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MENTAL HEALTH PRACTITIONERS' PERCEPTIONS OF TOUCH

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Kathleen Sarah McBride

May 1993

MENTAL HEALTH PRACTITIONERS' PERCEPTIONS OF TOUCH

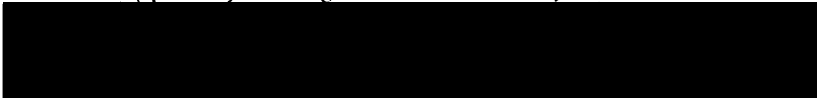
A Project
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by
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May 1993

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May 18, 1993
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ABSTRACT

The elemental need for comforting, affectionate touch has been well established. However, in the context of mental-health practice, issues of touch tend to become problematic. Using a post-positivist approach, developed into an open-ended questionnaire, this author explored mental-health practitioners' perceptions of touch when working with mentally-ill clients. Practitioners who participated in the research project worked with clients in a publicly funded mental-health clinic and represented a variety of professional affiliations. Regardless of professional affiliation, it was found that all respondents validated basic tenets of social work. Qualitative analysis of questionnaires revealed consistent themes, some consensus of opinion and many contradictions. Responses were found to be influenced by a participant's gender and professional affiliation. Based on consistent references by respondents that touch requires appropriate interpretation of intent, this author concluded that the establishment of programs to teach mentally-ill clients the appropriate interpretation and use of touch would benefit both practitioners and clients.

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INTRODUCTION

As direct practitioners working with mentally-ill clients, social workers face a multidimensional challenge. Consistent with social work tenets that consider human behavior in the context of the social environment, practitioners are expected to demonstrate competence in assessment skills, evaluation skills and strategies of intervention. Such competence requires consideration of the full range of human potential. In the field of mental-health, the human potential runs a gamut from abnormal to normative behavior. It is the task of the social work practitioner to ascertain how each client best fits into the normative scheme. If therapy is indicated, practitioners must then decide which therapeutic intervention best serves a client's need. Practitioners have a vast array of therapeutic interventions from which to choose. Interestingly, one therapeutic modality is rarely chosen. "Touch therapy," an ancient concept being re-discovered in various health-care fields,¹ is significantly under-represented as a practice choice by mental-health practitioners. The general reluctance of mental-health practitioners to use "touch therapy" may derive from the fact that touch, far from being a simplistic concept, has historically been imbued with such complex, symbolic significance that the taboos of touch may outweigh its

benefits. More fundamentally, and beyond the use of touch as a therapeutic modality, even the elemental need to touch, and be touched, presents as problematic for practitioners who work with mentally-ill clients. When thought of as running a continuum that includes gentle soothing, playful prodding, informal greeting, formal ritual, sexual intimacy, inflicted pain and corporal punishment, it becomes clear how complex the issue of touch can be. Frequently, the issue of touch surfaces to present the mental-health practitioner with incessant dilemmas.

PROBLEM STATEMENT

While working with mentally-ill clients at a publicly funded mental-health clinic, this author observed that issues concerning touch repeatedly emerged as problematic. There was, in fact, a formally coded rule referred to as the "No Touch Rule." This rule governed interaction between clients and interaction between practitioners and clients. Theoretically, the "No Touch Rule" incorporated an appreciation for the right of each individual to have "private space" and be free from unwanted intrusion. However, this sort of rationalization seemed only to address one end of the continuum of touch, the intrusive, or painful end. That being the case, several questions then arose as to how positive aspects of touch were addressed in the context of work with mentally ill clients.

To assuage a piqued curiosity, this author, held several informal discussions with various practitioners at the clinic. Information from these discussions revealed that practitioners recognized the elemental need for comforting touch but had reservations about the concept of touch as applied to mentally-ill clients, especially mentally-ill adults. Many practitioners acknowledged dilemmas inherent in the issue of touch and most felt that touch, in the context of mental-health practice, was problematic.

PROBLEM FOCUS AND LITERATURE REVIEW

Numerous studies have considered general sensory deprivation.² However, with the exceptions of blindness and deafness, the senses have rarely been studied as individual entities.³ Notably, the sense of touch, has primarily been studied in reference to children.⁴ As a therapeutic intervention in direct practice, touch has also been primarily reserved for work with children.⁵ Review of the literature revealed two major exceptions to the emphasis on children. Interestingly, these exceptions referenced touch as a therapeutic intervention to either "enhance" the healing of medical conditions,⁶ or "enhance" one's sense of self and one's connection with others in the context of a "group encounter."⁷

A disappointing paucity of literature was found

concerning mentally-ill adults and the issue of touch. However, an eclectic approach to the literature afforded an opportunity make some intriguing inferences. For example, it was found that developmental theorists consider touch an issue of primacy for the development of attachment⁸ and ethnologists emphasize the instinctual nature of touch in relationship to attachment and dependency needs.⁹ In turn, attachment theorists suggest that the development of attachment in children lays the foundation for affective behavior in adults. Affective relationships among adults are considered socially adaptive.¹⁰ Commonly, mentally-ill adults have been found to have difficulty with affect.¹¹ As such, fundamental aspects of attachment theory, in which the elemental need to touch and be touched has primacy, can be extrapolated to include mentally-ill adults.

Several studies have been done in reference to the importance of touch for optimal childhood development.¹² However, research on touch among adults is at best sparse and rarely addresses an adult's elemental need to be held, cuddled and comforted. Exceptional among studies reviewed was one done by M. H. Hollander and his colleagues. Hollander interviewed thirty-nine adult women who were being treated for acute psychiatric disorders. Interview questions concerned a patient's need to be cuddled and comforted in the context of sexual intimacy. Hollander found:¹³

The desire to be cuddled and held is acceptable to most people as long as it is regarded as a component part of adult sexuality. The wish to be cuddled and held in a maternal manner is felt to be too childish; to avoid embarrassment or shame, women convert it into the longing to be held by a man as part of an adult activity, sexual intercourse.

A review of studies done on the general adult population revealed several studies that addressed issues of touch in reference to "boundaries," "status" and "communication."¹⁴ Significant for mental-health practitioners were studies in which specific relationships were found between touch and status, and, between touch and gender. For example, Nancy Henley found that touching liberties were more one-sided, from higher status to lower status individuals.¹⁵ And, C. Forden, who asked college students to evaluate video tapes of touch between a man and a woman, found that:¹⁶

Identical touches by a man or woman were judged differently. When the female touched the male, she was rated as more dominant or masculine than when the man touched her or there was not touch. In contrast, when the male was touched, he was seen as more passive or feminine than when he touched or there was not touching. Touching was seen as male behavior and being touched was seen as female behavior.

Finally, one rather interesting study done by K.J. Gergen, M. M. Gergen and W. H. Brown, in which college students were placed together in a darkened room, occasioned the following observation:¹⁷

People, it seems, and perhaps not just Swarthmore college students, seem to have a hunger for

physical-sensual intimacy that is usually held in check by social norms that inhibit its expression. In the absence of factors that maintain or enhance these normative pressures, people seem to express their primitive need for contact.

It became apparent from literature reviewed that touch is considered an elemental need for all human beings. In addition to the elemental nature of touch, most studies also underscored the complex nature of touch. However, when mental-illness was added to confound the consideration of touch, few studies were found that addressed the needs of mentally-ill clients, especially the needs of mentally-ill adults. From these findings came an incentive for this author to explore mental-health practitioners' perceptions of touch.

PURPOSE OF THE RESEARCH PROJECT

Using an exploratory approach, this research project intended to gather information from mental-health practitioners concerning their perceptions in reference to the issue of touch when working with mentally-ill clients. From data obtained, it was anticipated that thematic patterns would emerge which would lead to the development of grounded substantive theory. The intent to explore mental-health practitioners' perceptions of touch was found to be consistent with professional tenets in social work which emphasize psychosocial assessment and are solidly based in systems theory. In fact, it was found that social work

practitioners, especially those in direct practice with mentally-ill clients, are optimally situated to explore issues of touch. As John F. Longres has noted:¹⁸

In the primary social service task of assessing the psychological well-being of clients, thorough knowledge is required of the affective, cognitive and behavioral subsystems in the psychological domain of the individual. These subsystems, which are also referred to as domains in their own right, are intimately interrelated and cannot be understood without consideration of all three. In order to promote psychological well-being in clients, the concept of normality also must be studied and understood.

RESEARCH QUESTION AND PROJECT DESIGN

Based on the premise that touch is an elemental need for all human beings, a project was designed to explore touch in the context of mental-health practice. Necessarily, mental-health practitioners deal with issues of touch. cursory scrutiny of policy in the mental-health field suggested that touch is problematic for mental-health practitioners. However, it was also found that mental-health practitioners are cognizant of attachment theory, developmental psychology and social psychology in which touch is presented as a beneficial, even necessary, entity. With these considerations in mind, the core research question became: How do mental-health practitioners perceive the issue of touch in reference to mentally-ill clients?

The nature of touch, a complex and rather ethereal concept, dictated that a qualitative research approach be

used. For this reason, a post-positivist paradigm, developed into an open-ended questionnaire, was the research design of choice. Such an approach gave project participants an opportunity to freely respond with anonymity. It was anticipated that the use of an open-ended format would generate a rich body of data for post-positivist analysis.

Purposive, non-random sampling of sixty-one practitioners, working at three clinics operated under the auspices of Desert Community Mental Health Clinic (DCMHC), was chosen as the sampling method for this research project. Practitioners sampled included social workers, psychologists, psychiatrists, nurses, case managers, psychiatric technicians and mental-health workers. DCMHC, funded by the Riverside County Department of Mental Health, is part of the publicly funded system of mental-health provided by the state of California. Clients served by DCMHC are primarily clients who receive some sort of public financial assistance and have major mental disorders.

Due to the unique nature of the therapeutic relationship, and due to the complex nature of touch, an instrument was designed specifically for this research project. This instrument combined a vignette approach with direct open-ended questions. Vignettes were similar in design to vignettes used by Kohlberg and Gilligan in their

studies of morality among children.¹⁹ Included in vignette presentations was an appreciation for cultural, age and gender diversity. Seven open-ended questions were posed after the presentation of vignettes. Project participants were asked to provide written responses. (See Appendix 1)

Sixty-one questionnaire packets were distributed to practitioners working in Desert Community Mental Health Clinics. These packets were placed in each practitioner's personal clinic mailbox. In addition to the questionnaire, each packet contained two stamped and addressed envelopes. Project participants were asked to mail consents back in one envelope and completed questionnaires back in a separate envelope.

Included in each questionnaire packet was a consent form that project participants signed and returned before completing the questionnaire. Contained in the consent form was a guarantee of anonymity for all project participants. To assure anonymity, questionnaires were not identified in any way by respondent and were not coded to identify how they were dispersed. In addition, a debriefing form was provided to each participant with information on whom to contact if a need for clarification arose.

DATA ANALYSIS METHODOLOGY

Consistent with the exploratory and qualitative nature of this research project, data analysis followed the coding

schemata proposed by Anselm Strauss and Juliet Corbin.²⁰

Open coding, in conjunction with axial coding, was initially used to define categories and infer causality. Data analysis then proceeded by use of selective coding in which core categories were selected and related to each other.²¹ To facilitate the process of selective coding, several "balancing matrixes"²² were used for data analysis. The data were then processed through "integrative diagrams," which afforded an opportunity to identify major themes and work toward the development of grounded theory.²³ An inductive line of reasoning was chosen due to the unique nature of direct practice. Grounded theory, developed inductively, reflected actual practice attitudes which were then compared to existing theory.

Strauss and Corbin explicitly state the conditions under which qualitative research follows the "canons of good science."²⁴ They suggest that the "usual canons of good science be retained, but require redefinition in order to fit the realities of qualitative research, and the complexities of social phenomena."²⁵ As such, Strauss and Corbin's guidelines were applied to this research project.²⁶

Given the same theoretical perspective of the original researcher and following the same general rules for data gathering and analysis, plus a similar set of conditions, another investigator should be able to come up with the same theoretical explanation about the given phenomenon.

The purpose of grounded theory is to specify the conditions that give rise to specific sets

of action/interaction pertaining to a phenomenon and the resulting consequences. It is generalizable to those specific situations only. Naturally, the more systematic and widespread the theoretical sampling, the more conditions and variations that will be discovered and built into the theory, therefore the greater its generalizability (also precision and predictive capacity).

Questionnaire responses were analyzed qualitatively. However, demographic data were also analyzed quantitatively using frequency analysis. Demographic patterns that emerged were identified then used for further qualitative analysis.

RESULTS

Of sixty-one questionnaires distributed, twenty-one were completed and returned. All twenty-one returned questionnaires were received within three weeks of distribution. Each completed questionnaire was used for data analysis.

Demographic analysis of respondents revealed that 67 percent of respondents were women. A majority of respondents (67 percent) were licensed and 86 percent of respondents held either a master's or a doctorate degree. Analysis of ethnicity found that 90 percent of respondents were Caucasian. Mean age for all respondents was forty-three years of age, with a range of thirty years of age to fifty-six years of age. Mean years of practice in mental-health for all respondents was ten, with a range of seven months to twenty-seven years. Over one third (38 percent) of respondents described their primary practice area as

working mainly with adults. Respondents who worked primarily with children comprised 29 percent of respondents. Less than half (42 percent) of the respondent population identified as social workers. Respondents who identified as psychologists represented 24 percent of the respondent population and respondents who identified as marriage, child and family counselors represented another 24 percent of the respondent population. Remaining respondents identified with nursing and mental-health work, which represented 10 percent of total respondents.

Qualitative analysis, working toward theme aggrandizement, found ten major themes represented by respondents: the need for touch, protection of the client, protection of the practitioner, appropriateness, recognition of personal boundaries, psychopathology of the client, sexual issues, legal issues, interpretation, and practitioner judgement. Following is a discussion of each major theme.

The Need for Touch. Each respondent answered a resounding, "Yes!" when asked if mentally-ill clients need to give and receive affectionate, warm touch. However, respondents were more likely to qualify their answers when this need was considered for adult clients.

Protection of the Client. Respondents made reference to protection of the client a total of seventy-six times. This was the most commonly mentioned theme found among

respondents. References to client protection commonly included issues of vulnerability, safety and respect for personal boundaries.

Protection of the Practitioner. The second most commonly found theme among respondents was the issue of protection for the practitioner. This area was referenced a total of sixty-six times and commonly included the mention of legal issues, safety issues and the potential for "misunderstanding."

Appropriateness. The next most commonly mentioned theme was the area of "appropriateness." The total respondent population mentioned the issue of "appropriateness" fifty-four times. Commonly, these mentions referenced the context of interaction between practitioner and client, as well as the individual interpretation of touch.

Recognition of Personal Boundaries. References to "boundary recognition" were found a total of forty-eight times among all respondents. Such references commonly included the mention of privacy, the need to set limits and a respect for individual preference.

Psychopathology of the Client. The issue of the client's psychopathology was referenced a total of forty-seven times. These responses were primarily found in respondents' rationale to previous replies. Such references commonly made mention of the client's inability to

appropriately interpret touch.

Sexual Issues. The direct mention of sexual issues concerned with touch was found a total of forty-four times. References to sexual issues commonly included the potential for clients to misinterpret a practitioner's behaviors.

Legal Issues. Respondents made reference to legal issues a total of thirty-nine times. References to legal issues commonly mentioned a practitioner's vulnerability due to existing law.

Interpretation. Issues of the "interpretation of touch" were cited singularly a total of thirty times. Such issues were commonly cited as issues in which a practitioner's touch could be "misinterpreted" by a client.

Practitioner Judgement. A total of twenty-five references to the need for practitioners to exercise judgement were found. Respondents referenced the practitioners's judgement most commonly as dependent on the context of interaction and the extent of the practitioner's familiarity with the client.

Following the development of themes, the data were analyzed in reference to demographic categories. Of eight demographic categories used in the research project, only two, "gender" and "professional affiliation," were found to have an appreciable impact on respondent replies. Table 1.0 lists frequencies found in which "professional affiliation" and "gender" were associated with major themes.

Table 1.0 - Gender and Professional Affiliation by Theme							
	Women	Men	SW	MFCC	PSY	N	MHW
Protect Client	48	28	34	14	24	2	2
Protect Pract.	49	17	36	10	15	3	2
Appropriate	41	13	25	22	6	1	0
Boundaries	35	13	22	19	6	0	1
Psychopathology	27	20	14	17	12	2	2
Sexual Issues	22	22	21	6	17	1	1
Legal Issues	20	19	17	10	12	0	0
Interpretation	20	10	9	11	8	1	1
Judgement	20	5	11	9	4	0	1

Key to Table Abbreviations: SW = Social Work, MFCC = Marriage, Child and Family Counseling, PSY = Psychology, N = Nursing, MHW = Mental Health Worker, Pract. = Practitioner

Scrutiny of frequency analysis for "gender" and "professional affiliation" revealed that there were differences among respondents. Using open and axial coding, the data were again analyzed in an attempt to discern trends that might exist. Some engaging trends were identified in this portion of analysis. Following is a discussion of trends that were found.

Protection of the Practitioner. This theme was referenced by all respondents. Further analysis revealed that a concern for practitioner protection was mentioned primarily in three forms: a potential threat to the practitioner's safety, a potential legal threat to the practitioner, and the potential for the client to sexually misinterpret the practitioner. Of these three areas of potential threat, the threat for sexual misinterpretation was found in all respondent questionnaires. Concern for the

practitioner's safety was found in 90 percent of questionnaires and the potential for the practitioner to be legally threatened was found in 52 percent of questionnaires. When data were analyzed by gender, female respondents were found to be more inclined to mention issues of practitioner safety. Male respondents were more inclined to mention the potential for legal and sexual threats to practitioners. Interestingly, these responses from male participants were found primarily in response to two vignettes in which female clients were presented. When direct questions were asked, male respondents also tended to reference legal and sexual implication more often than did female respondents. This was especially true when respondents were asked why they thought "No Touch Rules" existed.

When "professional affiliation" was considered in reference to "practitioner protection," respondents who identified as marriage, family and child counselors tended to mention issues concerned with practitioner safety more than did other professional affiliations. The vast majority (80 percent) of this respondent group mentioned practitioner safety issues in response to questions concerning the adult client's need for touch. Respondents who identified their professional affiliation as "psychology" were more inclined than other groups to mention legal and sexual issues. However, this was found to be true only in the context of

direct questions. Respondents who designated their professional affiliation as either nursing, or mental-health work, were the only respondents who did not mention legal issues.

Interpretation. Further analysis of the theme designated "interpretation" revealed that the vast majority (95 percent) of respondents referenced the potential for the negative "interpretation of touch." These references commonly cited the "intrusive nature of touch" and the fact that many clients had histories of physical and sexual abuse. Positive aspects of touch were mentioned by 81 percent of respondents. These positive references commonly mentioned the use of touch to communicate "caring," "acceptance," and "comfort." Interestingly, 82 percent of respondents who referenced positive aspects of touch did so by citing touch as a method by which to establish "rapport" for the sake of the therapeutic relationship. However, 24 percent of respondents also mentioned that the use of touch could "interfere" with the therapeutic relationship.

When gender was considered, more female respondents mentioned positive aspects of touch in response to vignette presentations than did male respondents. However, male respondents made more reference to positive touch in response to direct questions than did female respondents. These differences were especially apparent in response to one vignette in which a female client with poor hygiene was

presented. Answers to this vignette showed that 70 percent of female respondents reported they would allow the client to touch them in order to "establish a therapeutic relationship." Only 20 percent of male respondents indicated they would do the same. However, when male respondents responded to direct questions asking whether or not adult clients needed touch they tended to reference positive aspects of touch more often than did female respondents. Over half (57 percent) of male respondents felt that adult clients, due to touch deprivation, had a greater need for touch than the general population. Only 7 percent of female respondents gave the same response.

When "professional affiliation" was considered in conjunction with "interpretation," only respondents identified as marriage, child and family counselors tended to give one response more than respondents from other professional affiliations. The vast majority (80 percent) of this respondent group indicated they use touch to "encourage a therapeutic relationship."

Appropriateness, Judgement and Psychopathology.

Further data analysis revealed that these three themes were related to each other. Most commonly, respondents referenced practitioner judgement as a singular theme when responding to direct questions concerning adult clients. All respondents replied that adult clients have a need for touch, however, 62 percent of these responses were qualified

with the condition that the practitioner must exercise judgement when working with adults. When the themes, "appropriateness," "judgement," and "psychopathology," were combined it was most often in response to direct questions. This was best typified by responses to questions in which respondents were asked why they thought "No Touch Rules" existed and whether or not they use touch in their practice. In response to these two questions, respondents commonly reported that, "The appropriateness of a client's touch is best assessed by the practitioner, who takes into consideration the context of interaction and a client's psychopathology." Only four respondents cited the client's psychopathology as a singular reason to exercise judgement. All four of these respondents cited the diagnosis of "paranoia" as a reason to exercise judgement before engaging in touch with a client.

When gender was considered in relation to "appropriateness," "judgement," and "Psychopathology," it was found that more female respondents tended to mention issues of gender, age and familiarity than did male respondents. Also, more female respondents (57 percent) than male respondents (28 percent) cited familiarity with the client as a singular condition to exercise judgement.

Consideration of the respondent's professional affiliation in reference to thematic schemes of "appropriateness," "judgement," and "psychopathology," found

that respondents who identified with psychology tended to reference a client's psychopathology more than did other groups. Respondents who identified as marriage, child and family counselors made more singular mention of the need for practitioners to exercise judgement than did respondents from other professional affiliations.

Recognition of Personal Boundaries. Questionnaire analysis revealed that all project participants referenced the "recognition of personal boundaries," with female respondents more likely to mention personal boundaries than male respondents. However, in a seemingly contradictory finding, analysis of vignette responses found that more female respondents than male respondents engaged in reciprocal touch with clients. Also seemingly contradictory were results found in analysis of questions asking how a client's need for touch could be met. More female respondents than male respondents indicated a client's need for touch could be met in part by the practitioner. More male respondents reported that a client's need for touch should be met by a client's family or significant others.

When a respondent's professional affiliation was considered in reference to boundary, respondents who identified with social work tended to mention, slightly more often, the importance of personal boundaries than did respondents with other professional affiliations.

Protection of the Client. The final thematic area in

which further analysis was done concerned "protection of the client." All respondents made reference to "protection of the client." However, in response to vignette presentations, female and male respondents tended to mention "protection of the client" differently. Analysis of "Vignette #1," in which two adult clients were found sleeping in the same bed, revealed male respondents were more inclined to assist one client to find his proper room, and talk with the clients to determine reasons for their behavior. Female respondents to this vignette tended to cite policy more often and seek assistance before intervening. Analysis of responses to "Vignette #2," in which an intrusive female client with poor hygiene was presented, found that more female respondents mentioned the need to provide a safe environment for the client than did male respondents. Female respondents also indicated more than male respondents they they would allow this client to touch them to protect the client's self-esteem. Analysis of "Vignette #4," in which a potentially threatening nine year old female client was presented, found that 74 percent of female respondents indicated they would take control of the situation in order to assuage the client's fear and provide a safe environment. This contrasted with 43 percent of male respondents who indicated they would do the same.

While female respondents were found to mention client protection issues more often in response to vignette

presentations, male respondents did so more often in response to direct questions. This was best typified in response to the question in which respondents were asked why they thought "No Touch Rules" existed. More male respondents (43 percent) than female respondents (29 percent) made direct reference to issues of client protection.

There were no significant differences found when respondent professional affiliation was considered in relation to the theme of "protection of the client."

DISCUSSION AND RECOMMENDATIONS

In the exploration of practitioners' perceptions of touch, this author found that respondents validated the elemental need for all human beings to give and receive affectionate, warm touch. Respondents also validated the complexity inherent in issues of touch, especially when touch was considered in the context of mental-health practice. All respondents, regardless of professional affiliation, gave credence to core concepts in social work practice. This was evidenced by every respondent citing the importance of personal and environmental issues related to touch. These three results validate social workers' efforts to study the unique properties of touch.

Of interest were results referencing "protective" issues. The association of touch with negative consequences

appeared to diminish consideration of the beneficial properties in touch. Sexual issues, referenced by all respondents, were found to be reminiscent of Freudian admonishments against touching patients.²⁷ Sexual issues were also found to be intrinsically tied to legal concerns. This can best be understood as a reflection of the increasing social concern with sexual exploitation. Safety issues were found to be especially important to female respondents. This finding supports other research in which women reported being more timid and fearful than men.²⁸ All respondents were found to equate "protection" with the establishment of "No Touch Rules." Unfortunately, such rules were found to be enforced primarily at the adult client's expense.

Of equal interest were results which referenced the need to "interpret the appropriateness of touch." These findings validate such programs as those offered to children in which "good touch" is differentiated from "bad touch." Respondents' frequent referrals to the terms "appropriate" and "interpretation" suggested to this author that respondents agree with tenets in attachment theory. Attachment theorists postulate that certain elements of touch are learned behaviors. Acknowledging the learned component in touch makes it amenable to being taught. As with other socially adaptive behaviors, it is reasonable to assume that the appropriate interpretation of touch can be

taught, not only to children, but also to mentally-ill adults. If such programs were available, benefits to both practitioner and client would be immeasurable. Such programs would offer mentally-ill adults an opportunity to understand the entire continuum of touch, including warm, comforting and affectionate touch. With such an appreciation, mentally-ill adults would have less difficulty integrating into the larger society and would "appropriately" find ways to meet their elemental need to give and receive touch. For practitioners, the availability of such programs would absolve them from the need to engage in dilemmas inherent in touch issues. If these programs were also available to practitioners, an opportunity would be afforded for personal and professional growth.

Though the data showed some difference when "professional affiliation" was considered, for the most part "professional affiliation" made little impact on results. It was assumed that this was due to the nature of the subject researched. As noted earlier, touch is a complex and elusive entity. In his work done on "social touch," Stephen Thayer has written:²⁹

In many ways, touch represents a confirmation of our boundaries, and separateness while permitting a union or connection with others that transcends physical limits. For this reason, of all the communication channels, touch is the most carefully guarded and monitored, the most infrequently used, yet the most powerful and immediate.

Thayer's comment sums up nicely the sorts of complexities

and contradictions inherent to touch. When contradictory responses were found in the data, they tended to corroborate Thayer's contention that touch "confirms our separateness while permitting a connection with others."

One final comment on results found in this research project is in order. Analysis of the data showed female respondents more likely to engage in reciprocal touch than were male respondents. This result suggests the influence of gender socialization on mental-health practitioners. Studies done by M. Argyle et al. found women consistently more sensitive to nonverbal cues than men.³⁰ N. M. Henley, in a comprehensive study done on touch associated with status, found that "both females and males indicated greater expectations of being touched by higher-status persons, and of touching lower-status and female persons, than vice versa."³¹ Results from this research project tend to support Argyle and Henley's findings.

Consistent with the nature of qualitative data, this research project will be difficult to duplicate. However, it is recommended that a similar project be done with a larger group of practitioners in different practice settings. It is hoped that such studies will clarify findings from this research project.

Respondents were very gracious with the time it took to complete the questionnaire. Fortunately, they were also candid enough to report that the format was "far too

tedious." Future researchers would be better advised to use an interview format.

Finally, especially pertinent to social workers is a consideration of cultural diversity. Respondents in this research were predominantly Caucasian. Therefore no attempt was made to analyze data in terms of ethnicity. To date, research done on the influence culture has on the expression of touch tends to be contradictory and make errors in generalization.³² Such findings underscore the need for more cultural studies to be systematically done.

The intent of this research project was to explore practitioners' perceptions of touch and that intent was realized. Though time consuming, and more subjective than quantitative analysis, the qualitative nature of this project provided a rich body of data from which to draw practice based themes. It was the intent of this author to work toward grounded theory to add to the body of social work knowledge. In a small part, this was accomplished. The inclusion of project participants from various professional affiliations was intentional. Practitioners working in mental-health share unique circumstances. It seems only fitting to share knowledge.

Seemingly, an appropriate way to end what has been a fascinating journey, is with a passage borrowed from Stuart A. Kirk, which has been adapted to mirror the elusive world of touch:³³

Few areas of social behavior are so rich in intricacies, so elusive in rationale, and so imbedded in morality as is [touch]. Ironically, it is this concern, perhaps overconcern, for the propriety and structure of [touch] that makes it such a fertile field for deviation.

APPENDIX 1

Mental Health Practitioners' Perceptions of Touch Questionnaire

The following questionnaire is an effort to understand how practitioners, working in the mental-health field, perceive the issue of "touch" in reference to their own interaction with clients as well as client to client interaction. Due to the inherent complexity of the issue of "touch," an open-ended format has been chosen. It is hoped that this format will provide each respondent with the opportunity to explain and modify responses as needed.

The first section of the questionnaire consists of vignette presentations to which you are asked to respond. If you need more space for your answer than that which is provided, please use the back of the paper. If the back of the paper is used for your response, please note the number of the vignette to which you are responding.

Your time is appreciated.

Vignette #1

1. You are asked to make evening rounds on the in-patient unit and find that two, adult, male clients are lying in the same bed, asleep, fully clothed, with their backs to each other and their backs touching. One client, age 30, is well known to the clinic and is diagnosed with "Schizophrenia." He has religious hallucinations and

delusions in which he believes God and Satan have chosen him as their messenger. The other client is a 20 year old male, new to the clinic, diagnosed with "Major Depression" and has expressed a suicidal intent. Neither client has shown violent tendencies.

a. Upon finding the two men asleep, what would you do?

Please share your reasons.

b. How do you think the two men ended up sleeping in the same bed, next to each other?

Please share your reasons.

Vignette #2

2. You are asked to assess a client who is new to the clinic. The client is a 50 year old Caucasian woman who presents with very poor hygiene. She is wearing filthy clothes, her hair is obviously dirty and her teeth are few and markedly decayed. During the interview, the woman consistently wipes her running nose with the back of her bare hand. The woman reports she is being "stalked by shadows" but says she feels very comfortable with you. In fact, she reports that she feels safe for the first time in years. She moves her chair closer to you and each time you look away to make a note she puts her hand on your arm to get your attention.

a. How would you respond to this client, especially her continued touch of you?

Please share your reasons.

Vignette #3

3. You are asked to interview a 9 year old girl who has been referred to the clinic by Child Protective Services. The child does not want to be at the clinic. She is sullen and angry and enters your office alone. You ask the child her name and she suddenly snaps at you and says, "I'm not going to answer any of your questions and I'm going to tell everybody that you molested me in here, and they'll believe me because I've done it before." The child then runs toward you.

a. How would you respond to this client?

Please share your reasons.

Vignette #4

4. You are working with a group of adult clients, aged 20 to 45, all diagnosed with "Major Depression." The group is composed of 4 women and 5 men. One of the younger male clients is sharing and suddenly begins to cry while saying, "No one can stand me. I make people sick and they can't even look at me, let alone touch me. It's all because I have AIDS! Does that make me like a leper? Won't someone here please touch me? The other members of the group look to you for direction.

a. How would you respond in this situation?

Please share your reasons.

Vignette #5

5. You are interviewing a 19 year old woman and her 4 year old son who have come to the clinic for the first time. The woman has brought her son in for help because he has been torturing his pet dog. As the interview begins, the 4 year old boy sits on his mother's lap and you notice that he absent mindedly fondles his mother's breasts and genital area during the interview. The child's mother appears not to notice the child's touch, but suddenly she pushes him roughly off her lap and the boy curls into a fetal position on the floor and begins to cry. Shortly, the child comes toward you with arms outstretched.

b. How would you respond to this situation?

Please share your reasons.

Vignette #6

6. As you arrive at the clinic in the morning, a pair of clients who are well known to the clinic, stop you in the entry way. One client is a 28 year old Afro-American male who is diagnosed with "Paranoid Schizophrenia." The other client is a 45 year old, Hispanic female who is diagnosed with "Bipolar Disorder." The couple tells you that they are having a sexual relationship with each other and would like you to give them some advice about how to have a good relationship.

a. How would you respond to this couple's request?

Please share your reasons.

b. What sort of sexual behavior advice, if any,
would you offer them?

Please share your reasons.

The following questions deal specifically with the issue of touch as concerns mentally-ill clients. Please respond in writing to each question in the space provided. If additional space is needed for your response, please use the back of the paper. If you use the back of the paper, please indicate the question to which you are responding.

Question #7 - "No Touch Rules"

7. It is common for mental-health facilities to have "No Touch" rules. These rules apply to therapist and client interaction, as well as, client to client interaction. What do you feel the reasons for such rules are?

Question #8 - Children's Need for Touch

8. Do you feel that mentally-disturbed children have a need to give and receive affectionate, warm touch? Please share your reasons.

Question #9 - Meeting Children's Need for Touch

9. If you answered, "Yes," to question 8, please explain how you think a child client's need for affectionate, warm touch can be met.

Question #10 - Adults Need for Touch

10. Do you feel that adult mentally-ill clients have a need to give and receive affectionate, warm touch? Please share your reasons.

Question #11 - Meeting Adult Needs for Touch

11. If you answered, "Yes," to question 10, please explain how you think an adult client's need for affectionate warm touch can be met.

Question #12 - Practice Use of Touch

12. Do you use "touch" when working with clients? Please explain your reasons for doing so, or not doing so.

Question #13 - Type of Touch Used

13. If you answered, "Yes," that you use "touch" when working with clients, please describe what sort of touch is used, i.e. handshake, arm around the shoulder, pat, hug etc. and under what sorts of conditions.

Demographic Information

Please provide the following information. Circle one option for each area as it applies to you or fill in the appropriate information:

1. Your Gender:

- a. Male
- b. Female

2. Your Age: _____

3. Number of years you have worked in mental-health: _____

4. Your primary practice area:

- a. Work, or worked, exclusively with children
- b. Work, or worked, exclusively with adults
- c. Work, or worked, primarily with children and some adults
- d. Work, or worked, primarily with adults and some children
- e. Work, or worked, with both adults and children equally

5. Primary Professional Affiliation:

- a. Psychiatry
- b. Marriage, Family and Child Counseling
- c. Social Work
- d. Psychology
- e. Psychiatric Technician
- f. Mental Health Worker
- g. Nursing
- h. Other (please specify) _____

6. License Status:

- a. Licensed
- b. Unlicensed
- c. License Pending, Exams Completed
- d. Intern Status
- e. Other (please specify) _____

7. Highest Educational Degree:

- a. M. D.

- b. D.O.
- c. Doctorate
- d. Master's
- e. Bachelor's
- f. Associate Arts
- g. Diploma
- i. Other (please specify) _____

8. Ethnicity:

- a. Caucasian
- b. Latino
- c. African-American
- d. Native-American
- e. Asian-American
- f. Other (please specify) _____

Any additional comments you have would be greatly
appreciated.

Thank you for the time you have taken to complete this
Questionnaire!

APPENDIX 2

Study Participant Consent Form

for

Mental Health Practitioners' Perceptions of Touch

I consent to serve as a participant in the research investigation entitled, "Mental Health Practitioners' Perceptions of Touch." The nature and general purpose of the study have been explained to me by Kathleen McBride from the Department of Social Work at California State University, San Bernardino, California. I understand that the purpose of this research is an exploratory effort to understand how practitioners, working in the mental-health field, perceive the issue of "touch" in reference to their own interaction with clients as well as client to client interaction. The research procedures involve written responses to open-ended questions. The research questions are in the form of a questionnaire that is distributed to each study participant. The potential benefits to participants in this project are:

1. An opportunity to participate in the development of mental-health practice modalities based on grounded theory.
2. An opportunity to participate with colleagues in research that adds to the body of knowledge for mental-health practice.
3. An opportunity to analyze current practice policy.

4. An opportunity for personal and professional growth.

No risks to study participants are anticipated.

I understand that my participation is voluntary and that all information is confidential and that my identity will not be revealed. I am free to withdraw consent and to discontinue participation in the project at any time. Any questions that I have about the project will be answered by the researcher named below or by an authorized representative.

California State University, San Bernardino, and the investigator named below have responsibility for insuring that participants in research projects conducted under university auspices are safeguarded from injury or harm resulting from such participation. If appropriate, the person named below may be contacted for remedy or assistance for any possible consequences from such activities.

On the basis of the above statements, I agree to participate in this project.

Participant's Signature

Date

Researcher's Signature
Kathleen S. McBride
P.O. Box 565
Morongo Valley, CA 92256
Campus Phone (714) 880-5501

APPENDIX 3

Informational Letter and Debriefing Form for MSW Research Project "Mental Health Practitioners' Perceptions of Touch"

Dear Study Participant:

You are being asked to participate in a research project that explores how mental-health practitioners perceive the issue of "touch" in reference to their work with clients through Desert Community Mental Health Clinic (DCMHC). The attached questionnaire is being distributed to all DCMHC practitioners working with clients in the Indio, Palm Springs and Blythe areas. Please note that your responses will remain anonymous.

The format chosen for this research project requests that you respond to open-ended questions in writing. This particular format was chosen to afford you the greatest opportunity to clarify and modify responses as you deem necessary. Due to the complex nature of mental-health work, and the added complexity of the issue of "touch," it is felt that each practitioner should have ample opportunity for freedom of expression, therefore, responses will remain anonymous. To assure anonymity, questionnaires have no identifying marks and the consent to participate in the study is separate from the questionnaire.

There has been little research done as to how mental-health practitioners view the issue of touch when working

with clients. It is hoped that data from this research project will lead to the development of theoretical knowledge from which mental-health practitioners may better understand and further develop practice technique. It is also anticipated that a variety of practitioners will be represented in this research project, therefore, the opportunity to share knowledge among disciplines in mental-health practice is an exciting prospect.

Please note - two stamped, addressed envelopes are included in your packet. After signing the consent form, please return it in the white, stamped, addressed envelope. The large, brown envelope is for the return of your completed questionnaire.

If you have questions or need clarification concerning this research project, or if you are interested in the results of the project, please contact:

Kathleen McBride
P.O. Box 565
Morongo Valley, CA 92256

OR:

Dr. M. Hunt, Department of Social Work
CSUSB
5500 University Parkway
San Bernardino, CA 92407-2397

Sincerely;

Kathleen McBride

Date

NOTES

¹Marie-Therese Connell, "Therapeutic Touch: The State of the Art," in The Many Facets of Touch, ed. by Catherine Caldwell Brown, (Skillman, New Jersey: Johnson and Johnson, 1984), p. 152. "In many ways therapeutic touch stands at the crossroads of contemporary consciousness. It is an enigma to modern science, yet its conceptual underpinnings stem from concepts addressed by the earliest Greek philosophers and by physicists at the forefront of the current scientific revolution. It looks very simple, yet it is profoundly complex. It is an intuitive, subjective process, yet it must be subject to the scrutiny of scientific inquiry. It involves the intensely humanistic yet nonpersonal concern of one human being for another."

²Phillip Solomon, ed. Sensory Deprivation. (Cambridge, Mass: Harvard University Press, 1961).

³Catherine Caldwell Brown, ed. The Many Facets of Touch, (Skillman, New Jersey: Johnson and Johnson, 1984), p. xv. "Touch has been addressed empirically in combination with other systems - vestibular, pain, pressure, visumotor. The difficulty in isolating its effects has prevented attention to its importance as a modality."

⁴Kathryn E. Barnard and T. Berry Brazelton, Touch: The Foundation of Experience: Clinical Infant Reports, (Madison, Connecticut, International Universities Press, Inc., 1990).

⁵Ibid.

⁶Rene Weber, "Philosophers on Touch," in The Many Facets of Touch, ed. by Catherine Caldwell Brown, p. 8.

⁷Stephen Thayer, "Social Touching," in Tactual Perception: A Sourcebook, ed. by William Schiff and Emerson Foulke, (Cambridge, Mass.: Cambridge University Press, 1982), p. 283.

⁸Pillari Vimala, Human Behavior in the Social Environment, (Pacific Grove, CA: Brooks/Cole Pub., Co., 1988), p. 89. Touching and responses to it, eye-to-eye contact, odor, body heat and body movements, and voice tones are all reciprocal behaviors that result in attachment.

⁹Helen Bee, The Developing Child, (New York: Harper and Row Rublishers, 1985), p. 289.

¹⁰Robert L. Munroe and Ruth Munroe, Cross-Cultural Human Development, (Monterey, CA: Brooks/Cole Pub., Co., 1975), p. 37. Affective relationships have the adaptive advantage of bringing and keeping individuals close enough to facilitate cooperative undertaking and mutual learning.

¹¹American Psychiatric Assoication, Diagnostic and Statistical Manual of Mental Disorders, 3d ed. revised, (Washington, D.C.: American Psychiatric Association, 1987), p. 391.

¹²Stephen Thayer, "Social Touching."

¹³Ashley Montagu, Touching, 3d. ed. (New York: Harper and Row Rublishers, 1986), pp. 208-209, citing M. H. Hollander, "Women's Wish to be Held: Sexual and Nonsexual Aspects," Medical Aspects of Human Sexuality, (October 1971), pp. 12, 17, 19, 21, 25, 26.

¹⁴Nancy Henley and Jo Freeman, "The Sexual Politics of Interpersonal Behavior," Women: A Feminist Perspective, 4th ed. (Mountain View, CA: Mayfield Pub., Co., 1989), p. 462.

¹⁵Nancy Henley, "Status and Sex: Some Touching Observations," Bulletin of the Psychonomic Society, No. 2 (1973), pp. 91-93, cited in Jo Freman, Women: A Feminist Perspective, p. 462.

¹⁶Stephen Thayer, "Social Touching," p. 29, citing C. Forden, "The Influence of Sex Role Expectations on the Perception of Touch," Unpublished Manuscript, University of California, Santa Cruz, undated.

¹⁷Ibid., p. 285, citing K. J. Gergen, M. M. Gergen and W. H. Barton, "Deviance in the Dark," Psychology Today, (October, 1973), pp. 129-130.

¹⁸John F. Longres, Human Behavior in the Social Environment, (Itasca, Illinois: F. E. Peacock Pub., 1990), p. 345.

¹⁹Carol Gilligan, In A Different Voice, (Cambridge Mass.: Harvard University Press, 1982), p. 25.

²⁰Anselm Strauss and Juliet Corbin, Basics of Qualitative Research, (Newbury Park, CA: SAGE Publications, 1990).

²¹*Ibid.*, p. 130.

²²*Ibid.*, p. 219.

²³Anselm Strauss and Juliet Corbin, p. 222.

²⁴*Ibid.*, p. 250

²⁵*Ibid.*

²⁶*Ibid.*, p. 251.

²⁷Ashley Montagu, Touching, p. 279.

²⁸Janet Shibley Hyde, Half the Human Experience, 4th ed. (Lexington, Mass.: D. C. Heath and Co., 1991), p. 85, citing Jeanne H. Block, "Issues, Problems and Pitfalls in Assessing Sex Differences," Merrill-Palmer Quarterly, No. 22 (1976), pp. 283-308.

²⁹Stephen Thayer, "Social Touching," p. 298.

³⁰Nancy Henley and Jo Freeman, "The Sexual Politics of Interpersonal Behavior," p. 457, citing M. Argyle, V. Salter, H. Nicholson, M. Williams and P. Burgess, "The Communication of Interior and Superior Attitudes by Verbal and Non-Verbal Signals," British Journal of Social and Clinical Psychology, No. 9 (1976), pp. 221-231.

³¹*Ibid.*, pp. 462-463, citing N. M. Henley, Body Politics: Power, Sex, and Nonverbal Communication, (Englewood Cliffs, New Jersey: Prentice-Hall, 1977).

³²Stephen Thayer, "Social Touching," p. 292.

³³Stuart A. Kirk, "Society and Sexual Deviance," in The Sexually Oppressed, ed. by Harvey L. Gochros and Jean S. Gochros, (New York: Association Press, 1977), p. 28. "Few areas of social behavior are so rich in intricacies, so elusive in rationale, and so imbedded in morality as is sexual behavior. Ironically, it is this concern, perhaps overconcern, for the propriety and structure of sexual conduct that makes it such a fertile field for deviation."

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