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Cover Page Footnote

The authors wish to thank the participants of this study and for their willingness to share their experience.

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Abstract

The use of touch in psychotherapy is a topic often undiscussed in graduate training programs. Stenzel and Rupert's 2004 study showed that nearly 90% of clinicians never or rarely offered touch to clients during a session. This study examined the use of touch in a psychotherapeutic setting with culturally Deaf clients, since touch is a culturally accepted, even expected, practice. Results indicated that there was no statistically significant difference among culturally Deaf therapists compared with the Stenzel and Rupert's (2004) findings, but there is a statistically significant difference in those who identify as hearing and work with culturally Deaf clients. The implications of the study are also discussed.

Keywords: Therapy, Deaf culture, Use of therapeutic touch

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Touch is an integral part of daily life: a greeting by way of a handshake, a hand on the shoulder to show comfort, or a tap on the arm to indicate a directive to step aside. Professionals utilizing touch in their work include chiropractors, nurses, and physicians. Touch is often seen as a powerful healing force as well as an essential function that facilitates attachment and human development (Zur & Nordmarken, 2011). Touch also holds significant cultural components filled with layers of meaning associated with socialization and individual experiences (Chillot, 2013; Halbrook & Duplechin, 1994; Napoli, 2014; Phelan, 2009). Studies covering cultural observations found that Mediterranean/Latino cultures exhibited far more use of touch compared to those of Germanic/Anglo-Saxon origins (Zur & Nordmarken, 2011). For example, Jourard (1966) documented a variety of touching within a period of one hour in four distinct locations: Puerto Rico (180), London (0), Paris (110) and Gainesville, FL (2)). While the United States tended to use less touch, there were differences based on regions and ethnic or minority groups. For example, Californians were more prone to touch than New Englanders (Zur & Nordmarken, 2011).

In general, the subject of touch in a mainstream psychotherapeutic setting has frequently been viewed with trepidation based on the controversial nature of this topic (Bonitz, 2008) and perceived as taboo (Swade, 2020). Psychotherapists tend to be aware that the use of touch within therapy is fraught with ethical issues related to touching the body within the context of a professional relationship, including potential perceptions of sexualization (Briggs, 2018). The use of touch in therapy in the United States has generally been eschewed based on risk management directives stemming from concerns about inappropriate sexual touch in addition to "United States" cultural norms that do not reinforce the use of touch (Young, 2005; Zur & Nordmarken, 2011).

Three major United States mental health professional organizations (American Psychological Association [2016], American Counseling Association [2014], and American Association for Marriage & Family Therapy [2015]) have sections in their ethical codes prohibiting the use of sexual touch in a therapeutic setting; however, they do not address the use of nonsexual touch (Phelan, 2009). Only the National Association of Social Workers Code of Ethics addresses the use of touch in a therapeutic setting with a clear directive: "Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact" (2008, Standard 1.10 Physical Contact). Swade (2020), a psychotherapist, perceived the taboo of touching in psychotherapy as counterproductive and provided criteria for the safe and effective use of touch within the context of psychotherapy. Briefly these criteria are as follows: the client should be in control of any use of touch; the use of touch depends only on the client's need, not on the therapist's needs; both client and therapist should discuss the use of touch if it comes up and carefully examine boundaries; and competency regarding touch is important for therapists who use touch. With these criteria, Swade (2020) believes touch can be an effective therapy tool. Without these criteria, touch runs the risk of being ineffective and harming the therapy process. Therapists need to research the appropriate use of touch and be conscious of their own attitudes toward touch and how it might impact the therapeutic process.

Within the context of psychotherapy, touch refers to any physical contact between clients and psychotherapists, typically initiated by psychotherapists (Zur & Nordmarken, 2011). Zur and Nordmarken listed nonsexual types of therapeutic touch such as handshakes, consolation touch, and reassuring pats on the back as an adjunct to verbal therapy, which are often utilized for the purpose of greeting, calming, and reassuring the client. There are studies discussing aspects related to the use of touch in psychotherapy going as far back as 1969 (e.g., Alagna, Whitcher, Fisher, & Wicas, 1979; Bacorn & Dixon, 1984; Bonitz, 1984, 2008; Durana, 1998; Forer, 1969; Swade, 2020). In general, psychotherapists have noted potential positive benefits of nonsexual touch in therapy, taking extreme care to ensure such use is clinically appropriate, depending on client characteristics and symptomatology (Bonitz, 2008, Swade, 2020; Zur & Nordmarken, 2011). Knapp, Younggren, VandeCreek, Harris, and Martin (2013) presented examples of boundary crossings in psychotherapy that could be fraught with risk, including touch such as hugs, and indicate the importance of therapist judgment in considering the appropriate use of touch to facilitate treatment.

If psychotherapists are responsible for setting appropriate boundaries governing touch when working with their clients, educational settings and ethics boards need to step in and provide guidance. However, formal educational settings and ethics course offerings typically have not provided specific training regarding the use of touch in therapy with a few exceptions (e.g., Zur, 2007a; 2007b; Zur, 2015; Zur, 2019), likely because of risk management concerns (Zur, 2007a; Holub & Lee, 1990; Phelan, 2009).

In her review of studies on the use of touch with clients in psychotherapy, Bonitz (2008) noted while the percentage of therapists reporting sexual relationships was consistent across studies, the percentage of therapists touching clients in a nonsexual way ranged from 10% to 100%, primarily due to different population samples (e.g., psychologists versus social workers, point in time, and different definitions of touch (e.g., handshake versus hug). However, the frequency of different types of touch was generally consistent with nearly all therapists accepting or offering a handshake, a lower percentage hugging client, and even fewer psychotherapists holding clients' hands. Reports of behaviors such as kissing the cheek or sitting on the therapist's lap were extremely rare. Bonitz (2008) suggested therapists who use touch with clients were more likely to follow humanistic rather than psychodynamic forms of therapy and were more likely to be female rather than male. Bonitz also reported that they viewed touch as a healing factor and had their own positive experiences with touch.

Stenzel and Rupert (2004) explored the use of touch in a therapeutic setting by conducting a survey across the United States that incorporated responses from 470 psychologists. Their findings showed close to 90% of the sample surveyed almost never touched their clients other than using a handshake as a greeting. Factors related to the use of touch included therapist and client gender, theoretical orientation, and therapist's touch experiences. Specifically, female therapists were more likely to touch female clients compared to opposite-sex or male-male dyads, supporting the perception that women culturally may be more likely to resort to touch compared to men (Stenzel & Rupert, 2004). However, professionally, female therapists were less likely to touch male clients due to concern regarding the potential for inadvertently sexualizing the relationship (Stenzel & Rupert, 2004). From a theoretical perspective, humanistic respondents were more likely to use touch compared to therapists with a psychodynamic orientation. In terms of the therapists' touch experience, the more comfortable they were with the

professional use of touch, the more likely they were to use it within the context of therapy. Stenzel and Rupert (2004) concluded touch in therapy should not be a subject considered taboo, and further exploration into the use of touch within a cultural context was warranted.

Field (2010) explored the use of touch within a therapeutic context, and the use of touch has also been noted to be beneficial in a health setting (Kerr, Wiechula, Feo, Schultz, & Kitson, 2016) and in movement therapy (Cristobal, 2018). While the appropriate use of touch may be assumed as therapeutically beneficial for clients based on careful evaluation of their dynamics, the importance of taking the cultural context into account in understanding the role of touch in psychotherapy within a cultural context must be acknowledged, as has been indicated in numerous publications (e.g., Alagna, Whitcher, Fisher, & Wicas, 1979; Aquino, & Lee, 2000; Goodman & Teicher, 1988; Pinson, 2002; Stenzel & Rupert, 2004). Specifically, how touch is used within psychotherapeutic settings for clients who are part of a culture where touch is welcomed, even expected, has been minimally explored (e.g., Zur & Nordmarken, 2011). One such culture is that of Deaf culture. Next, a brief look is taken at Deaf culture and the role of touch within that culture.

Overview of Deaf Culture

Deaf culture is comprised of individuals who see themselves through a linguistic minority lens rather than through a pathological view of something needing to be fixed, namely the ear (e.g., Holcomb, 2013; Leigh & Andrews, 2017; Leigh, Andrews, & Harris, 2018; Padden & Humphries, 2005). While the deaf community originally came together based on the common bond of hearing disability, Deaf (the use of a capitalized “D” denotes identification with and membership in the culture) culture has been shaped based on visual orientation and an accompanying visual language, specifically American Sign Language (ASL). There are shared experiences, attitudes, social obligations, how members of this culture uniquely relate with each other using visual and tactile means, and how they cope in daily life. Holcomb (2013) focused specifically on language, heritage, customs, arts, and family as five cultural hallmarks that help to define the nature of Deaf culture. In addition to ASL, there is a long history of deaf people and how they coalesced into a community. Customs or ways of behaving, which also includes the role of touch in greetings, has evolved as part of this heritage, as have stories, artwork, and plays reflecting the Deaf experience (Holcomb, 2013). While deaf children of culturally Deaf parents are born into the culture, roughly 96% of deaf children are not born into the culture (Mitchell & Karchmer, 2004). Cultural brokers, such as leaders within the Deaf community, serve as a conduit in introducing many of these children into Deaf culture. Individuals who may identify with Deaf culture include not only deaf and hard of hearing individuals, but also hearing offspring of culturally Deaf parents and hearing professionals who are immersed in the Deaf community (Holcomb, 2013; Leigh & Andrews, 2017; Leigh, Andrews, & Harris, 2018).

Use of Touch in Deaf Culture

Touch is generally accepted as a cultural norm within Deaf culture. For example, getting someone’s attention typically includes the use of tapping or patting on the shoulder or upper body (Holcomb, 2013). Physical touching, including hugging, even when meeting for the first

time as well as saying farewell, is also common in Deaf culture (Leigh & Lewis, 2010). Deaf clients may even initially hug the psychotherapist (regardless of the Deaf/hearing status) at the first session, as an example of a Deaf culture phenomenon (Leigh & Lewis, 2010). For Deaf people, not engaging in hugs can encourage the perception of one being cold and distant. Empirical research addressing the general perception of touch in Deaf culture is available, albeit limited in its specificity (Napoli, 2014).

Goss (2003) conducted an exploratory study of communication preferences using a focus group of five Deaf individuals who were assembled to address two major issues related to 1) what they saw as communication preferences of deaf people and 2) whether Deaf communicators exhibit unique communication patterns that are part of Deaf culture. While findings were limited in generalizability due to the extremely small sample size, the consensus was that deaf communicators stand closer to each other than hearing people do and: "It is expected that you will touch and be touched" (Goss, 2003, p. 11). Furthermore, touching was reportedly used to indicate intention to say something or to interrupt someone. As Goss (2003) concluded: "In short, touching behavior is acceptable and convenient in deaf interactions (p.11)" to be used to gain attention. Additionally, researchers have found people who are born deaf may process the sensation of being touched differently than those who were born with normal hearing (Karns, Dow & Neville, 2012).

Touch is an integral part of the human condition. Within Deaf culture, taps on the shoulder are one way to gain attention. Yet, in psychotherapy, concern has repeatedly been expressed about how such touch can become sexualized and in turn threaten the patient or client's sense of body boundaries, thereby necessitating careful risk management. In contrast, Swade (2020) argued for the removal of touch as a taboo in psychotherapy. This leads to the question of how therapists working with deaf and hard of hearing clientele deal with the issue of touch.

Purpose of the Study

The purpose of this study was to explore the frequency of touch used by mental health practitioners who work with deaf and hard of hearing clients, the role of therapist characteristics such as age, gender, hearing status, and theoretical orientation, and descriptive information regarding what types of touch are utilized by these psychotherapists. Specifically, we wanted to know whether or not mental health practitioners were more likely to use touch with deaf and hard of hearing clients. In doing so, we relied on a 2004 study by Stenzel and Rupert, who detailed four objectives: descriptive information about the frequency of touch, usefulness of a taxonomy related to touch developed by Smith (1998), the role various characteristics of the therapist plays in non-erotic touch, and descriptive information of how touch is utilized in a therapeutic setting. As noted earlier, Stenzel and Rupert's results indicated a high percentage of non-touch in a therapeutic setting. To this end, we used the same paradigm in the discussion of the four different types of touch, "touch as an expression of the relationship, socially stereotyped touch, touch as technique, and conversational marker" (Stenzel & Rupert, 2004, p. 337). An example of "touch as an expression of the relationship" includes putting an arm around the person as an expression of support. "Socially stereotyped touch" could mean a handshake in greeting or farewell, while "touch as technique" usually includes body work such as massage or hypnosis, and "conversational

marker" can mean a light tap on the shoulder or knee for emphasis (2004). Because many Deaf individuals often utilize touch socially in greeting or to get attention, we focused our analysis on the use of socially stereotyped touch and relationship touch between mental health practitioners and clients who are deaf or hard of hearing.

In addition to the above characteristics, we investigated whether or not mental health practitioners' gender, hearing status (deaf or hearing) and identification as Deaf or hearing affected their use of touch with deaf and hard of hearing clients. Similar to Stenzel and Rupert's 2004 findings, we expected female mental health practitioners to engage in more frequent use of touch than male practitioners. Considering the possibility touch is of benefit therapeutically and that touch is an integral part of Deaf culture, we hypothesized practitioners who self-reported as deaf and identified as Deaf were more likely to engage in social and relationship touch with deaf clients than those who did not identify as Deaf.

Method

Participants

The participants for this study were 23 mental health practitioners involved in the practice of individual psychotherapy with deaf adult clients. Criteria for participation included: a) licensed practitioner in the United States; b) master's or doctoral degrees with specialization in providing psychotherapy for deaf adults aged 18 and older; and c) provision of psychotherapy services in private practice settings, agency outpatient services, and/or inpatient services. It is not known at this time how many individuals accessed our survey online (see Procedures below), given confidentiality. However, in contrast to the large number of therapists available for the general population, there are a limited number of professionals who work directly with clients who are Deaf (Vernon & Leigh, 2007), and as a result, the response rate was very low.

The average age of the participants was 51.09 (*SD*=12.40) with 60% (n=14) identifying as female while 40% (*n*=9) identified as male. Twenty-two percent (*n*=5) indicated their hearing status as deaf and 78% (*n*=18) identified as hearing or hard of hearing. Twenty-two percent (*n*=5) identified as culturally Deaf and 78% (*n*=18) identified as culturally hearing. The majority of participants identified themselves as white (*n*=22; 96%). Eight participants (35%) reported having obtained a doctoral degree, and 15 reported "other" as highest degree obtained (65%).

Table 1
Demographic Data

Characteristics	Respondents (*n*=23)
Age	M=51.09 (SD=12.40)
Gender	Male = 9 (40%); Female=14 (60%)
Hearing Status and Cultural Identification	
Deaf	5 (22%)
Hearing or Hard of Hearing	18 (78%)

Race	White= 22 (96%)
Highest degree	PhD= 8 (35%); Other =15 (65%)

Measure

The survey developed by Stenzel (2002) was used for this study with permission from the author to use and modify as needed. Our survey consisted of 56 close-ended items divided into four sections. The first section consisted of items that asked respondents to indicate how they "typically" interacted with their clients over the past five years, once for female clients and once for male clients. The touch items were based on Smith's 1988 taxonomy of hypothesized touch dimensions as follows: conversational marker (touch leg, shoulder, arm, or upper back); socially stereotyped touch; touch as an expression of the relationship (place arm around, hold hand, hold in arms, hold in lap); touch techniques (touch associated with bodywork, relaxation training, hypnosis, or massage); aggressive touch (restrain, hit or punch); and sexual touch (touch genital area or breasts, kiss on lips, sexual intercourse, kiss on cheek). Ratings were selected from a Likert Scale ranging from 1=Never, to 5=Very Often. In the second section, respondents also used this Likert Scale to rate items separately for males and females covering when they used touch (initial greeting, parting at the end, during the session, at termination), how they used touch (ask permission, explain or discuss use, and why touch was used, for example, to emphasize a point, nurture or support, provide experience of safe touching, etc.). The third section explored the mental health practitioners' personal experience with touch, whether they received training in somatic practices, ethical training of touch in their education, or whether they had formal or informal complaints filed against them. Items related to the respondents' own history of childhood sexual abuses were not asked, as this was not the primary focus of this study. A fourth section asked demographic questions at the end of the survey. In addition to questions about gender, race/ethnicity, and marital status, items were added that asked whether participants were audiologically deaf, hard of hearing, or hearing, and whether they identified themselves as culturally Deaf or culturally hearing.

Procedure

With Gallaudet University Institutional Review Board approval, the survey was posted via an online survey tool that allowed for confidentiality and encryption. Eligible participants were recruited via various resources, including listings in the Mental Health Resources Directory, 5th edition (http://research.gallaudet.edu/resources/mhd/), listservs focused on mental health clinicians working with deaf adults, and professional networks. Participants were informed at the beginning of the survey that they could cease participation in this study at any time, based on human subject guidelines.

Results

Male-Female Practitioner Differences

Using a repeated measure analysis of variance with client gender as the within-group variable and practitioners' gender as the between-group variable, we did not find significant differences

between male and female mental health practitioners (F(1,21)=3.32, $p > .05$) for relationship touch. Table 2 illustrates these mental health practitioners' reported use of social and relationship touch as a function of their gender and client gender. No within-group differences were found between client gender (F(1, 21)=2.93, $p > .05$) but significant interaction was observed (F(1,21)=4.50, $p < .05$) with female practitioners far more likely to engage in relationship touch with female clients (M=2.31, SD=.76) than with male clients (M=1.90, SD=.83) or male practitioners with female clients (M=1.58, SD=.51) and male clients (M=1.62, SD=.48).

For social touch, we found no significant differences between practitioners' gender (F(1, 21)=.33, $p > .05$). We observed significant differences between the gender of their clients (F(1, 21)=6.32, $p < .05$) with practitioners, both male and female, more likely to show social touch to their male clients (M=3.41, SD=1.13) than female clients (M=3.28, SD=1.24).

Table 2
Mental Health Practitioners' Mean Responses to Relationship and Social Touch by Gender (Standard Deviation)

	Relationship Touch		Social Touch	
Mental Health Practitioners	Male Clients	Female Clients	Male Clients	Female Clients
Male	1.62 (.48)	1.58 (.51)	3.67 (1.22)	3.39 (1.47)
Female	1.90 (.83)	2.31 (.76)	3.25 (1.09)	3.21 (1.12)

Deaf-Hearing Practitioner Differences

Since we were interested in whether culturally Deaf mental health practitioners use touch more frequently than hearing practitioners working with deaf and hard of hearing clients, an independent sample *t*-test was conducted with hearing identity (culturally Deaf or hearing) as a between-group variable and relationship touch and social touch as dependent variables. Culturally Deaf mental health practitioners (M=1.64, SD=.65) showed no significant difference in the use of relationship touch compared with those who identified as hearing (M=1.98, SD=0.69) (t(21)= -0.99, $p > .05$). However, mental health practitioners who identified as culturally Deaf reported significantly less use of social touch (M=2.55, SD=0.45) than those who identified as hearing (M=3.57, SD= 1.23) (t(19)=-2.89, $p < .05$). Because Levene's test indicate unequal variances (F=7.82, p=.01), degrees of freedom were adjusted from 21 to 19 for use of social touch with clients. We then conducted post-hoc analysis on items classified under social touch: accepting and offering hugs and accepting and offering handshakes.

Independent sample *t*-tests reveal culturally Deaf practitioners were less likely than their hearing counterparts to offer handshake to their clients but this difference bordered on statistical significance (t(19)=1.96, p> .05). However, both deaf and hearing mental health practitioners showed no differences in accepting handshakes from their clients (t(19)=1.11, p

> .05), offering hugs to clients (t(19)=.54, p > .05) and accepting hugs from clients (t(19)=.31, p > .05).

Table 3
Mean responses (Standard Deviation) of culturally deaf and hearing mental health practitioners on items classified as Relationship Touch and Social Touch

Item	Culturally Deaf n=5	Hearing n=18	*p-value*
Relationship Touch	1.64 (0.65)	1.98 (0.69)	0.33
Social Touch	2.55 (0.45)	3.57 (1.23)	0.01**
Accepting Hugs	2.60 (1.34)	2.78 (1.10)	0.76
Offering Hugs	2.20 (1.64)	1.86 (1.14)	0.68
Accepting Handshake	3.50 (0.87)	4.11 (1.13)	0.23
Offering Handshake	1.60 (0.89)	3.03 (1.54)	0.06

Discussion

While we were not able to make inferences based on the data due to the limited sample size, the results showed interesting trends that should be further investigated. Especially noteworthy and contrary to our hypothesis was the finding that therapists who self-reported as deaf and identify themselves as culturally Deaf were less likely to engage in social touch (offering and accepting handshakes or hugs) than those who identified as culturally hearing. No significant differences were found between deaf and hearing mental health practitioners in the frequency of relationship touch, defined by Stenzel and Rupert (2004) as holding hands, holding in arms, putting an arm around the client, or holding in their lap. As the sample number for culturally Deaf participants was only five compared to 18 culturally hearing participants, this finding needs to be interpreted with extreme caution. However, our sample size may proportionately reflect the approximate number of practitioners who identify themselves as culturally Deaf compared to those who are culturally hearing.

The Deaf culture values touch in that it is considered polite to tap another individual on the shoulder or to give a hug in greeting or parting. One possible reason why therapists who identified as culturally Deaf were less likely to touch their clients than their counterparts not identifying as culturally Deaf may be because they were especially cognizant of the power of touch and the multiple negative attributions related to the possible misuse or misinterpretation of touch within the field of psychotherapy. This has been reinforced by various ethical prohibitions of anything that could be misinterpreted as sexual, even if the intent was not sexual. Consequently, these therapists may have restrained themselves from the use of touch to reinforce the professional nature of the psychotherapeutic relationship in comparison to the normative touch within Deaf culture social situations. This interpretation is reinforced by a vignette presented by Leigh and Lewis (2010) that demonstrates the culturally Deaf

psychotherapist's discomfort with the culturally Deaf client's hugs pre- and post-session. In the following session, the client refrained from hugging the psychotherapist.

Alternatively, those therapists who did not identify as culturally Deaf may have overcompensated for their cultural status outside Deaf culture by using physical touch in order to put their culturally Deaf clients at ease and subtly informing them they are familiar with Deaf culture norms regarding touch.

There were no gender differences in the expression of relationship touch; however, there were differences in same-sex expression of touch. Therapists who identified as female were more likely to engage in touch with their female clients, as were male clients with their male clients. Male therapists, however, were less likely to engage in touch with the opposite gendered client. These results parallel the findings in the Stenzel and Rupert (2004) study, and thus are not surprising. In comparison with the Stenzel and Rupert study, practitioners in this study were more willing to engage in socially stereotyped touch (e.g., a handshake) as well, again perhaps due to the need to put their clients at ease.

Limitations and Future Research

Clearly the small number of respondents is a serious limitation. It is possible respondents were reluctant to report their use of touch, or many who engage in the use of touch simply chose not to complete the survey. Due to the fact such a small number of therapists participated in this study; we cannot make any conclusive inferences. Participants in this study were not compensated for their time; their participation was voluntary. For this reason, consideration of some form of compensation for future research is warranted. An alternate possibility would be to run focus groups of psychotherapists working with Deaf clients and separately of Deaf individuals who have experienced psychotherapy in order to explore the use of touch in a psychotherapeutic setting. This would be beneficial in enhancing our understanding of how touch may or may not be used in a psychotherapeutic setting with Deaf clients.

Since touch is an integrative part of Deaf culture, it is interesting to note the results from this study appear to parallel what has been found with therapists working with the general hearing population. As touch is a critical component of the human experience, but fraught with many concerns regarding its appropriate use within the psychotherapeutic context, future studies need to explore how touch is best utilized within therapy when the client is deaf. Additionally, a better understanding of what is provided in graduate training related to the delivery of therapeutic comfort and ethical considerations, particularly for graduate students who are training to work with culturally Deaf clients, would significantly enhance their therapeutic repertoire. Ethical considerations in working with culturally Deaf clients, which are thoughtfully reviewed in Boness (2016) and Gutman (2005), can provide a basis for discussion on the role of touch within the context of psychotherapy.

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