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Touching in Psychotherapy: A Case Study

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TOUCHING IN PSYCHOTHERAPY: A CASE STUDY

by
Cassandra L. Tyson

Bachelor of Science, Purdue University, 1973

A Thesis

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master of Arts

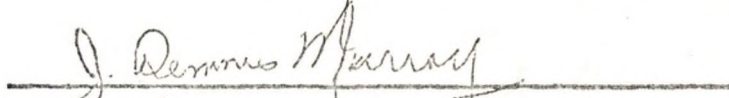
Grand Forks, North Dakota

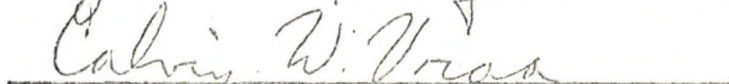
August
1975

This Thesis submitted by Cassandra L. Tyson in partial fulfillment of the requirements for the Degree of Master of Arts from the University of North Dakota is hereby approved by the Faculty Advisory Committee under whom the work had been done.



(Chairman)







Dean of the Graduate School

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ABSTRACT

There is a wide range of opinion among psychotherapists as to the appropriateness of physical contact between therapist and client. Some suggest that touching facilitates the development of the therapeutic relationship; others, however, argue that potentially harmful effects far outweigh possible benefits.

In the present case study, touching was manipulated using an ABA reversal design during each of four initial meetings of a male therapist and female client. Dependent measures included therapist and client immediacy and speech production, and client self-disclosure. Time series data for each dependent measure were examined to determine whether client and/or therapist behavior changed in response to touch. Additional correlational analyses were performed to provide information on patterns of concomitant variation, over time, among the various immediacy, speech, and disclosure measures.

Therapist-initiated touch increased client speech production in two of the sessions, but also produced compensatory reductions in client immediacy (e.g. reduced gaze, backward lean), especially in early sessions. The results suggest that the effects of touch on the client-therapist

relationship can be quite complex and may change as the therapeutic relationship develops. The results also highlight the importance of examining therapist as well as client response to physical contact.

CHAPTER I

INTRODUCTION

There is a wide range of opinion among psychotherapists about the appropriateness of physical contact between therapist and client. Some (e.g. Gendlin, 1964; Jourard, 1968; Mintz, 1969) suggest that touching facilitates the development of the therapeutic relationship; others (Wolberg, 1967; Spotnitz, 1971), however, argue that potentially harmful effects far outweigh possible benefits.

Arguments favoring touch in psychotherapy come from a variety of theoretical orientations. Several psychoanalysts (Bosanquet, 1970; Forer, 1969; Burton and Heller, 1964) have stressed the utility of touch in facilitating transference, resolving resistance, meeting preoedipal personality needs, and encouraging social interaction. Eclectic therapists such as Mintz (1969) and O'Hearne (1971) have focused on physical contact as a form of nonverbal communication which can be used when speech is not sufficient. Experiential and client-centered therapists, who offer perhaps the strongest advocacy of touching, emphasize its role in communicating empathy, warmth, and genuineness. For example, Gendlin (1964) views touch as a way of expressing the concern and emotional availability of the therapist. Similarly, Varley

(1959) suggests that touch, better than words, communicates the therapist's understanding and acceptance of the client's emotional state.

Other therapists (e.g., Wolberg, 1967; Spotnitz, 1971) many of them psychoanalytically oriented, hold the view that physical contact is contraindicated because it can mobilize sexual feelings in the client or therapist, precipitate regression to infantile behavior, lead to violent outbursts of anger, or cause excessive dependency. These therapists also stress that touching interferes with development of transference by involving the therapist in a more active relationship with the client.

Although speculation about effects of touch in psychotherapy is abundant, the literature includes little related empirical research. The research that has been done is limited to (a) an investigation of effects of touch by psychiatric nurses (Aguilera, 1967), (b) a laboratory-analogue study of touching and self-disclosure (Jourard and Friedman, 1970), (c) a survey study in which therapists described their experiences with physical contact (O'Hearne, 1971), and (d) a widely cited experimental study focusing on touch during an initial counseling interview (Pattison, 1973).

In the Pattison (1973) study, twenty female subjects who had requested personal counseling were randomly assigned to touch and no touch groups. Those in the touch condition experienced therapist-initiated physical contact during the initial counseling interview. In the physical contact

condition, the therapist shook hands with the client prior to the interview, indicated seating position by placing his hand on the client's shoulder, placed his hand on her forearm or hand twice during the interview, and again placed his hand on the client's shoulder as he escorted her out of the office. Both touch and no touch subjects received client-centered counseling stressing reflection of feelings. When the interviews were divided into five minute segments and rated by trained judges using the Depth of Self-Exploration Scale (Traux and Carkhuff, 1967), clients in the touch condition showed significantly greater self-exploration than those who were not touched. However, the touch and no touch groups did not differ in their post-session response to the Barrett-Lennard (1962) Relationship Inventory, which assessed the client's perception of the therapist in terms of empathy, regard, congruence, and willingness to be known.

The study by Jourard and Friedman (1970) employed a relatively trivial touch manipulation in which the experimenter placed his hand on the subject's back while guiding him into the room. Dependent measures included "client" self-disclosure and positive feelings toward the experimenter and the research setting. Generally, it was found that experimenter self-disclosure, a second independent variable, influenced client behavior to a much greater degree than did touching. When the effects of touch were separated from those of experimenter self-disclosure, touch produced no significant results.

In an earlier study, Aguilera (1967) investigated the effects of touch on interactions between nurses and psychiatric patients. Based on reports of the nurses, patients, and an observer, she concluded that touch gestures initiated by the nurses resulted in increased verbal interaction, improved rapport, more frequent approach behavior, and more positive patient attitudes.

O'Hearne (1971) interviewed twenty-five psychotherapists who touch their clients in therapy. The therapists, who used clinical judgment in determining when touching would be helpful, gave very favorable reports. They were aware of the possible misinterpretation of their touching behavior but felt that misinterpretation occurred more often among their colleagues than among their patients. O'Hearne's subjects also reported touching clients more in group settings than in individual therapy.

To summarize, the available empirical research provides tentative evidence that touch has generally positive effects when used in helping relationships. However, it is important to recognize that (a) the testimonials of satisfied therapists (O'Hearne, 1971) cannot be considered "hard" evidence, (b) Jourard and Friedman used a rather limited touch manipulation which occurred before and not during the interview, and (c) Aguilera's results, while suggestive, are based on gross measures of verbal behavior and attitudes, and her experimental procedures are not described with enough precision to assess their adequacy. There are no data available

on how touch effects nonverbal aspects of the therapist-client relationship, or on possible changing effects of touch over time (or sessions). In addition, it may be naive to assume that therapist-initiated touch affects only the client. For this reason, it seems important to look at effects of therapist touching not only on the client but also on the process of the therapeutic dyadic interaction.

Social-psychological theory and research concerning "intimacy-equilibrium" in dyadic interaction, (Argyle and Dean, 1965; Patterson, 1973) though not directly related to psychotherapy, is also pertinent to the touching issue. Argyle and Dean proposed that in interpersonal situations there are both approach and avoidance forces (e.g. affiliative needs, fear of intimacy) which eventually balance at some level of mutual comfort for the interactants. Once a comfortable intimacy equilibrium has been established, any change in intimacy by one interactant requires a compensatory adjustment by the other. Empirical research using nonverbal measures of intimacy or immediacy (e.g. interpersonal distance, eye contact, forward lean) generally supports this hypothesis (see review by Patterson, 1973a). For example, there is evidence that increases in immediacy (e.g. increased proximity) on one nonverbal dimension are often accompanied or followed by immediacy decreases (e.g. reduced eye contact) on other dimensions. Since touch is generally considered the most intimate or immediate of the nonverbal behaviors (Mehrabian, 1972), its initiation by a therapist might under some circumstances be expected to precipitate compensatory withdrawal by the client.

The present study employed an intensive (N=1) case-study design (Leitenberg, 1973) in examining the effects of therapist touching on client self-disclosure, and on client and therapist speech and nonverbal immediacy. Touch was manipulated using an ABA reversal design within each of four therapy sessions, thus adding a longitudinal dimension not present in previous research and allowing for the identification of possible changes in the effects of touch over sessions. By monitoring the speech and nonverbal behaviors of both participants, it was possible to study effects of therapist touching not only on the client but also on the process of the ongoing dyadic interaction.

The dependent measures were selected because of their hypothesized relevance to the therapeutic process. Client self-disclosure is conceptually similar (though not identical) to the self-exploration measure which was sensitive to the touch manipulation in Pattison's study. Jourard and others (e.g. Rogers, 1961; Mowrer, 1964) consider self-disclosure, or the "act of revealing personal information to others" (Jourard, 1971, p. 2), to be an important process variable in psychotherapy. Research has demonstrated that client self-exploration, which usually involves self-disclosure, leads to favorable outcome in psychotherapy (Rogers, 1964; Rogers and Traux, 1962, 1967; Traux and Carkhuff, 1964, 1967).

The nonverbal immediacy cues (gaze, forward lean, and body orientation) were included because they have been shown to be important in communicating interpersonal attitudes

(Mehrabian, 1972) and thus provide behavioral indicators of closeness or rapport which are independent of self-report. The immediacy behaviors were also used to assess the applicability of the intimacy-equilibrium hypothesis to psychotherapy.

The final dependent variables were therapist and client speech duration. Since psychotherapy is primarily a verbal interaction between the client and therapist, it is important to know whether touching grossly enhances or inhibits speech production.

The results will speak to several questions: Does touch, as its advocates claim, facilitate closeness, rapport, and disclosure in a therapeutic relationship? Or, on the other hand, does physical contact inhibit therapeutic progress by precipitating client withdrawal? If touch does have demonstrable effects, do these effects change over time? Finally, since both client and therapist behaviors will be monitored concurrently, the data should also provide information on how these behaviors vary together over time.

CHAPTER II

METHOD

General Design

Touching was manipulated using an ABA reversal design (Barlow and Hersen, 1973; Lietenberg, 1973) during each of four initial meetings of a male therapist and a female client. Time series data on client and therapist speech duration, client and therapist nonverbal immediacy (other-directed gaze, body orientation, forward lean), and client self-disclosure were examined to determine (a) whether client and/or therapist behavior changed systematically during the touch phase of each session relative to the preceding baseline, and (b) whether such changes, if they did occur, were reversible. Additional correlational analyses were performed to provide information on patterns of concomitant variation, over time, among the various immediacy, speech, and disclosure measures.

Subject

The subject was a 19-year-old, female college student who prior to attending the university lived in rural North Dakota. During her first two years on campus, she participated at the University Counseling Center in individual psychotherapy, which focused on improving interpersonal

relationships, increasing self-acceptance, and clarifying future vocational goals. Her therapist reported that no physical contact had occurred in their sessions and described her attitude toward touching as "disbelief that anyone would have good feelings toward her and would want to touch and comfort her."

The subject was selected primarily because she was available as a Counseling Center client and was willing to participate in a "study of therapist behavior" which would entail her meeting with a new therapist for four, one-hour sessions, each of which (she understood) would be tape-recorded and observed by research personnel located behind a one-way mirror. The client was thus aware that she and the therapist were to be observed but was given no information concerning the specific behaviors (i.e., lean, orientation, etc.) which would be monitored. She was also assured that only the research staff would have access to recordings of or data from the experimental interviews and that agency confidentiality policies would otherwise be scrupulously followed.

Therapist

The therapist was a 39-year-old, male counseling psychologist, well respected in the University community, with eight years of post-doctoral counseling experience. At the time of the present study, he was a member of the Counseling and Guidance Department faculty and a staff member of the University Counseling Center. The therapist was generally

client-centered in orientation and was selected in part because of his willingness to use physical contact in therapeutic interviews.

Prior to the study, the therapist was given written guidelines (see below) describing the touch procedure and criteria to be used in determining when to make physical contact with the client. He then practiced the procedure in a preliminary session with a volunteer subject and received informal feedback from the experimenter and the volunteer as to the naturalness and/or appropriateness of his touching behavior.

Setting, Apparatus, and Material

The experiment was conducted in a carpeted, 10 X 12-foot room located in the University of North Dakota Psychological Services Center. The room was furnished with two straight-back chairs, a desk, and a bookcase. A small green light, used to signal the therapist of appropriate times for touching, was concealed among plants on the bookcase. Alongside the chairs was a 4 X 3 foot one-way mirror through which the therapist and client were observed from an adjacent room. Observers used Standard Electric running time meters to monitor the duration of gaze and speech. Data sheets were used to record duration data and observers' ratings of lean and orientation.

Procedure

Four, one-hour therapy sessions were held during a two-week period. Except for the touch procedure, the therapist conducted the sessions as he would normally do client-centered therapy. Each session was divided into three, 20-minute phases following an ABA reversal design. The first phase (A₁) was a baseline period during which no touching occurred. Physical contact as described below was initiated by the therapist during the middle 20 minutes (phase B) of each session. During the final phase (A₂) no touching occurred. The reversal design thus allowed for assessing immediacy, speech, and client self-disclosure in the touch phase (B) relative to both the preceding no-touch baseline (A₁) and the reversal phase (A₂) during which touch was discontinued.

Physical contact followed guidelines described by Pattison (1973): Touching could include the therapist placing his hand on the client's hand or lower arm or placing his hand and arm on the client's upper back or shoulder. The timing, frequency, and length of physical contact within touch phases was left to the judgment of the therapist. Criteria upon which judgments were to be based followed O'Hearne (1971) and Pattison (1973). In general, the therapist could touch (1) when interrupting to seek clarification or to summarize; (2) when the client held herself rigid while showing despair or rapidly increasing anxiety; (3) when the client needed support and reassurance of her "loveableness";

(4) when the client made an effort to change characteristic maladaptive behavior, or (5) when other communication channels were blocked.

Dependent Measures

Data for immediacy, speech duration, and self-disclosure were collected during four therapy sessions. Following the ABA reversal design, each session was divided into three 20-minute phases. For purposes of data collection, each 20-minute phase was further divided into two, nine-minute observation segments and two, one-minute rest periods (for the observers). Within each nine-minute segment, one data point for each dependent measure was obtained in each of 18 consecutive 30-second intervals. Thus, for each measure, there was a total of 36 data points per phase or 108 data points per session.

The time series data were simplified by pooling (averaging) across three adjacent 30-second intervals, ultimately yielding a total of 12 data points per measure in each 20-minute phase (36 in a full session). Accordingly, each data point in the figures and analyses to be presented below represents a 90-second interval.

Measurement of Immediacy and Speech Duration

Client and therapist forward lean, body orientation, other-directed gaze, and speech duration were monitored by three observers behind a one-way mirror. As described above, data were collected during a number of 30-second recording intervals. During the first 15 seconds of each interval,

observer #1 operated a running time meter whenever the client looked in the vicinity of the therapist's eyes. This provided the measure of client other-directed gaze. Therapist other-directed gaze was monitored in a similar manner by Observer #2. Observer #3 operated two running time meters, one for each participant, whenever the client or therapist spoke. This provided the measure of speech duration. At the 15-second point, observer #1 noted client forward lean and body orientation while observer #2 made similar ratings of the therapist. During the remaining 14 seconds, all observers entered the meter readings and ratings on data sheets and reset the time meters for the next recording interval. A timer-tape playing in the observation room signaled to observers the beginning and midpoint of each 30-second interval.

The following immediacy and speech duration measures were recorded for the therapist and client:

- (1) Forward lean: Based on the number of degrees that a plane from the participant's shoulders to his hips is away from a vertical plane (Mehrabian, 1972), a four-point rating scale was used, ranging from "4" (lean approximately 60 degrees forward from a vertical plane), through "3" (lean approximately 30 degrees forward from a vertical plane) and "2" (vertical position), to "1" (leaning back approximately 45 degrees from a vertical position).
- (2) Body orientation: Based on the number of degrees a plane perpendicular to the plane of the communicator's shoulders is turned away from the median plane of the receiver (Mehrabian, 1972), a four-point rating scale was used. A directly frontal orientation was rated "4," with progressive deviations from frontal orientation in either direction rated "3" (30 deviation), "2" (60 deviation), and "1" (90 deviation), respectively.

- (3) Other-directed gaze: The percentage of the 15-second recording interval during which the participant looked in the vicinity of the other participant's eyes.
- (4) Speech duration: The percentage of the 15-second recording interval during which the participant spoke.

Reliability data were obtained during a preliminary session during which pairs of observers monitored and rated independently the speech and immediacy behaviors of the same practice subjects. Following the procedure described above, observers #1 and #2 recorded gaze, lean, and orientation for the same subject over a 20-minute time period. Observers #2 and #3 then monitored speech duration for both subjects during another 20-minute time period. Observers' ratings of each measure, when correlated over 18 data points, yielded inter-judge reliabilities of $r = .74$ for lean, $r = 1.00$ for orientation, $r = .94$ for gaze, and $r = .96$ for speech duration. Percent-of-agreement, based on the number of identical ratings made for each measure by the two observers, was 100 percent for body orientation and 94 percent for forward lean. The reliability estimates for each of the speech and immediacy estimates thus appear to be generally satisfactory; however, since reliability data were collected in a practice session when observers may have been especially vigilant, there can be no assurance that ratings taken during the therapy sessions proper had comparable reliabilities (see Patterson, 1973b).

Measurement of Self-Disclosure

Therapy sessions were recorded using a Wollensak tape recorder, located in the observation room and connected to the audio-monitoring facilities of the Psychological Services Center. Therapy tapes were divided into 30-second intervals corresponding to those used for the collection of speech and immediacy data. The tape segments were then transcribed by the experimenter and given in random order to two judges.

Self-disclosure ratings were based on the Haymes (1969) technique, which defines self-disclosure as "expressions of emotion and emotional processes, expressions of needs, expressions of fantasies, strivings, dreams, and hopes, and expressions of self-awareness (Jourard, 1972, p. 216)." A three-point scoring system was used in which self-disclosure with a first person reference receives two points while reflexive third person references receive one point. Speech not falling into one of the disclosure categories receives a score of zero. Each statement within a 30-second interval was rated using this system with the score of the maximally disclosing statement in the interval being used as the rating for the entire interval.

Two graduate students in clinical psychology served as the self-disclosure judges. Prior to rating the transcribed tape segments, the judges read Haymes' description of the self-disclosure categories and studied examples of one- and two-point disclosures in each category.

Reliability data for the self-disclosure measures were obtained at two points during the rating process. Judges initially provided independent ratings of 70 identical intervals from the transcribed tape. After rating 100 of the remaining intervals (50 each), the judges were given 30 identical intervals to determine whether they had drifted apart while rating different material. (Judges rated identical intervals only during the reliability estimation procedures.) Pearson product-moment correlations and percent-of-agreement scores were used to estimate reliability. Combined reliability for all 100 intervals was estimated to be $r = .71$ by the correlational method with an interjudge agreement of 80 percent. For the initial 70 and middle 30 intervals, reliabilities, as estimated by the correlational method, were $r = .80$ and $r = .60$ with interjudge agreements of 81 percent and 73 percent, respectively.

CHAPTER III

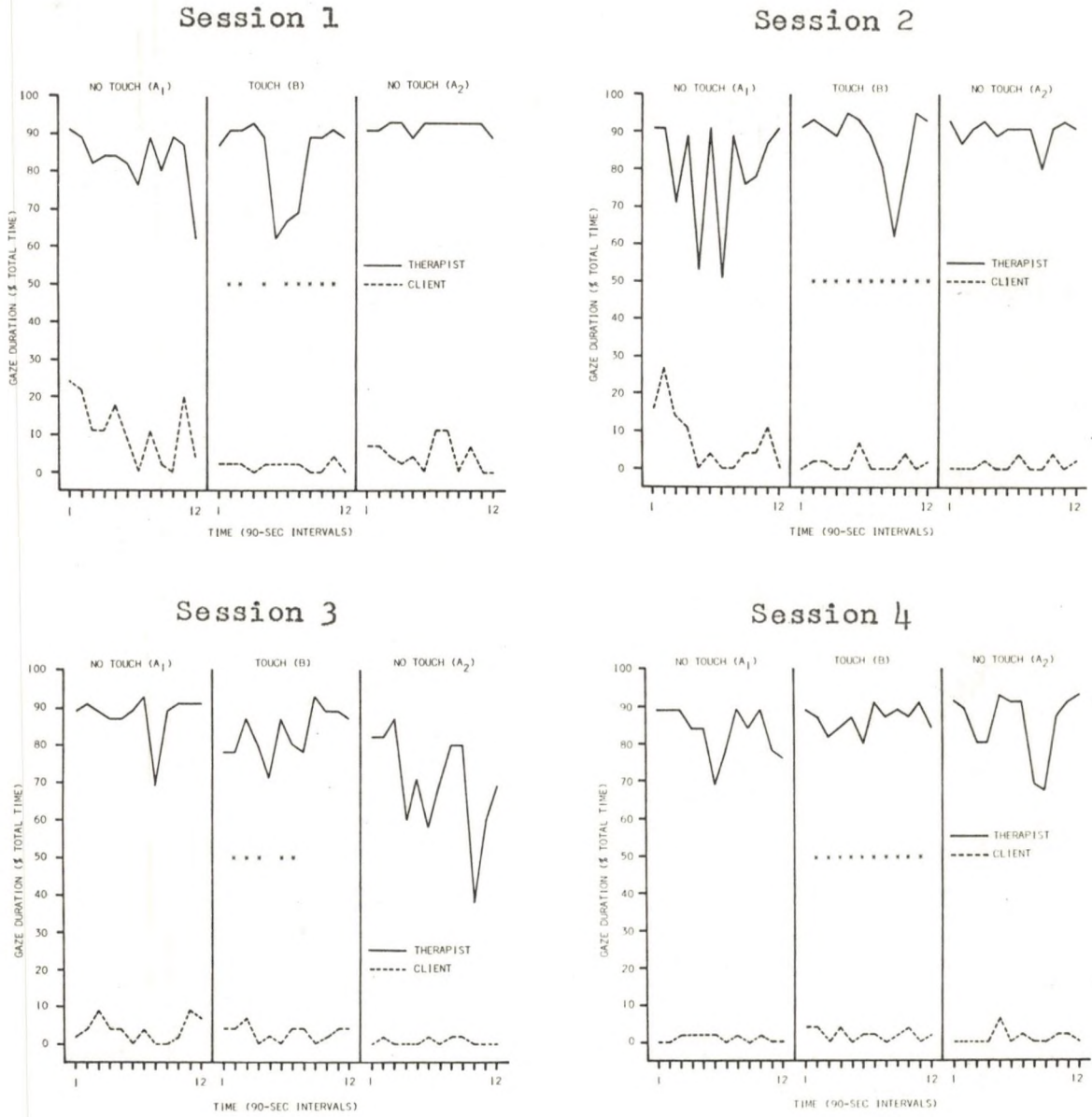
RESULTS

Analysis of Reversal Data

Time series data for gaze, forward lean, speech duration, and client self-disclosure are presented in Figures 1-4, respectively. Figures 1, 2, and 3 include both client and therapist data for each of the four sessions. Figure 4, however, shows only client data (ratings of therapist disclosure were not obtained) and encompasses only three therapy sessions (Session 1 was not recorded due to equipment failure). In all figures, time is plotted on the abscissa. For a given session there is a total of 36 data points, 12 from each phase of the ABA reversal design. Since each data point was obtained by pooling scores from three consecutive, 30-second recording intervals, the units on the abscissas of Figures 1-4 represent 90-second time intervals.

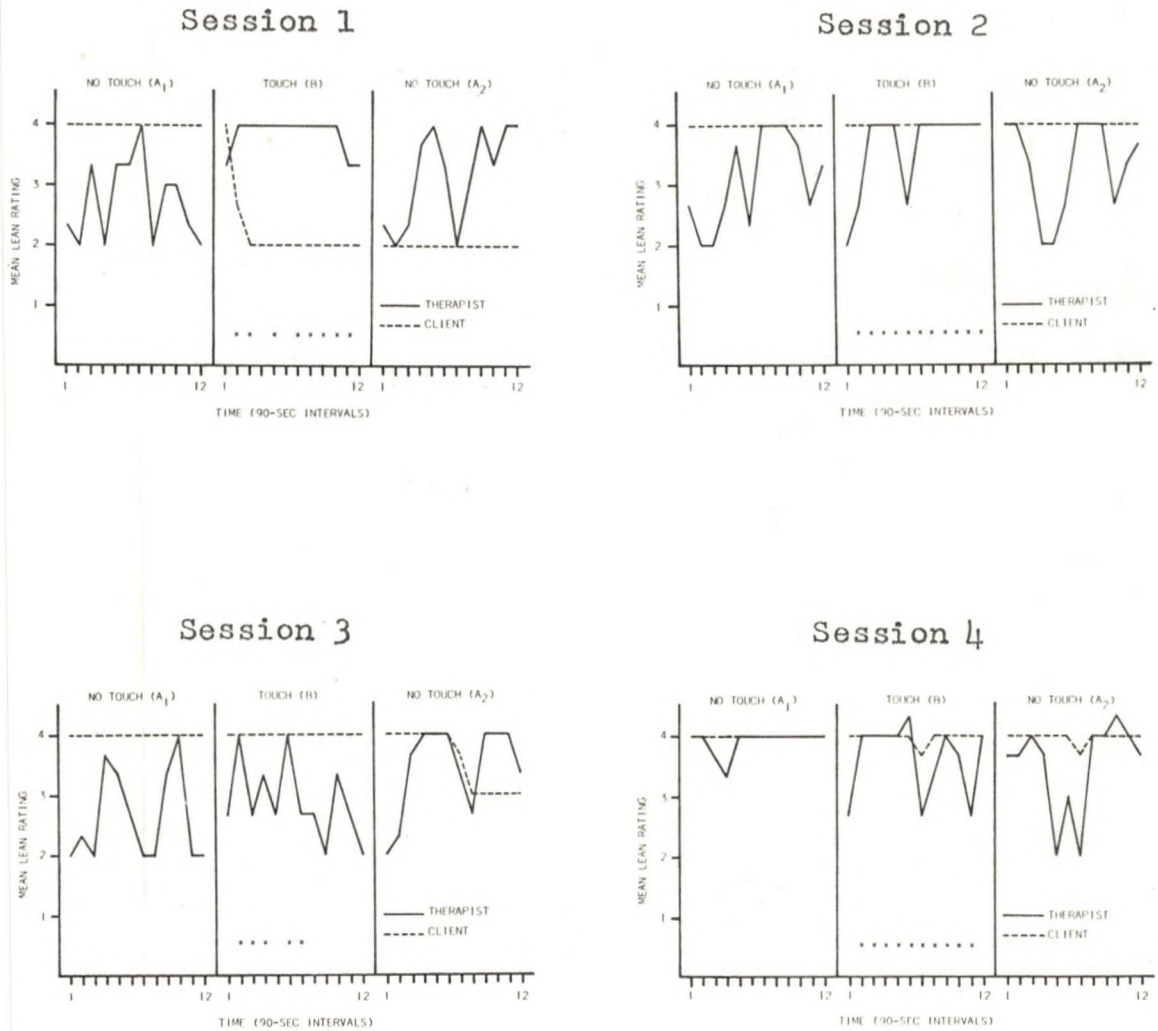
Niether the client nor the therapist varied directness of body orientation during any of the sessions. For this reason, the orientation measure was dropped from subsequent analyses.

The main question to be answered by the reversal data is whether speech, immediacy, and disclosure levels changed as a result of therapist-initiated touch. In general,



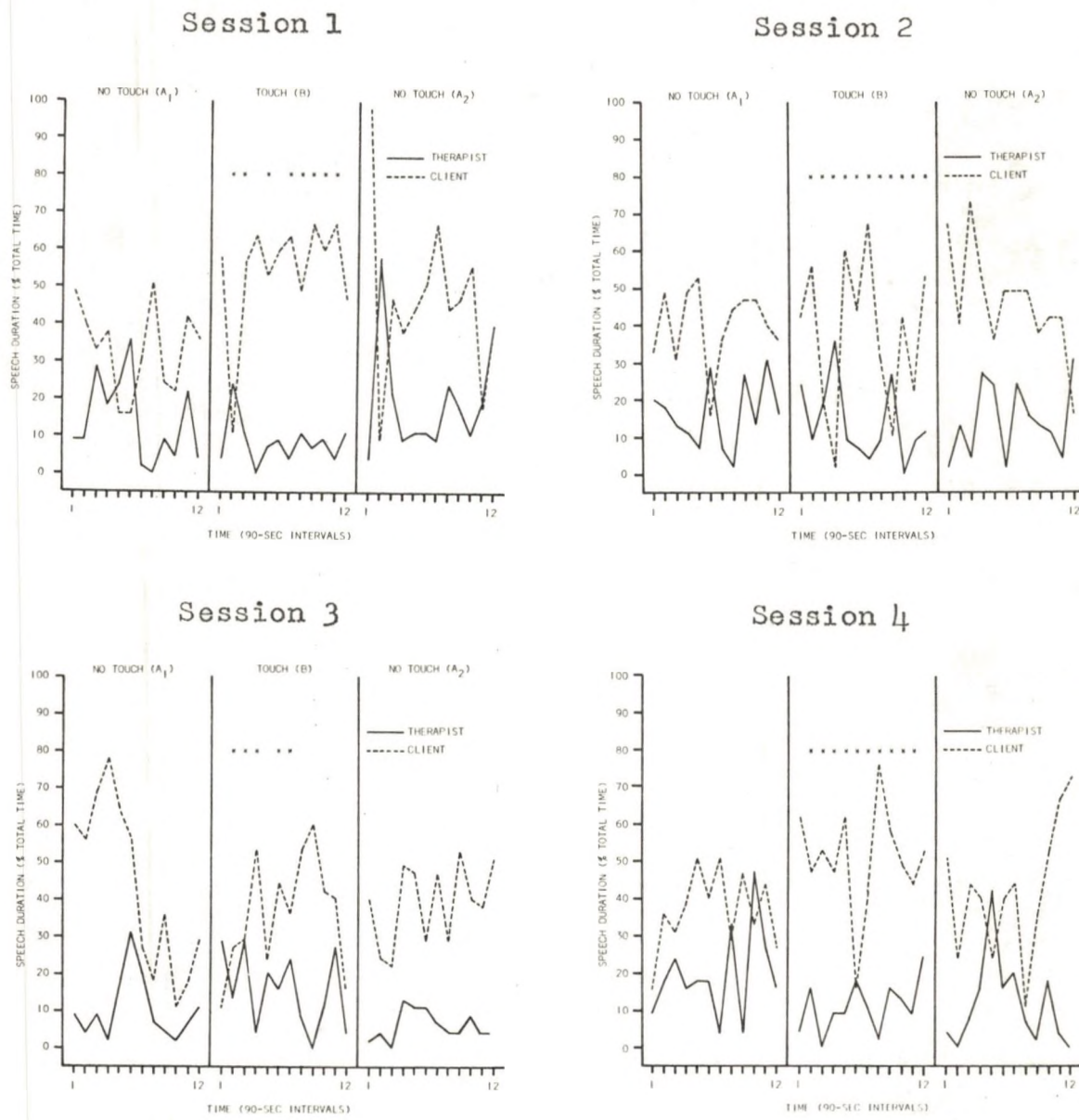
*Indicates an interval during which touch occurred

Fig. 1. Client and Therapist Other-Directed Gaze



*Indicates an interval during which touch occurred

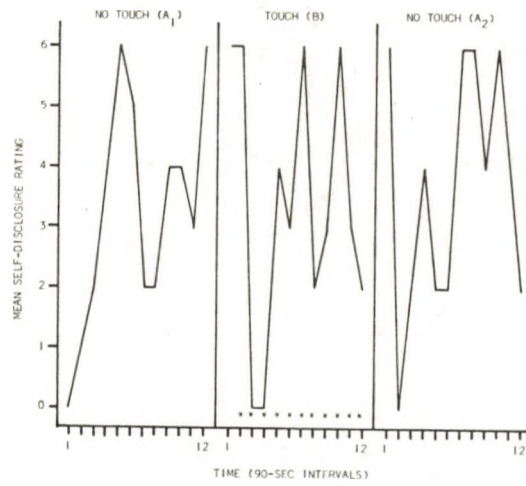
Fig. 2. Client and Therapist Other-Directed Forward Lean.



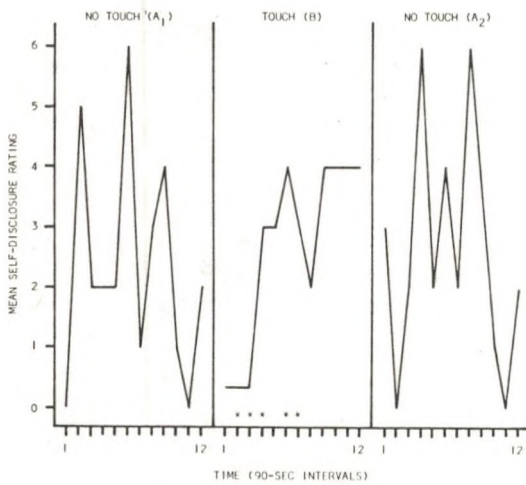
*Indicates an interval during which touch occurred

Fig. 3. Client and Therapist Speech Duration.

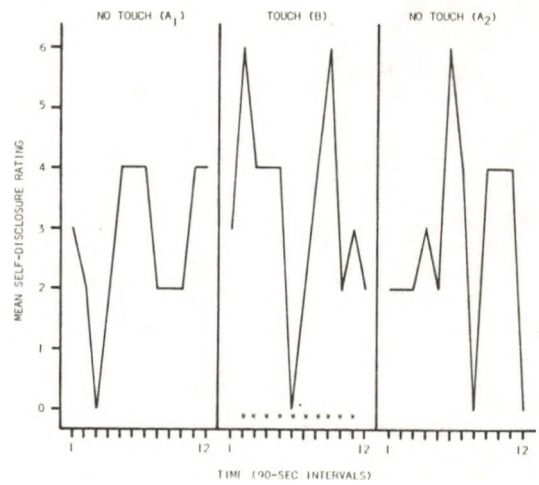
Session 2



Session 3



Session 4



*Indicates an interval during which touch occurred

Fig. 4. Client Self-Disclosure

changes from phases A_1 to B indicate effects of introducing touch, whereas changes from B to A_2 indicate effects of removing touch. Inferences about presence or absence of change in each case were based primarily on visual inspection of the data. When applicable, however, statistical criteria based on the Shewart procedure (Gottman and Lieblum, 1974) were also applied. According to the Shewart method, a significant treatment effect ($p < .05$) is inferred if at least two successive observations of the dependent variable drift outside a confidence interval established by the baseline mean and standard deviation. There are problems in using this procedure if baseline data show linear trend, or there is a limited range through which the dependent measure can increase or decrease (ceiling and floor effects). Since both occurred with some frequency in the present data, the formal Shewart analyses, though computed, were not heavily relied upon for inferences about presence and absence of change.

Phase-to-phase changes (A_1 to B and B to A_2) for all measures in all sessions are summarized in Table 1. Here, the direction of change is signified by arrows (\uparrow or \downarrow), and asterisks (*) indicate comparisons for which the Shewart test was significant ($p < .05$). Where arrows are accompanied by question marks (?), phase-related changes should be regarded as tentative.

The gaze data suggest that effects of therapist touch, where they occurred, were mainly compensatory. As may be seen in Figure 1, client gaze appeared to decrease in response

TABLE 1

SUMMARY OF PHASE-RELATED CHANGES

	1		2		3		4	
	$A_1 \rightarrow B$	$B \rightarrow A_2$	$A_1 \rightarrow B$	$B \rightarrow A_2$	$A_1 \rightarrow B$	$B \rightarrow A_2$	$A_1 \rightarrow B$	$B \rightarrow A_2$
Client Lean	↓*	—	—	—	—	↓*	—	—
Client Gaze	—	↑*	—	—	—	—	↑*	—
Client Speech	↑*	—	—	—	—	—	↑*	—
Client Self-Disclosure	—	—	—	—	—	—	—	—
Therapist Lean	↑?	↓*	—	↓*	—	—	↓*	—
Therapist Gaze	—	—	—	—	↓?	↓*	—	↓*
Therapist Speech	—	—	—	—	—	—	—	—

to the touch introduced in phase B of the first two sessions. This effect seems to have been irreversible, in that client gaze did not return to baseline levels following the removal of physical contact. Decreases in therapist gaze occurring during the reversal phase (B to A₂) of the final two sessions suggest that the therapist himself may have compensated (reduced immediacy) following the touch period.

The lean data (Figure 2) give some additional indication of compensation, and also suggest a possible confounding of touch with other therapist behavior. A marked decrease in client lean occurred in response to the introduction of touch in the first session. Again, the effect of introducing touch seems to have been irreversible, in that client lean did not return to baseline levels following the removal of physical contact. A possible confounding of touch and other therapist immediacy behaviors is suggested by the therapist's tendency to lean forward during the touch (B) period, especially in the first session. Thus it is difficult to determine whether touch per se was responsible for the compensatory reaction shown by the client.

Client self-disclosure (Figure 4) appears not to have been influenced by the touch manipulation, although peak levels of disclosure did occur at isolated points during the touch phases of Sessions 2 and 4. The only clear evidence that touch facilitated the therapy process was an increase in client speech duration during the touch phase of Sessions 1 and 4 relative to the baseline phase of those sessions.

Several overall differences in the immediacy and speech patterns of the therapist and client also deserve comment. As would be expected in a therapeutic situation, the client tended to talk more than the therapist (Figure 3). Also, the therapist tended to maintain consistently high levels of eye contact, whereas the client's gaze levels were generally quite low, not highly variable, and if anything, tended to decrease over sessions (Figure 1). In fact, the client appeared to spend most of the therapy time staring at her hands which she held in her lap. A similar lack of variability in the client's lean (Figure 2) reflects the fact that throughout most of the sessions she maintained the same body position, leaning forward with her head bowed.

To summarize, therapist-initiated touch appeared to facilitate client speech, but also to produce compensatory reductions in immediacy, especially in early sessions. The changes in speech and immediacy which were observed appear to have been irreversible within the sessions in which they occurred. In general, client self-disclosure was little affected by the touch manipulation.

Analysis of Concomitant Variation

P-correlations (Cattell, 1966) shown in Tables 2-5 reflect the manner and degree to which the immediacy, speech, and disclosure variables covaried together over time. Each correlation coefficient is based on 36 observations obtained from all three phases of a given session. Positive correlations

TABLE 2

P-CORRELATIONS FOR SESSION 1

	Client Lean	Client Gaze	Client Speech	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean						
Client Gaze	.53 ^c					
Client Speech	-.43 ^c	-.11				
Therapist Lean	-.45 ^c	-.66 ^c	.03			
Therapist Gaze	-.18	.13	.02	-.17		
Therapist Speech	.04	.27 ^a	-.60 ^c	-.21	.14	

^a $p < .10$

^b $p < .05$

^c $p < .01$

* Due to lack of variability a correlation could not be completed for these variables.

TABLE 3

P-CORRELATIONS FOR SESSION 2

	Client Lean	Client Gaze	Client Speech	Client Self- Disclosure	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean							
Client Gaze *							
Client Speech *		-.06					
Client Self- Disclosure *		-.26	.41 ^c				
Therapist Lean *		-.54 ^c	-.05	.01			
Therapist Gaze *		.04	.21	-.01	-.21		
Therapist Speech *		.18	-.64 ^c	-.22	-.24	.07	

^a p < .10

^b p < .05

^c p < .01

* Due to lack of variability a correlation could not be completed for these variables.

TABLE 4

P-CORRELATIONS FOR SESSION 3.

	Client Lean	Client Gaze	Client Speech	Client Self- Disclosure	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean							
Client Gaze	.28 ^a						
Client Speech	-.08	-.13					
Client Self- Disclosure	.17	-.30 ^a	.14				
Therapist Lean	-.33 ^b	-.46 ^c	.11	-.04			
Therapist Gaze	.54 ^c	.45 ^c	.04	-.05	-.53 ^c		
Therapist Speech	.27 ^a	.29 ^a	-.12	.10	-.12	.10	

^a p < .10

^b p < .05

^c p < .01

*Due to lack of variability a correlation could not be completed for these variables.

TABLE 5

P-CORRELATIONS FOR SESSION 4

	Client Lean	Client Gaze	Client Speech	Client Self- Disclosure	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean	*						
Client Gaze	*						
Client Speech	*	.07					
Client Self- Disclosure	*	.01	.38 ^b				
Therapist Lean	*	-.33 ^b	-.04	.00			
Therapist Gaze	*	.29 ^a	.25	-.05	-.48		
Therapist Speech	*	.39 ^b	-.31 ^a	-.14	-.14	.21	

^a_p < .10

^b_p < .05

^c_p < .01

* Due to lack of variability a correlation could not be completed for these variables.

indicate that two measures increased or decreased together over the course of a given session; negative correlations, on the other hand, indicate that two measures were inversely related--that is, as one increased the other decreased. Thus, negative correlations between measures of client and therapist immediacy are descriptively consistent with a compensation-like process (Argyle and Dean, 1965; Patterson, 1973a), whereas positive correlations suggest a pattern of reciprocation (e.g. Rosenfeld, 1966). Unfortunately, correlational data say little about the nature or direction of cause and effect. Since "compensation" as an explanatory construct refers to increased immediacy by person A causing compensatory withdrawal in person B (Patterson, 1973a, p. 238), evidence of concomitant variation among therapist and client behaviors in the present study should be interpreted cautiously.

The analyses of concomitant variation, like the reversal data described above, give some indication that compensation may have been occurring. Most consistent in this respect were significant negative correlations (ranging from $-.33$ to $-.66$) between therapist lean and client gaze. Although it is tempting to speculate that the client reacted to increases in therapist immediacy, it is equally possible that the therapist decreased his lean in response to increased client gaze, or that variations in both behaviors were "caused" by something else entirely. Also suggestive of compensation were significant negative correlations between client and therapist lean in Sessions 1 and 3, which indicate

that as one participant leaned forward, the other tended to lean back. Again, the direction of causality is difficult to determine. Other significant negative correlations found between client and therapist speech duration suggest simply that the participants tended to take turns talking.

Interestingly, there was some indication that the magnitude of compensatory relationships between therapist and client immediacy behaviors decreased over sessions. For example, the negative correlations between therapist lean and client gaze decreased significantly ($p < .10$) from $r = .66$ in Session 1 to $r = .33$ in Session 4. This observation is consistent with the reversal data described above, which suggest that compensatory reductions in immediacy were more common in earlier session. It is also interesting to note that positive correlations between therapist and client gaze reached significance only in Session 3 and 4. Although apparently unrelated to the touch manipulation, these relationships may indicate that reciprocation of therapist-client immediacy became more important as the therapeutic relationship developed.

Significant positive correlations between therapist speech duration and client gaze were found in Sessions 3 and 4, indicating that at least in later sessions the client tended to look at the therapist more when he was speaking. In Sessions 2 and 4, increased client speech was positively and significantly correlated with self-disclosure. Otherwise,

client self-disclosure was generally unrelated to measures of therapist and client behavior.

Further questions concern the extent to which patterns of concomitant variation were influenced by the touch manipulation. To determine this, correlations between therapist and client immediacy, speech, and disclosure measures were calculated separately for each phase of each session (see Appendices). Comparison of P-correlations from touch (B) and nontouch (A) phases suggests that most of the correlations reported above were significant across all phases; that is, touch did not seem to influence many of the previously discussed relationships. The only important exception involved significant positive correlations between client speech and self-disclosure, which were found only during the touch phases of Sessions 2 and 4. This latter finding is important because it suggests that the touch related increases in client speech seen in Sessions 1 and 4 (Figure 3, Table 1) may have been associated with therapeutically relevant content.

CHAPTER IV

DISCUSSION

The results provide tentative evidence of both disrupting and facilitating effects of touch in psychotherapy. Indications of disruptive effects appeared in the client's tendency to reduce her gaze and/or lean back in response to therapist-initiated touching. These compensatory reactions, which are consistent with predictions from the Argyle and Dean (1965) intimacy-equilibrium hypothesis (cf. Patterson, 1973), were observed only in Sessions 1 and 2, suggesting that potentially disruptive effects of touch may be most important early in the development of a therapeutic relationship.

Facilitating effects were clearest for the speech measure, which showed touch-related increases relative to baseline levels in two of the four therapy sessions. The fact that the client tended to talk more during touch phases says nothing about the content of her verbalization. However, since speech duration and self-disclosure were positively correlated during touch (B) phases, there is reason to believe that her increased speech production may have been therapeutically relevant.

Although client self-disclosure appears to have reached peak levels at isolated points during touching phases, the

disclosure data were highly variable and generally fail to replicate Pattison's (1973) findings with respect to touch and client self-exploration. The discrepancy between the present findings and those of Pattison may be due to the fact that a different content measure was used in the present study. However, as Pattison herself points out (1973, p. 170), disclosure and self-exploration constructs are closely related conceptually. The Traux and Carkhuff (1967) Depth of Self-Exploration Scale, which was originally to be used as the primary content measure in the present study, was discarded in favor of the Haynes (1972) Self-Disclosure Technique when satisfactory inter-rater reliability could not be obtained. Interestingly, Pattison does not report the interjudge reliability she obtained using the Traux and Carkhuff scale.

One implication of the results is that compensatory and/or reciprocatory interaction patterns may change as the therapeutic relationship develops. As indicated above, the client's compensatory reactions to therapist touch were most pronounced in Sessions 1 and 2 and were generally absent in Sessions 3 and 4. The analyses of concomitant variation further suggest that the negative correlations between therapist and client lean and between therapist lean and client gaze duration tended to decrease over sessions. Similarly, positive correlations between therapist and client gaze, suggesting reciprocation, reached significance only during Sessions 3 and 4. Thus, with respect to nonverbal

immediacy at least, compensatory processes are most characteristic of client and therapist interactions occurring early in the therapeutic relationship. As rapport develops over sessions, compensation appears to decrease and reciprocation of immediacy becomes more prominent. This observation is consistent with the idea that the presence or absence of compensation depends on the nature of the relationship between the interactants (Jourard and Friedman, 1970).

The results also highlight the importance of examining therapist as well as client response to touch in psychotherapy. In several sessions the therapist appears to have himself withdrawn (compensated) by leaning back and/or reducing eye contact following the touch manipulation (phase A₂). If this occurred, it is consistent with experimental research on compensation (Patterson, 1973a) which shows that even trained confederates instructed to maintain constant levels of immediacy at different interaction distance have difficulty doing so. It is also difficult to be assured that changes in client behavior which accompany touching result solely from the manipulation of physical contact (cf. Pattison, 1973; Aguilera, 1967). Since other indicators of therapist immediacy (e.g. forward lean, eye contact) often change during the act of touching, it may be more meaningful in future studies to examine client response to changes in overall levels of therapist immediacy of which touch is only one component.

Finally, it is important to emphasize that the case study (N=1) design, while offering greater experimental precision than large-N studies of group averages (Lietenburg, 1973; Bergin and Strupp, 1970), is limited in its generalizability. Thus, findings from the present study regarding effects of touch or patterns of concomitant variation among immediacy, speech, and disclosure measures may not be obtained with other clients or therapists, or in other therapeutic situations. For example, the low levels of eye contact (gaze) and general postural rigidity shown by the client in the present study are probably not representative of most clients. In addition, it is important to remember that the client had two years of experience with psychotherapy, and may have therefore brought to the present study an established pattern of responding to the therapeutic situation. In any case, the results of the present case study do suggest that effects of touch on client-therapist interactions can be quite complex, and that these effects may change as the therapeutic relationship develops.

P-CORRELATIONS FOR NONTOUCH PHASES

	Session 1					
	Client Lean	Client Gaze	Client Speech	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean						
Client Gaze	.47 ^b					
Client Speech	-.37 ^a	.09				
Therapist Lean	-.29	-.57 ^c	-.25			
Therapist Gaze	-.51 ^c	.04	.29	.02		
Therapist Speech	-.10	.18	-.51 ^c	-.08	.09	

^a p < .10

^b p < .05

^c p < .01

*Due to lack of variability a correlation could not be computed for these variables.

P-CORRELATIONS FOR NONTOUCH PHASES

		Session 2					
	Client Lean	Client Gaze	Client Speech	Client Self-Disclosure	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean							
Client Gaze	*						
Client Speech	*	-.16					
Client Self-Disclosure	*	-.36 ^a	.20				
Therapist Lean	*	-.58 ^c	.15	.25			
Therapist Gaze	*	.07	.09	-.01	-.23		
Therapist Speech	*	.29	-.60 ^c	-.05	-.32	.21	

^a p < .10

^b p < .05

^c p < .01

*Due to lack of variability a correlation could not be computed for these variables.

P-CORRELATIONS FOR NONTOUCH PHASES

	Session 3						
	Client Lean	Client Gaze	Client Speech	Client Self-Disclosure	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean							
Client Gaze	.29						
Client Speech	-.05	.06					
Client Self-Disclosure	.15	-.29	.10				
Therapist Lean	-.37 ^a	-.51 ^c	.10	.00			
Therapist Gaze	.54 ^c	.53 ^c	.02	-.03	-.57 ^c		
Therapist Speech	.25	.06	.20	.27	-.19	.12	

^a p < .10
^b p < .05
^c p < .01

*Due to lack of variability a correlation could not be computed for these variables.

P-CORRELATIONS FOR NONTOUCH PHASES

		Session 4					
	Client Lean	Client Gaze	Client Speech	Client Self-Disclosure	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean							
Client Gaze	*						
Client Speech	*	-.04					
Client Self-Disclosure	*	-.03	.19				
Therapist Lean	*	-.57 ^c	.10	-.05			
Therapist Gaze	*	.36 ^a	.16	-.21	-.43 ^b		
Therapist Speech	*	.58 ^c	-.21	-.06	-.32	.31	

a p < .10

b p < .05

c p < .01

* Due to lack of variability a correlation could not be computed for these variables.

P-CORRELATIONS FOR TOUCH PHASES

	<u>Session 1</u>					
	Client Lean	Client Gaze	Client Speech	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean						
Client Gaze	.12					
Client Speech	-.23	-.12				
Therapist Lean	-.45	-.24	-.10			
Therapist Gaze	.14	-.03	-.15	-.23		
Therapist Speech	.09	.18	-.93 ^c	.16	.07	

^a p < .10

^b p < .05

^c p < .01

*Due to lack of variability a correlation could not be computed for these variables.

P-CORRELATIONS FOR TOUCH PHASES

				Session 2 Client Self-	Therapist	Therapist	Therapist
	Client	Client	Client	Disclosure	Lean	Gaze	Speech
	Lean	Gaze	Speech				
Client Lean							
Client Gaze	*						
Client Speech	*	.12					
Client Self-Disclosure	*	.10	.67 ^b				
Therapist Lean	*	-.24	-.26	-.45			
Therapist Gaze	*	.09	.45	-.01	-.28		
Therapist Speech	*	-.44	-.72 ^c	-.49	-.07	-.21	

a p < .10

b p < .05

c p < .01

*Due to lack of variability a correlation could not be computed for these variables.

P-CORRELATIONS FOR TOUCH PHASES

		Session 3					
	Client	Client	Client	Client	Therapist	Therapist	Therapist
	Lean	Gaze	Speech	Self- Disclosure	Lean	Gaze	Speech
Client Lean							
Client Gaze	*						
Client Speech	*	-.60 ^b					
Client Self- Disclosure	*	-.48	.40				
Therapist Lean	*	-.27	.09	-.17			
Therapist Gaze	*	-.06	.29	.47	-.30		
Therapist Speech	*	-.59 ^b	-.49	-.40	.06	-.20	

^a p < .10

^b p < .05

^c p < .01

*Due to lack of variability a correlation could not be computed for these variables.

P-CORRELATIONS FOR TOUCH PHASES

	Client Lean	Client Gaze	Client Speech	Session 4 Client Self-Disclosure	Therapist Lean	Therapist Gaze	Therapist Speech
Client Lean							
Client Gaze	*						
Client Speech	*	-.05					
Client Self-Disclosure	*	-.07	.63 ^b				
Therapist Lean	*	.07	-.23	.13			
Therapist Gaze	*	-.02	.45	.40	-.78 ^c		
Therapist Speech	*	.33	-.46	-.23	.40	-.20	

^a p < .10

^b p < .05

^c p < .01

* Due to lack of variability a correlation could not be computed for these variables.

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