a bigger venue, it's more than just me talking about my life, and it’s about you touching me and me being touched by you and the effect of that.” As stated earlier, touch is powerful and important because it can facilitate a depth to the relationship between the client and the therapist. Supervisor four explained his thoughts on why touch is becoming more common in psychotherapy when he says, “therapists and analysts are more aware of their own bodily experience, it's like suddenly there are two bodies in the room” he goes on to describe this “shift in the understanding of the

therapeutic process, the therapeutic relationship.” Two supervisors discussed touch as having a relational aspect to it as there are two people engaging in the activity.

In conclusion, this theme explored four different, and yet connecting, sub-themes of how supervisors view touch in psychotherapy. These sub-themes include that touch is simply another intervention, an important component of human experience, a powerful tool and a relational process.

The Role of the Supervisor



The results revealed that there are various aspects of the role that supervisors need to provide. The main role of the supervisor, as emphasized by all of the participants, was the importance of reflective practice. This includes looking at the context of the relationship, if the therapist is comfortable with touch, and the therapist’s feelings about touch. For example, supervisor three asked questions like, “Why would you use touch here? Why would I say yes you should be using touch here?” Supervisor three assessed why the supervisee wanted to use

touch with a client and why the supervisor would agree to that answer. Supervisor one asked questions like, “What’s happening for the practitioner?” Supervisor two asked questions concerning awareness around why the supervisee would use touch and where that idea came from. All of the supervisors asked “why” questions to the supervisees and encouraged them to think about their role and their feelings in relation to what was happening. Essentially, all of the supervisors encouraged their supervisees to look beyond the techniques. The importance of including reflective practice in supervision is evidenced by the fact that all of the participants discussed some aspect of having their therapist think beyond the techniques. With such an emphasis and importance placed on reflective practice, it may be a suggestion to start including and introducing beginning therapists to the practice. Reflective practice could be assumed to be the best way to approach grey ethical areas in the therapeutic relationship.

All of the supervisors discussed how most of the time touch would only be discussed in supervision if the supervisee initiated the topic. Two participants mentioned how they would introduce the topic of touch if they thought it could be useful to the specific client being discussed. To illustrate, supervisor one mentioned how he would initiate the topic because “based on what I am hearing this client could really benefit from, I would name what that might be, would that be something you would be open to?” Supervisor three discussed how she would initiate the conversation by providing it as an option among a few other treatment strategies for the supervisee to explore. Therefore, when these supervisors introduced the topic in supervision, they did so because they thought it could be beneficial for the client. However, they also assessed whether the therapist would be comfortable with the proposed idea.

All of the body-oriented supervisors interviewed greatly emphasized the critical importance of the supervisor having extensive touch training as “they can’t exceed in their

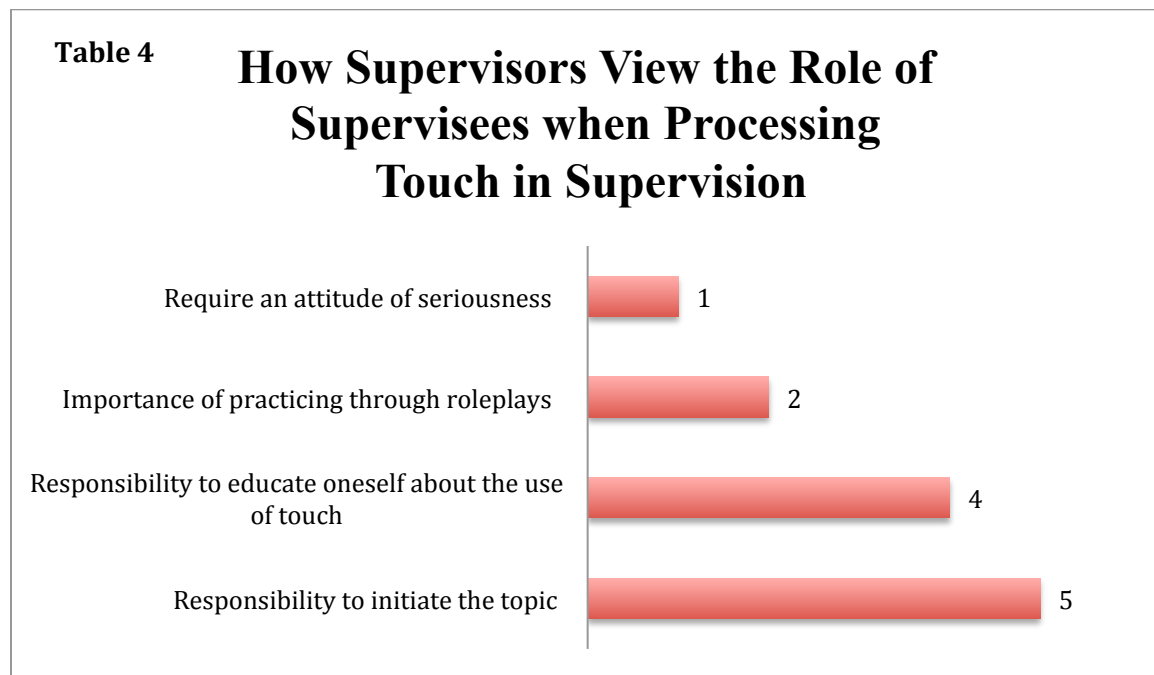
supervision that which they have not experienced” (Supervisor 5). Supervisor four discussed that without formal training on the use of touch; the supervisor should refer the supervisee. In addition to formal touch training, supervisor five stated that supervisors should be trauma trained because “if they treat casual touch as an everyday social activity with clients then they are way off target and they would be misinforming their supervisees.” However, supervisor five stated that if working with students and discussing incidental touch the supervisor needs “to have thought out their own principled ways of working with clients in that atmosphere.” Therefore, all participating supervisors recommended that the supervisor have touch training and trauma training when a supervisee would like to use touch as a formal intervention and technique. On the other hand, if the supervisee is discussing incidental touch, the supervisor should at the very least have an idea of their thoughts and philosophy about touch in psychotherapy.

Supervisors highlighted various red flags to help signal possible misuse of touch. These red flags include supervisees who accommodate to the client too much, supervisees insisting that the client is resisting and not viewing touch as an impactful encounter. In support of this sub-theme, supervisor five noted that he would pay attention for therapists being “flippant” or not taking the conversation seriously. In addition, supervisor one said that a red flag for him is when the therapist is calling the client resistant because the therapist is “judging the client as resisting... [When] I think that [clients] get to say no in the way that they know how to say no because we are asking something of them that is not appropriate of them at the time.” Supervisor one also stated that supervisors need to “be aware that there can be practitioners who will under-report how much they are actually touching, and that is a red flag for people who are probably beyond their training level.” Essentially, it appears that the red flags the supervisors identified are concerns about the therapist’s self-awareness and attitude.

All of the supervisors included questions that they ask in supervision when addressing the use of touch (see appendix G). Participants one and four discussed important teachings that may be part of the discussion when addressing touch in supervision, these teachings include that touch should not be given for comfort and learning how to have difficult conversations with clients regarding bodily functions or shame. Supervisor one and three explained how another major teaching is the idea that psychotherapist are allowed to touch. Both of these supervisors explained how they often have experiences of supervisees telling them that they were advised to never touch their clients. Therefore, these supervisors concluded that part of the teaching is informing the supervisees that psychotherapists are actually allowed to touch their clients.

In summary, theme two discussed how the supervisors viewed their role in assessing the use of touch in psychotherapy. The sub- themes found in this theme include the importance of, encouraging reflective practice, initiating the topic, touch training, trauma training, knowing red flags, assessing with questions, and of teaching.

The Role of the Supervisee



It was clear from what the supervisors were describing, that supervisees need to present in supervision with an open mind, education on the use of touch and preferably with a trauma informed lens. For example, supervisor five said that a therapist who had a trauma lens would know “that the smallest of interactions could trigger the client.” Having a trauma informed lens allows the supervisee to understand that any touch, even incidental, can have a huge impact on the client. Therefore, the role of the supervisee is to maintain an attitude that is not only open but also one that takes seriously the impact and implications of using touch in therapy.

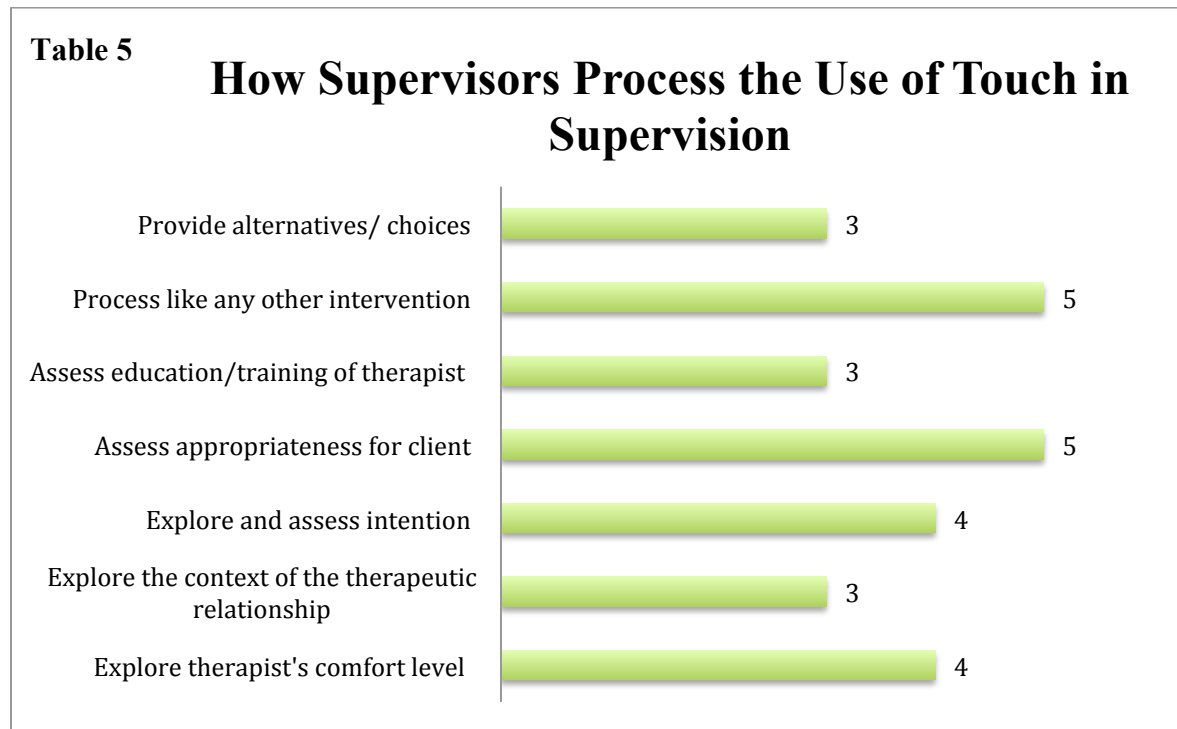
When working with people who would like to improve their skills, one participant said that he would recommend this person do role-plays with volunteers. Many of the supervisors mentioned that the therapist should practice on a few people before using touch with clients and supervisor one explicitly stated “the [therapist] isn’t actually touching me... but we could pretend.” This supervisor expressed how he would encourage the supervisee to practice with someone like a friend or colleague to gain experience. It seemed as though touch would not happen in the supervision relationship. Therefore, if a supervisee needed more practice, they would have to find and practice on a volunteer, friend or colleague.

Supervisor three stated that if a therapist wants to learn how to use touch, they should become educated equivalently to “if you want to learn CBT you should go take at least a course on it.” Since using touch as an intervention or technique comes from a theoretical orientation, supervisor three states that a supervisee should become educated before engaging in it. Furthermore, although supervision can be used to titrate the skills of the theory, it is not the place to be learning a new theory.

Another role, as previously discussed, is the role of initiating the conversation or topic in supervision. All supervisors agree that it is almost always the supervisee who is bringing the topic into supervision for discussion.

In summary of this theme, according to the participants, there are many roles that a supervisee must fulfill in supervision. These roles include appreciating the complexity and power of using touch, to practice by engaging in role-plays, to educate oneself on the theory or technique and to initiate the topic in supervision.

Processing the Use of Touch



Generally, the topic of touch is discussed with open curiosity by the supervisors; some portray touch as a choice among many different treatment options. For instance, supervisor three discussed how supervision can be helpful to discuss the “preferred intervention” more specifically when, where and who would benefit from touch. Supervisor one discussed how there

could be “alternatives, where we support the client to touch herself, or imagine someone [touching them].” Supervisor four emphasized this by stating that “part of the supervision is helping a therapist to find choices”, whether that be in the direction of touch or not.

For many, it was a normal topic of conversation and these supervisors were sought out specifically to discuss the topic of touch. For example, supervisor four mentioned how “many of the people who seek me out for supervision are interested in finding ways of bringing the experience of the body more actively into the therapeutic process.” Participant four discussed how he has found that therapists come to him for consultation for three reasons; 1) The therapist touched and is now anxious, here they want advice on how to talk about it with their client, 2) Develop more skill in the area, 3) The therapist is being pressured by the client to touch and needs to think the decision through. This same participant discussed how number three is the most common reason people seek consultation with him.

When asked how supervisors addressed touch in supervision, the common answer was, “just like any other intervention”. After being introduced in supervision, the supervisors described that it would be like any other supervision session; the supervisor would assess and ask questions for understanding. Supervisor one explained how addressing touch in supervision is like a typical supervision, “the therapist is telling me about the client, giving me some history, gender, how long they have been working with the person, why the person came in the first place, what is the difference since they first started, what their goals are now, and is the therapist stuck and what is the need to talk about this client now.” He explained that where they go is based on the answer to these questions. In contrast, someone who has no formal training on the use of touch, the second supervisor said that she would comment on the “underlying meaning of when it came up and when it didn’t come up and how they used it and what they did and what

these things meant". The common themes the supervisors discussed which could be linked to how other supervisors would approach any other intervention, were concepts like education/training of therapist, appropriateness for the specific client, the process of the interaction, limitations of the intervention and how the intervention is client centered. To expand on these concepts, all of the body-oriented therapists mentioned that they would assess the level of education/ training that the therapist had with the use of touch. Three supervisors also mentioned that their approach to supervision would differ based on the supervisee's education level. Supervisor one explained how he would discuss the more technical side of the intervention with a supervisee who is just starting with touch. However, with a more advanced supervisee, it became about more than just the technique, but instead about the relationship and self-awareness.

Appropriateness for the specific client referred to whether touch would be an appropriate intervention. For example, supervisor five discussed how for clients with trauma "even casual touch has a significant edge." In addition, supervisor three discussed how touch can be appropriate for those who's injury "happened before a child was born or in the early years before they are really using language" because touch "is the language that is appropriate for the memory that they are working on." Process of the interaction refers to the techniques of the how the therapist used the intervention and what happened when they used the intervention, including how the client reacted. Just as there are clients that touch would be appropriate for, there are clients that touch would not be appropriate for, and there are boundaries and limits to touch. For example, supervisor one discussed how too much touch can be counter productive and that we have to be careful "because things happen at a very deep level that we don't necessarily see or know." Finally, the intervention needs to be client centered. Supervisor one stated that before using touch the client should have been informed about touch and "giving them choice every

step of the way.” To place emphasis on why it is important to inform the client, supervisor one stated that “if a client goes to a body worker they are implicitly agreeing to be touched... when they come to counselling or therapy that is not generally the assumption.” All of these themes are important when assessing any other intervention a therapist may use and this research found that touch should not be addressed any differently. Essentially, this means that all trained supervisors are able to assess the possibility of incidental touch in therapy.

With that considered, there are four concepts that therapists have to pay attention to when using touch, that they would not necessarily have to attend to with any other intervention. The four concepts are: non-verbals of the client, the therapist’s intention, the therapeutic relationship, and the comfort level of the therapist. Supervisors one and four discussed how therapists should be tracking and paying close attention to the non-verbals of the client. For example, supervisor one said, “we have to pay attention to how the body or nervous system responds to the intervention.” This supervisor also discussed how supervisees have to pay attention to the non-verbal so that they can be aware of the client’s reactions to what is happening in order to stop the intervention. Supervisor four stated that he “would try to get the supervisee to describe the non-verbal behaviours.” Supervisor one explained how a client might be communicating nervousness or a request to stop through their nonverbal behaviour.

All of the supervisors stated that before touch is used, the therapist must be very clear about their intention or motivation. Supervisor five expressed that they need to have, “that conversation about what their motivation is.” Supervisor one stated he “would want to encourage other supervisors to pay attention to what is the intention.” Finally, supervisor three reinforces the importance of understanding intention when she said, “it needs to be really clear about the

intention about touch.” All of the supervisors underlined the significance of understanding the supervisee’s intention for using touch.

Again, supervisors one and four mentioned how the therapeutic relationship is an important concept because, as supervisor one said, touch “takes a particular context of a relationship, for a dynamic to be safe enough.” Supervisor four discussed if a client requested touch, and, for whatever reason the therapist does not want to, this difference should be discussed “in a meaningful way that facilitates the therapy.” To elaborate, supervisor four discussed how, instead of a supervisee saying no to touch, as a, “pronouncement that says psychotherapists don’t touch” but, that there should be an open discussion that can help to facilitate the therapeutic goal. These supervisors understood that touch happens in a trusting relationship between two people.

Lastly, all of the body oriented supervisors mentioned how the therapist must be clear on their comfort level on using touch, and, how touch will not be effective if the therapist is not comfortable. Supervisor three discussed the importance of assessing the supervisee’s comfort level when she says: “having a conversation about a person’s comfort level, you should not be touching if you are not comfortable”. Similarly, with intention of touch all of the supervisors underlined the importance of the therapist’s comfort level.

Interestingly, most of the supervisors referred to the term ‘consultation’ rather than ‘supervision’. Participant three defined this difference, as “consultation instead of supervision is that there isn’t legal responsibility, if we do supervision then we take legal responsibility for the treatment that people are doing”. Therefore, in consultation, the consultant does not have to be legally concerned about actions done by the supervisee.

In conclusion, the analysis of this research has found four major themes and various subthemes within each of those themes. The first theme that was found was the theme of how the supervisors viewed touch in supervision. The subthemes in this theme included, that touch is just another intervention, that touch is an important part of human experience, that touch is a powerful tool, and touch is a relational process. All of the participants had mentioned the first four subthemes; the last sub-theme was discussed by all but one supervisor. The second theme that emerged from the interviews was how the supervisors viewed their role in supervision: the subthemes included were the importance of encouraging reflective practice, initiating the topic, training in the use of touch and trauma, red flags, questions, and teaching. The third theme, of how supervisors view the role of supervisees when processing touch in supervision, has four subthemes including, a required attitude of seriousness, the importance of practice through role-plays, the responsibility to educate oneself in the use of touch, and the responsibility to initiate the topic in supervision. The fourth theme of how supervisors process the use of touch in supervision has seven emerging subthemes which include providing alternatives, process like any other intervention, assess education or training level, assess appropriateness, explore intention, explore the context of the relationship and explore therapist's comfort level. Therefore, all of these themes have informed the research intention of exploring supervisor's views and experiences of processing touch in supervision and to understand the practices surrounding the processing of touch in supervision.

Discussion of Research Findings

The purpose of this study was to gain a greater understanding of the experiences on supervisors in addressing the use of touch in supervision. The following is a discussion of the results gathered from the five semi-structured interviews with practicing psychotherapy

supervisors. Four major themes emerged from the analysis: 1) how supervisors view touch, 2) how supervisors view their role in processing the use of touch in supervision, 3) how supervisors view the role of supervisees when processing touch in supervision and, 4) how supervisors process the use of touch in supervision. Each theme, including the various subthemes, will be discussed in relation to the current state of the knowledge and theories about the use of touch in psychotherapy and the process of supervision.

Supervisors View of Touch

When addressing the issue of touch in supervision, a variety of supervisor values and beliefs emerged. All supervisors found touch to be an important part of human experience and an important element in therapy. Some supervisors discussed the use of touch as another intervention, as a powerful tool and a relational process. In contrast to these findings, some research has found that supervisors view the use of touch in psychotherapy as a minor clinical mistake (Daniels, 2000). Daniels (2000) conducted semi-structured interviews with seven supervisors and practitioners who have many experiences with complaints. In regard to this previous research, the positive view of touch expressed by supervisors in our study could be explained by the fact that the four out of five of supervisors interviewed in our study were body – oriented therapists.

The supervisors in this study expressed their view that touch is an important human need, and thus can be a powerful tool in psychotherapy. For example, several supervisors discussed the importance of touch for development and attachment. Research suggests that human touch is a basic need for survival and studies have found that touch deprivation can have detrimental effects on human development (Leung, 2015). Typically, no one disputes the research findings that “abnormal behaviour results” when the need for human contact or touch is not satisfied

(Montagu 1986, p.46). According to Horton et al., (1995), touch is a basic need for human development and can have healing effects including: self-acceptance and increased self-esteem for clients in psychotherapy. The supervisors in this study generally aligned with this viewpoint and expressed the belief that touch can be used as a powerful tool and thus can be seen as an important intervention in the psychotherapy process. Aligned with this view, Pattison (1973) found that physical contact, including a handshake, hand on the back and hand on the arm, could help clients reach into deeper parts of self – disclosure, exploration and move through painful and difficult emotions. Furthermore, in a recent study, Leung (2015) found that her participants discussed how touch evoked complex and conflicted emotions. Supervisor four mirrored the current literature when he said, “facilitate body awareness, body process... self experience, self awareness that are not as easy to access verbally.” In conclusion, touch can be seen as an important part of human development and the research suggests that touch in psychotherapy can be a powerful healing tool. Similarly, the supervisors in our study viewed the use of touch as another intervention or technique that therapists could use to help clients deepen self-awareness, portray acceptance, and help ground. Indeed, research has found that the use of touch by a therapist can help a client manage difficult feelings, can increase self esteem, and can increase self-awareness (Horton et al., 1995).

While the supervisors discussed touch as just another intervention, they also highlighted its relational and intersubjective process. The supervisors discussed how there are two bodies in the room when touch is occurring and thus both bodies are being affected. The touch and psychotherapy literature has yet to study the impacts of the use of touch on the therapist. From the general literature about touch and how touch impacts human beings one could assume that the therapists are also being impacted, whether or not it's verbalized in the literature.

In summary, the supervisors in this study all viewed touch as an important therapeutic element having the advantage of deepening self and body awareness. However, it is interesting to note that while they were activists on the use of touch, they were aware of the precarious nature of touch. For example, Supervisor three highlighted this complexity when she stated that the benefits of touch outweigh the risks. The supervisors in this study all viewed touch as important and having therapeutic value. Some of the supervisors viewed touch as a specific intervention that can be used to deepen self-awareness and connect clients to their bodies. An implication for this theme is that if touch is an important intervention and contains therapeutic value then it is an important competency to be addressed and developed in supervision. It is important for this competency to be developed in supervision to ensure that this competency is being used correctly and not harm the client. Moreover, touch is a relational process that impacts both therapist and client; as such supervision may be the place for therapists to discuss what happened when they used touch.

The Role of the Supervisor

The second theme that emerged from the supervisors' interviews relates to how they view their role in processing the use of touch in supervision. Related to this theme the supervisor's discussed subthemes including, the importance of encouraging reflective practice initiating the topic, touch training, trauma training, knowing red flags, assessing with questions, and importance of teaching. All of the supervisors stressed the importance of encouraging their supervisee's to engage in reflective practice. Similarly in the literature self-reflection is viewed as a foundational competency (Rodolfa, Bent, Eisman, Nelson, Rehm, & Ritchie, 2005; Fouad, Grus, Hatcher, Kaslow, Hutchings, Madson, & Crossman, 2009; Goodyear, 2014). Supervisor questioning is thought to be an effective means to encourage reflective practice (Moffett 2009;

Orchowski, Evangelista, & Probst, 2010; Overholser, 1991; Scaife, 2010). Scaife (2010) describes the benefit of uses questions to “encourage the making of links, challenge people’s stories about themselves and their lives, encourage openness to new ideas, and can lead to deep learning about oneself and the impact of oneself in others” (p. 89) The supervisors of our study all discussed the importance of encouraging reflective practice and explained doing so by using questions that allowed the supervisee to reflect on the many components of using touch.

The final subtheme found within this theme was the importance of teaching in supervision. An important aspect of supervision is teaching (Borders et al., 2014). Taking a teaching role has been found to be the most frequently used role taken by supervisors (Milne et al., 2008). Direct instruction or teaching in supervision includes the supervisor modeling the task or conversation, having the supervisee practice the same task and then the supervisor provides direct feedback. The supervisors discussed various topics that they would use teaching or direct instruction to help their supervisee gain specific skills related to the use of touch. For example, supervisor one stated that he would often practice conversation on how to introduce touch in therapy and how to educate the client about touch with supervisees. Therefore, we have seen that supervisors can use the main learning mechanisms to develop the competency of touch. Supervisors in this study used the learning mechanisms of self-reflection, direct instruction, feedback, and modeling.

Supervisors also discussed the need to initiate the topic of touch in supervision. Therefore, the supervisors in this study presented touch as an option for intervention if supervisee’s felt it was appropriate to use. From a developmental perspective, supervisors are best served to introduce interventions while considering a variety of supervisee factors such as training, therapeutic context and client needs (Borders, Glossoff, Welfare, Hays, Dekruyf,

Fernando & Page, 2014). When presenting the use of touch as a possible intervention option the supervisors often questioned supervisees about whether the intervention aligned with their competence, therapeutic context and client needs. Questions from supervisors included asking whether the supervisee was comfortable with the use of touch and whether they felt that would be appropriate for their client. The supervisors also would encourage the supervisee to brainstorm about why the supervisor was suggesting touch as an intervention. Not only did the supervisors provide touch as an alternative but they also assessed whether that option was a comfortable fit for the supervisee. Therefore, the supervisors respected the choice and feelings of the supervisee and moved to discuss other options if touch was not suitable for the supervisee.

The two subthemes that supervisors should have touch and trauma training go together. Both the participants and the literature discuss how supervisors should only be supervising areas that they have training and experience with (Borders et al., 2014). Which implies that supervisors should not be supervising the use of touch in therapy if they have not received training on the use touch. Supervisor five discussed how if the touch is not being used as a formal intervention the supervisor should have at least reflected on their values and beliefs about the use of touch in psychotherapy.

Another subtheme found within the theme on the way supervisors view their role in processing the use of touch in supervision is the subtheme of knowing “red flags”. According to Borders et al., (2014) the main responsibility of a supervisor is to ensure client welfare and safety. It is therefore important for supervisors to know the possible warning signs or behaviours of supervisees that might lead the supervisor to suspect a misuse of touch in psychotherapy. Research has found that supervisees will often not disclose important information to their supervisors, including clinical mistakes (44%) and being aware of red flags can serve to identify

moments that would benefit from further exploration.

The Role of the Supervisee

Studies have shown that certain characteristics of the supervisee can affect supervision outcomes (Bernard & Goodyear, 2014). However, little research has been conducted in the area of supervisee's roles and responsibilities when engaging in supervision (Vespia, Heckman-Stone & Delworth, 2002). The supervisors in this study named four roles and responsibilities they felt supervisee's have with regards to processing touch in supervision. The four roles and responsibilities include, an attitude of seriousness, importance of practicing their skills, responsibility to educate themselves about the use of touch and the responsibility to initiate the conversation in supervision. One of the only studies to research the roles and responsibilities of the supervisee according to both supervisees and supervisors created a list of 52 roles (Vespia et al., 2002). In comparison with the current study, Vespia et al. (2002) study did not include a direct agreement with the roles however there are some similarities. Vespia et al. identified that a role of the supervisee is to strive to achieve specific supervision goals and attempt new behaviours or interventions, which could be similar to the importance of practicing and educating oneself. Another role that was found to be similar in between Vespia et al. (2002) and the current one was the responsibility for the supervisee to identify important issues to address, which could be similar to the responsibility to initiate the topic. This study found a role or responsibility that was not included in Vespia et al. (2002) study, having an attitude of seriousness. This related to the idea that supervisee's should demonstrate the knowledge that touch is an important intervention, and that they recognize the risks involved in engaging in this use of touch. This was so important to the supervisors that they included this also as a red flag that supervisors should watch for when supervising the use of touch. It would be safe to assume that if the supervisee is

not taking the discussion of touch seriously that this may have implications that they are uncomfortable with touch or that they do not understand the implications of touch and thus should not be using touch. Using touch with this mindset may have the potential of harming both the client and the therapist. This implies that supervisors have a responsibility for monitoring seriousness, which could be discussed at the outset of supervision to foster collaborative and mutual understanding and goals for supervision.

Processing the Use of Touch

The supervisors in this study combined supervision processes and touch guidelines to process the use of touch in supervision. The supervisors described using typical supervision techniques such as Socratic questioning and instruction to assess whether touch was an appropriate intervention for the supervisee to use. Therefore, subthemes included providing touch as a choice or alternative, process like any other intervention, assess education and training, assess appropriateness for client, explore therapist intent, explore therapeutic relationship, and explore therapist's comfort level. That being said as evidence by the guidelines for using touch provided in the literature the last five subthemes are especially important for a supervisor to assess. Furthermore, the supervisor assessing these qualities on the use of touch allows the supervisee to internalize this process, and thus develop reflective practice that they could use in the future.

Throughout this discussion section the results of this studied have been supported through the supervision and touch in psychotherapy literature. The first theme on how supervisors view touch has been connected with how psychotherapists view touch in psychotherapy. The second theme of how supervisors view their role in addressing touch in supervision has been connected to various aspects of the literature including that supervision is the place for counselors to

develop skills such as the use of touch. The third themes of how supervisors view the role of supervisees in addressing the topic of touch in supervision was linked to supervision research that discusses the responsibility of supervisees in supervision. And finally the fourth theme of how touch is processed in supervision was similar components of general learning mechanisms in supervision. Once supervisees have developed the basic techniques for the competency of touch, the supervisor's model and encourage reflective practice to ensure that the supervisee internalizes this quality and thus go through the reflective process by themselves. When supervisees are able to independently utilize the reflective they will be able to make better-informed decisions on whether they should use touch with their clients.

Important Findings and Clinical Implications

This research has highlighted a few implications for supervisors to consider when addressing the use touch in supervision. This section will discuss those important findings and discuss why they are relevant for clinical practice.

This study found that many of the supervisors only addressed touch in supervision if the supervisee had initiated the topic. Therefore, supervisors may have a tendency to wait for supervisees to bring up the topic of touch before addressing it. The risk of this is that even if supervisees are using touch they may not initiate the topic in supervision. As discussed in the literature review, 44% of supervisee's did not disclose clinical mistakes to their supervisors. The supervisors in this study discussed how they often had to reteach their students, that students had been taught the incorrect notion that they were not allowed to touch clients. The supervisors discussed the ambiguity of touch in the ethics guides stating that the only touch that is prohibited is sexual touch; the professional bodies do not thoroughly discuss the non-erotic use of touch in therapy. They highlighted that it is a disservice to both the students and their clients for students

to have the false understanding that the use of touch is prohibited. However, without an appropriate knowledge base or sufficient guidelines regarding the use touch supervisees and their supervisors are left vulnerable. How could supervisors combat this? Supervisor five suggested that supervisors consider their values and beliefs about the use of touch in psychotherapy. Supervisors could have an open discussion about their beliefs and values around the use of touch with their supervisees in an effort to encourage their supervisees to disclose. If a supervisor were to incorporate these conversations into their supervision, this study has helped to understand ‘red flags’ that supervisors could look for and questions supervisors could ask (See appendix G).

Another important finding was that some of the supervisors referred to consultation rather than supervision. The distinction made was that in consultation one does not hold ethical responsibility for the client. This leads the researcher to ask the question of whether there is still fear of supervising supervision because of the risks it carries?

Future research

This research was the first to understand how to integrate the use of touch in psychotherapy in supervision. This research was the first step into understanding how supervision can address the use of touch. Further research needs to be done to create a universal model of how touch should be addressed in supervision. How should supervision address the use of touch? Are there tools or activities that could aid in the knowledge and understand of the use of touch for supervisees? Can a model be developed to help supervisors address the use of touch in supervision? Key areas that should be addressed in further research is the initiation of the topic of touch, supervisor education about the use of touch, and the best practices for developing the competency of using touch.

Conclusion

It can be concluded that this study has fulfilled its aim of understanding whether or not touch is addressed in the context of supervision and how the supervisors made sense of their experiences. This study has contributed to the understanding of how supervisors view the use of touch, how supervisors view their role and the role of the supervisee when processing the use of touch in supervision and how supervisors process the use of touch in supervision. This study explored supervisor's experiences that can inform how to incorporate and process the use of touch in supervision. Although more research needs to be conducted in this area, this research has highlighted the importance of supervisor initiation and reflective practice when processing the use of touch in supervision. This study has also identified 'red flags' for improper use of touch and questions supervisors could use when assessing the use of touch in supervision.

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Appendix A



UNIVERSITÉ
SAINT-PAUL
UNIVERSITY

01-04-2016
dd-mm-yyyy

Bureau de la recherche et de la déontologie
Office of Research and Ethics

**Ethics Certificate
Research Ethics Board (REB)**

REB File Number 1360.16/15

Principal Investigator / Thesis supervisor / Co-investigators / Student

| <u>Last name</u> | <u>Name</u> | <u>Affiliation</u> | <u>Role</u> |
|------------------|-------------|---------------------------|-----------------|
| Kosierb | Samantha | Faculty of Human Sciences | PI-MA candidate |
| Bilodeau | Cynthia | Faculty of Human Sciences | Supervisor |

Type of project Master's Thesis

Title Teaching Touch: A phenomenological study of how touch is addressed in clinical supervision.

| <u>Approval date</u> | <u>Expiry Date</u> | <u>Decision</u> |
|-----------------------------------|-----------------------------------|---------------------|
| 01-04-2016 (dd-mm-yyyy) | 31-03-2017 (dd-mm-yyyy) | 1 (approved) |

Committee comments

**The Research Ethics Board (REB) approved the project.
The researcher is invited to use the reference number 1360.16/15 when recruiting participants.**

In accordance with the Tri-Council Policy Statement, the Saint Paul University Research Ethics Board has examined and approved the application for an ethics certificate for this project for the period indicated and subject to the conditions listed above.

The research protocol may not be modified without prior written approval from the REB. This includes, among others, the extension of the research, additional recruitment for the inclusion of new participants, changes in location of the fieldwork, any stage where a research permit is required, such as work in schools. Minor administrative changes are allowed.

The REB must be notified of all changes or unanticipated circumstances that have a serious impact on the conduct of the research, that relate to the risk to participants and their safety. Modifications to the project, information, consent and recruitment documentation must be submitted to the Office of Research and Ethics for approval by the REB.

The investigator must submit a report four weeks prior to the expiry date of the certificate stated above requesting an extension or that the file be closed.

Documents relating to publicity, recruitment and consent of participants should bear the file number of the certificate. They must also indicate the coordinates of the investigator should participants have questions related to the research project. In which case, the documents will refer to the Chair of the REB and provide the coordinates of the Office of Research and Ethics.

Signature

Louis Perron
Chair
Research Ethics Board (REB)

1/1

Appendix B

Semi-structured Interview Questions

(With each question the researcher may follow up with “Can you give me a specific example to illustrate your response?” to illicit fuller and richer qualitative data.

Preliminary Questions:

1. How long have you been a supervisor?
2. What theoretical framework informs your clinical practice?
3. Do you engage in touch with your clients?
4. Have you ever received formal training on the use of touch in therapy?

Exploratory Questions:

What has your experience been when teaching the topic of touch in supervision?

How has the topic of touch been initiated in supervision? Did student or supervisor initiate it?

What are the reasons you have included the topic of touch in supervision?

What do you feel is the value of including touch in supervision?

What are your thoughts and beliefs around the use of touch in psychotherapy?

How does this influenced the way you present the topic of touch in supervision?

What types of things do you take into consideration when talking about touch in supervision?

Why do you feel it is important to talk about the use of touch in supervision?

Based on your experience, what are your recommendations for how to teach touch in supervision?

If not, what has been your experience around not including the topic of touch in supervision?

Have there been specific reasons for not including the topic of touch in supervision?

Closing Questions:

Do you have anything that you would like to add to what we have covered? Or that you feel is important to add?

Do you have any questions for me at this point?

Closing statement:

Thank you for contributing your time and energy to my study. I will be sending you a copy of the transcript of this interview as soon as it is ready for your review and comments. Please feel free to contact me at any time with any concerns or questions through email or phone. The researcher will contact you in a few days to follow up, giving you an opportunity to share any additional thoughts that you may want to share and address any concerns that may arise. Thank you once again for your participation in this study.

Appendix C



CLINICAL SUPERVISORS

YOU ARE INVITED TO PARTICIPATE IN THE PROJECT:

“Teaching Touch: A phenomenological study of how touch is addressed in clinical supervision”

This study seeks to explore and understand from the perspective of clinical supervisors, how issues of touch are addressed in the context of clinical supervision. Your participation will require you to engage in a one-on-one qualitative interview that will last no more than 60 minutes. Your participation is voluntary and will remain confidential.

If you would like to participant or would like to receive further information about this study please contact the researcher listed below:

Addressing Touch
Samantha Kosierb
skosi050@uottawa.ca

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skosi050@uottawa.ca

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Appendix D



CLINICAL SUPERVISORS

YOU ARE INVITED TO PARTICIPATE IN THE RESEARCH PROJECT:

“Teaching Touch: A phenomenological study of how touch is addressed in clinical supervision”

This study seeks to explore and understand from the perspective of clinical supervisors, how issues of touch are addressed in the context of clinical supervision. Your participation will require you to engage in a one-on-one qualitative interview that will last no more than 60 minutes. Your participation is voluntary and will remain confidential.

If you would like to participate or would like to receive further information about this study please contact:

Appendix E



Hello to all supervisors,

M.A. Candidate Samantha Kosierb (under the supervision of professor Cynthia Bilodeau) from the School of Counselling, Psychotherapy and Spirituality at Saint-Paul University In Ottawa, Canada is looking for your participation in a study aimed at understanding supervisor's experiences of addressing issues of touch in supervision.

Your very valuable participation in this study will allow you to contribute to this knowledge base. Your confidential participation in this study will require no more than a brief one-hour interview at your earliest convenience. Telephone interviews can be arranged if you reside outside of the Ottawa area.

If you are interested in participating or would like to know more about this research, please contact Samantha Kosierb at skosi050@uottawa.ca.

Thank you for your participation!

Appendix F



Consent Information for Supervisors

Title of research project:

Teaching Touch: A phenomenological study of how touch is addressed in clinical supervision.

Description of the research project:

The purpose of the study is to understand the experiences of clinical supervisors when addressing touch in supervision.

Participation in the research project:

Your participation will consist essentially of one hour-long interview during which you will be asked to answer research questions. The interviews have been scheduled for June and July 2016 at Saint Paul University or via telephone. You will also be asked to review and provide feedback once the data has been analyzed.

Confidentiality

We assure you that all your answers will be strictly confidential. Anonymity and confidentiality will be assured throughout the study. Only members of the research team (Cynthia Bilodeau and Samantha Kosierb) will know who participated in the research and only they will have access to the results. Data will be kept under lock and key at the office of professor Bilodeau, located at Saint Paul University and only the research team will have access. Data will only be analyzed to inform **this research project**. The data will be retained for 5 years and then destroyed.

Possible advantages and disadvantages of this research:

Your participation in this research will not be paid. However, if a summary of the results of the study becomes available, it will be emailed to you if that is your wish. Your participation in this study will provide you with the opportunity to share your experiences and further your reflexive practice. Your participation in this study will contribute to the advancement of understanding of how touch is addressed in supervision. If participation in this study generates in you a psychological discomfort, which is unlikely, and you would like to further explore this discomfort, we recommend that you contact the Student Counselling Services at Saint Paul University (613) 317-2179. Note participation in this study poses minimal risk.

Your participation in this research:

Your participation in this research is completely voluntary and you are free to withdraw from the research at any time or refuse to answer certain questions. The results will be reported in a comprehensive manner and no names will appear in papers published from this study.

Your questions:

If you have any questions, concerns or comments about this study, please contact the principal investigator, Cynthia Bilodeau, at the following address: cbilodeau@ustpaul.ca. For information about your rights as a participant, you can contact Dr. Louis Perron, Director of the Ethics Committee for Research at Saint Paul University, to the following email address: lperron@ustpaul.ca

Thank you for your attention and please accept our warmest regards,



Cynthia Bilodeau, Ph.D.
Assistant Professor
Saint-Paul University
Faculty of Human Sciences and Philosophy
Tel: (613) 236-1393 ext. 2455

Samantha Kosierb, M.A. Candidate
Saint-Paul University
Faculty of Human Sciences and Philosophy
Tel: (613) 236-1393 ext. 4237

Consent

I _____, agree to participate as a volunteer in this study. I have read the information provided in the consent form and have been given the opportunity to ask all the questions that I have about the study and all such questions and inquiries have been answered to my satisfaction. I understand that I am free to withdraw my consent and terminate my participation at any time. I have received a copy of this signed form.

Participant signature

Date

Investigator's signature

Date

I would like to be notified by email once the results are made available or published: _____

Appendix G

Questions Participants Ask in Supervision

Supervisor 1

How much training does this supervisee have?

Are they a body worker or not?

How much have they actually practiced touch work?

What is their comfort level?

Are they giving the client enough information about it as possible?

What is the intention of wanting to touch?

Why do you think that would be the most helpful thing?

What was being called at that time when you did want to move into touch and did or didn't follow it?

Supervisor 2

When did it come up?

How did they use it?

What specifically they did and what these things meant?

Supervisor 3

What is their experience with touch?

What is the client's experience with touch?

Do you know how to track that client?

Do you know that they can say no?

What is their comfort level?

What is their own level of experience?

Do they fully understand the reason that touch is being used or that it is being suggested?

Why they are doing it? Intention of using touch?

Supervisor 4

Where the client is in the treatment process?

How long a therapist and a client having been working together?

Whether there is a kind of transition that's emerging in the therapy where there needs to be a shift from a verbal cognitive style of interaction to more direct body interaction.

If the therapist has already established in the basic frame of the treatment process that there may be times when the focus will be on the person's bodily experience?

Supervisor 5

What training they have had?

Have they done the full advanced training which gives them some information about touch?

What their professional status is?

What professional group do they belong to?

What other training that they have that relates to touch?

What other course they have had that would support the use of touch?

What is the context in which they're talking about using touch? is it private practice? is it an institution of some sort or a group?

What are the parameters within that that particular group?

Within their professional discipline what is their scope of practice?

Are they at the beginning or have moved on to working with more than just a few clients?

What have they noticed in their conversations and observations of the client?

What is it that they are imagining is going on in the nervous system?

What is or are the interventions they would be taking with that particular client and why?