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Breaking the Silence

Challenges to Professional Boundaries in Therapeutic Work - A Qualitative Exploration

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Breaking the Silence:
Challenges to Professional Boundaries in Therapeutic Work:
A Qualitative Exploration

Carrie Way

July 2018

This thesis is submitted as partial fulfilment of the regulations for the doctorate in Clinical Psychology

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SECTION 1

Breaking the Silence:

Challenges to Professional Boundaries in Therapeutic Work:

A Qualitative Exploration

Thesis Abstract

This thesis examines two areas of professional importance that to date have received little clinical and research attention: therapist pregnancy and therapeutic touch.

A meta-synthesis of qualitative research studies explored the professional experiences of 157 pregnant psychotherapists. The paper identified 13 studies, mainly unpublished doctoral dissertations, which conducted interviews with pregnant therapists about various aspects of their experience. Findings indicated that therapist pregnancy was associated with a variety of new therapeutic challenges, including pregnancy disclosure, fluctuating boundaries and elevated guilt. It was determined that therapists lacked the necessary knowledge, support and clinical expertise to navigate this new clinical terrain. Thus, recommendations focus upon enhancing supervisory awareness of the challenges afforded by therapist pregnancy, which in turn it is hoped will increase professional dialogue and therapist support.

The empirical study explored trainee clinical psychologists' (trainees) views and experiences of touch in the therapeutic relationship. Nine trainees participated in individual semi-structured interviews that were subsequently analysed using Interpretative Phenomenological Analysis. Three super-ordinate themes emerged: Secrecy to Confession, Fear of the External Monitor, and Conflicting Identities. The

empirical study indicated that the absence of teaching, supervision and professional guidance on touch contributed to trainees' perceptions that touch was incompatible with their professional role, increasing reticence to discuss or use touch. The study calls for touch tuition to be incorporated within training curricula and greater supervisory dialogue, both of which may help to alleviate the perceived stigma surrounding therapeutic touch.

The final paper details the personal reflections of the main author and examines how key study findings may be understood from various theoretical underpinnings. Priorities for future research are also considered alongside clinical implications related to both studies in this volume.

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Firstly, thanks must go to the trainee participants who contributed their perspectives so freely and articulately, and without whom this project would not have been possible.

Renee and Carolien: the micro and the macro, my supervisory dream team. Thank you for your unending patience, dedication, support and understanding. And most importantly, thank you for keeping the faith when my own faltered; I appreciate it more than you will ever know.

To Tom, my rock, my container contained; thank you for everything I can put into words and the things that I cannot. Your support each and every day amazes me. I could not ask for a better partner in life, or a more loving father for our daughter. Let's continue to support each other's dreams and see where life takes us.

To my family, friends and parents, thank you. This really has taken a village. And especially to my mother, whose selflessness teaches me about love everyday.

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SECTION 2: Literature Review

An Unavoidable Bump: Psychotherapists' Experiences of Navigating Therapy

While Pregnant: A Meta-Synthesis.

Research in Psychotherapy: Psychopathology, Process and Outcome Submission Guidelines:

<http://www.researchinpsychotherapy.org/index.php/rpsy/about/submissions#onlineSubmissions>

Running Title: Pregnant psychotherapists' therapy experiences

An Unavoidable Bump: Psychotherapists' Experiences of Navigating Therapy While Pregnant: A Meta-Synthesis.

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Renee Rickard: NWCPP Clinical Director and Clinical Psychologist for BCUHB NHS Trust.

Conflicts of Interest: None.

Abstract

Despite psychotherapists' pregnancy being a common occurrence with recognised impacts for both clients and clinicians, there remains a dearth of empirical qualitative investigations into the lived experiences of these health professionals. This meta-synthesis therefore aims to integrate the research findings of thirteen studies exploring the experiences of pregnant and newly post-partum psychotherapists. Utilising Noblit and Hare's (1988) meta-ethnographic approach, papers were analysed with a view to capturing shared experiences across studies, alongside points of divergence. Analysis led to the development of four key concepts: Identity Changes, Pregnancy necessitates Disclosure, Therapeutic Challenges and Guilt. Clinical implications and future research directions are discussed.

Introduction

Pregnancy represents a time of change for therapists who may be used to having unidirectional therapeutic relationships, which focus on clients' needs and issues. Traditionally, for psycho-dynamically orientated clinicians, the approach necessitates being a 'blank screen' onto which clients can project their fantasies. Regardless of therapeutic orientation, pregnancy represents a therapeutic transgression, literally and figuratively, drawing attention towards the therapists' personal life within the professional realm. Indeed, pregnancy in itself is indicative of further implicit disclosures, including the therapists' desire for a family and the likely presence of a personal and intimate relationship outside the therapeutic sphere.

Although pregnancy may be facilitative and represent an opportunity to model successful changes, for example in body image (Katzman, 1993) and life stage

transition (Grossman, 1990), most research has indicated that pregnancy and maternity leave may interfere with clients' therapeutic progress. Pregnancy and impending maternity leave may signal the therapist's changing availability, priorities and the impending withdrawal of regular support. As such, most research exploring the impact of therapists' pregnancy for clients has documented increased risk-taking behaviours (Bassen, 1988), abandonment fears (Gibb, 2004), premature treatment termination (Berman, 1975) and non-attendance (Napoli, 1999), all of which may indicate that the therapists' pregnancy may be viewed as an unwanted '*intrusion*' (Fenster, 1983) within the therapeutic space.

Despite pregnancy and maternity leave being a common occurrence within a largely female professional group and the potential deleterious impact on clients; there remains a paucity of professional guidance on how to navigate the clinical issues that may emerge in response to a therapist's pregnancy (British Psychological Society; personal communication, August 2017). It is therefore unclear how, and from whom, pregnant therapists may source their guidance.

Research indicates that there is often limited supervisory or organisational support available for pregnant therapists (Fenster, Phillips & Rapoport, 1986; p.67), with studies reporting dismissive or even hostile attitudes towards pregnant colleagues (Baum & Herring, 1975; Baum & Itzhaky, 2006). While such unsympathetic reactions may not be confined to clinical workplaces, the potential for pregnancy themes to encroach upon psychotherapists' working practices may be comparatively amplified due to the emphasis on the therapeutic alliance. Therefore, research

identifying sources of professional support and guidance for expectant therapists may be particularly warranted.

Published enquiries into pregnant and post-partum therapists' experiences of pregnancy have often lacked sufficient methodological rigour, using personal reflections and case vignettes to illustrate potential clinical issues (i.e., McGourty, 2013; Silverman, 2001; Whyte, 2004). Alternatively, studies purporting to use empirical methodologies have tended to summarise interview data without including raw transcript excerpts (i.e., Bassen, 1988; Baum & Herring, 1975; Naparstek, 1976), thus limiting opportunities to assess study transparency and validity. Dyson and King observe that the content of published investigations rarely explores therapists' lived experiences, noting that the *"literature has mainly focused on the reactions of clients to the therapist's pregnancy. Even when therapists do discuss their clients' reactions, they omit to comment on their personal experiences of pregnancy and their experiences with clients"* (2008; p.28). Although such omissions may be due to study design or professional proclivities toward client experiences, this also signals a paucity of empirical understanding regarding therapists' lived experiences of pregnancy and motherhood.

To date, there have been limited attempts to pool the empirical findings of qualitative studies in this area. Indeed, a recent systematic review (Schmidt, Fiorini & Ramires, 2015) of pregnancy in psychoanalytic psychotherapists identified only one empirical qualitative paper (Tonon, Romani & Grossi, 2012). The present meta-synthesis therefore looks to provide a comprehensive review of empirical, qualitative study findings relating to therapists' personal experiences of pregnancy and motherhood. In

order to capture the greatest possible divergence and convergence of study findings, this paper explores the experiences of therapists employing a range of therapeutic orientations (as opposed to Schmidt et al.'s exclusive focus on psychoanalytic practitioners). Utilising Noblit and Hare's (1988) meta-ethnographic approach, this research looks to explore the personal experiences of pregnant and post-partum psychotherapists who provide long-term interventions to clients with an eclectic range of difficulties. By keeping the scope of inquiry broad, this meta-synthesis aims to capture a wide range of psychotherapist experiences.

The present research defines psychotherapists as mental health practitioners who offer interpersonal individual or group based therapies for a range of client presentations, across various specialisms.

Methods

Rationale for a Meta-Synthesis

An emergent approach, meta-syntheses involve the interpretative synthesis of different qualitative sources of enquiry into a given phenomenon. Qualitative meta-syntheses therefore look to preserve the existing interpretations and meanings embedded within the original texts (Walsh & Downe, 2005), whilst developing novel interpretations that emerge through consideration of the wider corpus of studies. To this end, meta-syntheses are concerned with deriving exploratory insights, rather than aggregative or descriptive accounts (Mohammed, Moles & Chen, 2016).

Meta-syntheses are associated with multiple benefits including broadening understanding of key phenomena of interest, the development of new insights,

theories and conceptual understandings and the identification of gaps in existing literature (Mohammed et al., 2016). To this end, meta-syntheses may prevent the need for multiple linear investigations into the same research area (Finfgeld, 2003). In summary, meta-syntheses aim to contribute methodological and theoretical advancements by expanding the existing research body, and may help to inform health policy, practice and research (Mohammed et al., 2016).

Although meta-syntheses have been described as the qualitative equivalent to quantitative meta-analyses (Schreiber, Crooks & Stern, 1989; cited in Bondas & Hall, 2007), there remains no '*recognised gold standard*' for conducting meta-syntheses (Mohammed et al., 2016). The lack of consensus regarding the optimal approach to data selection and analysis reflects qualitative paradigms that view truths as subjective and multiply constructed (Finfgeld, 2003; Walsh & Downe, 2005). Subsequently, it is considered acceptable that meta-syntheses may combine findings of qualitative studies using different methodologies in the pursuit of generating a holistic interpretative synthesis (Sandelowski & Barroso, 2003a).

While researcher subjectivity is a common critique of all qualitative research, meta-synthesists may be at increased risk of interpreting data in accordance with their own views and perspectives as these researchers were not involved in the original data collection (Bondas & Hall, 2007). It is therefore imperative that meta-synthesists look to enhance methodological transparency through processes such as researcher triangulation and personal reflexivity statements (Mohammed et al., 2016), which may in turn help to substantiate this nascent methodology (Finfgeld, 2003). To this end, it is important to acknowledge that the first author's (C.W) interest in, and

awareness of the issues related to therapist pregnancy have been shaped largely through personal experiences of navigating therapeutic work whilst pregnant with her first child. The present meta-synthesis therefore reflects the combined analysis of the thirteen research studies, interpreted through the perspectives of a pregnant, and then recently post-partum trainee clinical psychologist. Researcher triangulation was used throughout all stages of the meta-synthesis to reduce potential bias (research scope, data collection, quality appraisal, data analysis, write up), however it is noted that both other authors (C.L & R.R) also identify as mother-therapists.

Data Collection

The electronic databases ProQuest¹ and PsycARTICLES were systematically searched in September 2017 using the abstract domain. A Boolean search incorporating the following wildcard operators enabled the following key terms to be combined:

“Expectant AND therapist” OR “pregnant AND therapist” OR “pregnancy AND therapist” OR “pregnant AND social work*” OR “pregnant AND psychologist”.

To capture studies from the widest range of sources, the only search limit applied was that studies must be published in English. Other databases (such as MEDLINE) and search terms such as ‘psychiatrist’ did not result in the discovery of additional articles and therefore were not included in the final search strategy. It was further decided not to combine the phrases ‘pregnancy AND therapy’ as this led to a high return of

¹ ProQuest was utilised to concurrently search the following databases: PsycINFO; Social Services Premium Collection; ASSIA; Social Science Index and Abstracts; Social Science Database; and ProQuest Dissertations & Theses: UK & Ireland.

irrelevant articles, for example those focusing upon medical management or treatment trials for gestational conditions.

Considerable attempts were made to access articles and theses that were unobtainable via University access or inter-library loan. These included contacting authors directly via email (n=6), ResearchGate (n=14) and University libraries (n=6) to request article access. Thirteen responses and nine articles were gained, of which three were included in the final synthesis (Davis, 1997; Kariv-Agnon, 1988; Lyndon, 2013). A further four unavailable unpublished doctoral theses were purchased from ProQuest Dissertation Repository (Bashe, 1989; Byrnes, 2001; Fenster, 1983; Locker-Forman, 2005).

Inclusion & Exclusion Criteria

Study inclusion criteria for the meta-synthesis were as follows: i) published in English, ii) conducted qualitative interviews or focus groups with psychotherapists who have first-hand experience of providing therapy while pregnant, iii) exclusively reports the experiences of female psychotherapists, iv) where therapists are involved in established therapeutic relationships on which they can reflect on any potential impact of pregnancy, v) include sufficient raw data pertaining to the experiences of therapist participants, vi) raw data excerpts pertaining to the experiences of psychotherapists can be clearly differentiated from other clinical groups studied within the same research. Finally, vii) only research reporting original study findings were included, as opposed to texts that recount summaries of otherwise unavailable papers.

Studies were excluded based on the following criteria: i) quantitative design, ii) insufficient raw transcript excerpts, iii) lacking analytic interpretation of study findings, iv) undergraduate or masters dissertations (which may lack sufficient rigour and external ratification), v) research pertaining to the experiences of therapists solely offering brief interventions relating to issues of fertility and pregnancy (i.e., genetic counsellors).

As the objective of meta-syntheses is to retrieve all relevant studies as opposed to a composite sample (Barroso et al., 2003), unpublished doctoral theses were sought for holism. Whilst doctoral theses lack the blind peer-review process afforded to published articles, by virtue of the viva voce examination, doctoral theses have arguably gone through a similarly stringent process of peer review to attain the doctoral award. Indeed, it is argued that due to the quantity of data available for syntheses, unpublished dissertations may be preferable to peer-reviewed articles that may impose strict word limits and prevent extensive engagement with the data (Finfgeld, 2003). Therefore, the inclusion of unpublished grey literature may hold valuable insights alongside reducing publication bias (Beck, 2002b; cited in Bondas & Hall, 2007).

Search Procedure and Outcome

The final search strategy identified thirteen studies for inclusion in the synthesis (Diagram 1). After removing duplicates, all retrieved articles were screened by title. Eighty-eight abstracts were read that were considered likely to be relevant to the topic of enquiry or where this was indeterminable from article title alone. Twenty full text articles were retrieved and assessed for eligibility. As qualitative research is often

poorly indexed (Mohammed et al., 2016) or unusually titled, full text articles were subject to snowball sampling of reference lists to identify other potentially relevant studies. This iterative approach led to the inclusion of an additional five studies.

Diagram 1 **[INSERT HERE]**

The total procedure lead to the inclusion of three peer reviewed articles, one book chapter and nine unpublished doctoral theses. While the ratio of published papers appears low, many published meta-syntheses have reported analyses pertaining to four or fewer peer-reviewed qualitative studies (Hannes & Macaitis, 2012).

As is evident from Diagram 1, the majority of studies included in the meta-synthesis are unpublished doctoral theses. There may be several potential reasons why empirical research pertaining to therapist pregnancy may not reach formal publication. Firstly, it is acknowledged that the experiences of pregnant therapists may represent a niche research interest. During the final study selection process, it was noted that six authors of unpublished theses alluded to personal experience of pregnancy while conducting research. Speculatively, this may indicate that factors related to the experience of pregnancy and motherhood may increase interest in the research area; while simultaneously reducing the likelihood of subsequent publication.

Quality Appraisal of Selected Studies

The most frequently utilised quality assessment tool for meta-syntheses (Hannes & Macaitis, 2012), the Critical Appraisal Skills Programme (CASP, 2017) assesses the

credibility, relevance and rigour of qualitative research. The checklist comprises ten aspects of quality assurance, the presence of which were subsequently endorsed, refuted or queried by the first author and independently triangulated by the other authors, see Table 1.

Table 1 **[INSERT HERE]**

According to the CASP, the quality of most studies was considered adequate, with no notable differences in quality according to when research was conducted, or between published and unpublished works. Indeed, the only study appraised as endorsing all ten quality aspects was an unpublished work (Davis, 1997). However, the majority of studies were found to insufficiently consider two key quality areas: a critical examination of the researchers' own position (achieved by only four studies: Davis, 1997; Grossman, 1990; Locker-Forman, 2005; Zackson, 2012) and although all studies alluded to consideration of ethical safeguards, this was only comprehensively documented in three papers (Davis, 1997; Lyndon, 2013; McCluskey, 2017).

The oldest eight studies (1983–2005) did not specify using particular qualitative approaches, which may reflect the emergence of qualitative methodologies over time. Lack of methodological specification has been noted by other meta-syntheses researchers (i.e., Atkins et al., 2008) without compromising analytic capacity for meta-synthesis. Thus it is acknowledged that even when study methodologies are inadequately or incorrectly reported, this does not necessarily equate to substandard research (Atkins et al., 2008; Sandelowski et al., 1997).

Analytic Procedure

Noblit and Hare's (1988) meta-ethnographic approach to data analysis was selected for the present meta-synthesis. Arguably the most established approach to conducting meta-syntheses, Noblit and Hare's (1988) method allows for an interpretative and dynamic process of data analysis via an iterative seven-step procedure.

The seven phases of analysis comprise i) identifying a research interest, ii) determining relevant accounts, iii) repeated readings, iv) considering the inter-relationships of studies, v) study translation, vi) synthesising translations, and vii) reporting the final synthesis.

The first two stages were achieved through literature searches as previously outlined. Repeated readings of the selected studies enabled a deep and active engagement with the data. First, second and third order constructs were identified and tabulated to identify emergent themes and concepts. Constant comparison identified complementary patterns, themes or concepts across studies. Findings that were incongruent with the emerging analysis were also considered from the perspective of refutation, providing a representative account of the full dataset. These were expressed in the final synthesis alongside novel interpretations apparent across studies, elevating the analytic contribution.

As there remains a lack of consensus regarding what study information may be considered interpretable data, the present meta-synthesis analysed the complete results sections of published studies. Owing to the considerable variability of presented findings across doctoral theses, all sections in the main text that included

raw transcript excerpts were subsequently analysed (primarily findings and discussion chapters). All data were analysed line by line, whereby a single quote could lead to the development of multiple codes, thematic codes, subthemes or the development of larger master concepts.

Three of the selected studies conducted a comparative analysis of the experiences of pregnant therapists with other clinical groups (clients, physicians and expectant adopting therapists respectively; McCluskey, 2017; Matozzo, 2000; Davis, 1997). In these instances, only information pertaining to the experiences of pregnant therapists was included in the analysis.

Results

While the majority of studies focus on the therapists' experiences during pregnancy, one study primarily explored the post-partum experiences of new mothers returning to therapeutic work (Zackson, 2012). Seven studies employed retrospective interview designs to elicit information pertaining to therapists' pregnancies. Four studies interviewed therapists prospectively, with at least two interview points during pregnancy and post-partum (Byrnes, 2001; Fenster, 1983; Grossman, 1990; Locker-Forman, 2005), providing a wider range of experiences and limiting recall bias. Six studies reporting the experiences of therapists up to one-year post-partum (Baum, 2006; 2010, interviewed five therapists during third trimester, and five up to one-year post-partum). Additionally, three studies document longitudinal experiences of post-partum therapists up to three, five, and more than ten years, respectively (Matozzo, 2000; McCluskey, 2017; Lyndon, 2013), reducing sample homogeneity.

Demographic Characteristics

The present meta-synthesis reports the cumulative experiences of 157 therapists across thirteen studies (Table 2). Study publication spans 34 years (1983 – 2017), with research primarily conducted in North America (n=11) and two linear studies originating in Israel (Baum, 2006; 2010). Variance in reporting therapist demographics was identified, with some studies providing limited information, precluding clear appraisal of the represented therapist population. The extracted frequencies below therefore reflect the available study data as opposed to an inclusive overview. Two published studies used the same set of pregnant therapists as participants (Baum, 2006; 2010); therefore, only data pertaining to Baum (2006) is included in the demographic information. The total demographic study information is thus comprised from twelve of the thirteen included studies.

Table 2 [**INSERT HERE**]

Most studies interviewed therapists about their experience of their first pregnancy (n=119), most commonly during the third trimester (n=88). Nine studies provided details of therapists' ages, with a collective age range between 25 and 52 years. Seven studies detailed the experience level of therapists, with an overall range between 0 – 14 years. Seven studies recruited psycho-dynamically or psychoanalytically trained therapists (n=89), with remaining studies reporting that therapists practised a variety of eclectic or integrative approaches. While the majority of therapists worked with adult populations, a smaller proportion exclusively or additionally worked with children and young people (n=49), or groups (n=12). Therapist professional backgrounds included psychologists (n=87), social workers (n=40), psychiatrists

(n=6) and other related professions (n=6). The experiences of 27 pregnant therapists enrolled in training programmes were represented across seven studies (Bashe, 1988; Baum, 2006; 2010; Byrnes, 2001; Locker-Forman, 2005; Lyndon, 2013; Zackson, 2012).

Meta-synthesis Findings

For the present meta-synthesis, four key concepts emerged: Identity Changes, Pregnancy necessitates Disclosure, Therapeutic Challenges and Guilt. The relative endorsement of the four key concepts across the thirteen original studies is demonstrated in Table 3.

Table 3 **[INSERT HERE]**

Key Concept 1: Identity Changes

A highly prevalent theme described by psychotherapists in twelve studies reflects the emerging awareness that pregnancy signifies the development of a new identity: self as mother. Therapists' descriptions indicated that the mother identity was frequently perceived as being in conflict with the therapists' professional identity. This conflict was most pronounced in trainee therapists, whose identities as professionals seemed comparatively underdeveloped, leading to feelings of loss and role ambiguity.

Pregnancy also led to a re-evaluation of therapists' relationship with clients, with many relinquishing maternal feelings for clients in favour of their unborn child.

Most therapists spoke excitedly of pregnancy, whilst also expressing apprehension that motherhood may alter their existing self-concept. For some, prospective

motherhood represented a “*big, big identity*” (Davis, 1997; p.70), with the potential to eclipse existing identities. Therapists reported concerns that they may be unable to maintain both professional and mother identities concurrently, depicting the two as competing drives (Bashe, 1989; Baum, 2010; Davis, 1997; Lyndon, 2013). For some, this constituted a “*horrible identity crisis*” (Grossman, 1990; p.65) whereby one’s professional identity was markedly impacted, or stood to be lost entirely (Bashe, 1989; Baum, 2006; 2010; Davis, 1997; Fenster, 1983; Grossman, 1990; Kariv-Agnon, 1988; Locker-Forman, 2005; Lyndon, 2013; Zackson, 2012). Themes of loss were apparent in therapists’ narratives, whereby pregnancy was considered a transitional stage between professional forfeiture and complete attainment of the mother identity (Davis, 1997; Grossman, 1990). For therapists who were undertaking professional training or had recently qualified, the prospect of losing one’s professional identity was especially pronounced. As one trainee reflected: “*I don’t even know what it feels like to be a therapist. I only know what it feels like to be a pregnant therapist*” (Locker-Forman, 2005; p.85), indicating that pregnancy may interfere with role assimilation. Professional curtailment was another shared concern for trainees (Bashe, 1989), whereas for more experienced psychotherapists and second-time mothers (Byrnes, 2001), motherhood represented a temporary hiatus from professional advancement that could be recaptured (Lyndon, 2013; Zackson, 2012) and thus, did not produce the same identity concerns.

Pregnancy also led to a revision in therapists’ perceptions of their clinical role (Zackson, 2012), with many identifying that the maternal and protective feelings previously held towards clients had been largely or entirely redirected towards their unborn child (Fenster, 1983; Grossman, 1990; Kariv-Agnon, 1988; Locker-Forman,

2005). This distinction was particularly notable for child psychotherapists and appeared to signify the loss of a special therapeutic alliance: “*It’s almost like I’m playing mommy, and now I’m going to be a real mommy...I feel less that she’s my child*” (Locker-Forman, 2005; p.70). Conversely, a few adult therapists indicated that pregnancy increased maternal transference (Byrnes, 2001; Davis, 1997; McCluskey, 2017).

Pregnancy and motherhood were considered to increase identification with and appreciation for clients who were parents, with some considering that their new identity afforded them additional professional credibility (Byrnes, 2001; Locker-Forman, 2005; Zackson, 2012). Simultaneously, therapists reported reduced tolerance for clients who employed abusive or substandard parenting practices (Byrnes, 2001; Zackson, 2012). Several therapists reported increased difficulty encountering child abuse in their work (Byrnes, 2001; Locker-Forman, 2005), finding such themes “*very triggering*” (Lyndon, 2013; p.93) and increasing the propensity to refer such clients onwards (Zackson, 2012). Some therapists reflected that these difficulties were due to newfound awareness of the vulnerability of children (Locker-Forman, 2005), feeling ineffectual, or over-identification with their own child (Locker-Forman, 2005; Lyndon, 2013; Zackson, 2012).

Key Concept 2: Pregnancy necessitates Disclosure

Therapists across ten studies discussed the issue of pregnancy disclosure. One striking feature of primiparous therapists’ accounts relates to the tendency to defer pregnancy disclosure until clients broach the topic. While this may reflect maintenance of the psychoanalytic blank screen, pregnancy necessitates a clear violation of the therapists’

anonymity. Further, compared to the management of other therapeutic changes for which the therapist retains responsibility, discussion of pregnancy appears to be qualitatively distinct. It appears to be placed back with the client, representing a source of considerable anxiety, confusion and guilt. Therapists' regrets regarding disclosure appear linked to the lack of clinical guidance and supervision, which is further discussed in the subsequent subtheme.

Subtheme 1: Telling. The majority of therapists reported disclosing pregnancies during the second and third trimesters (Bashe, 1989; Byrnes, 2001; Davis, 1997; Fenster, 1983; Matozzo, 2000). Of those who announced their pregnancies during the third trimester, many cited delaying disclosure to provide clients with sufficient opportunity to articulate their observations directly (Bashe, 1989; Byrnes, 2001; Davis, 1997; Fenster, 1983; Grossman, 1990; Matozzo, 2000), or via derivatives (a psychoanalytic term referring to subconscious awareness of a phenomenon; Bashe, 1989; Fenster, 1983; Locker-Forman, 2005). Although this provided some valuable opportunities to explore clients' perceptions: *"I'm glad I didn't just jump to tell straight away because I don't know that some of the material would have emerged if I had disclosed prematurely"* (McCluskey, 2017; p.4); many therapists encountered an impasse whereby clients did not raise the issue (Bashe, 1989; Byrnes, 2001; Davis, 1997; Fenster, 1983; Grossman, 1990; Locker-Forman, 2005; Matozzo, 2000). Although some therapists acknowledged that social and therapeutic etiquette might have prevented clients from broaching the subject (Bashe, 1989; Fenster, 1983; Grossman, 1990), others considered this *"odd"* (McCluskey, 2017; p.4) and necessitated therapists initiating the conversation: *"I had to tell her at 7 months. I couldn't believe [the client] hadn't said anything. I was bigger than a house. It was so*

obvious” (Matozzo, 2000; p.53). This reticence regarding pregnancy disclosure marks a deviation from therapists’ standard practice of raising changes to therapeutic arrangements, leaving limited opportunity to explore the pregnancy therapeutically: *“I probably only had three sessions before I was set to leave”* (Byrnes, 2001; p.169). Conversely, prompt disclosures were reported by multiparous and more experienced therapists (Byrnes, 2001; Davis, 1997; Locker-Forman, 2005) and those initiating therapy with new clients, indicating that factors separate from therapeutic orientation may influence disclosure decisions. Additional factors reported to affect the timing of disclosures included awareness that the pregnancy was showing (Byrnes, 2001), to prevent the client learning of the pregnancy via alternative channels (Bashe, 1989) and client formulations (Byrnes, 2001; Fenster, 1983; Grossman, 1990).

Pregnancy was emotionally complex for therapists and produced an array of affective experiences; some described sharing as a *“relief”* (Grossman, 1990; p.74), and explained that withholding felt *“secretive”* (McCluskey, 2017; p.4), *“unnatural”* (Grossman, 1990; p.66) and like *“a betrayal”* (Byrnes, 2001; p.150). However, the majority reported that disclosure was difficult and anxiety provoking (Bashe, 1989; Byrnes, 2001; Davis, 1997; Kariv-Agnon, 1988; Matozzo, 2000; Zackson, 2012) due to fears of inciting client anger (Bashe, 1989; Matozzo, 2000) or causing therapeutic ruptures (Bashe, 1989; Matozzo, 2000). For several therapists, the act of disclosure was guilt inducing: *“I felt like I was betraying her”* (Locker-Forman, 2005; p.80). Resultantly, therapists often planned disclosures carefully (Kariv-Agnon, 1989; Matozzo, 2000;), while others attempted to conceal their pregnant form (Locker-Forman, 2005), or did not disclose at all (Davis, 1997; Fenster, 1983; Locker-Forman, 2005).

In retrospect, therapists acknowledged shortcomings related to their pregnancy disclosures, with some voicing concerns that it had been poorly managed (Bashe, 1989; Kariv-Agnon, 1988; Locker-Forman; 2005). Many cited late disclosure as the key factor for client dropout: “*because we did not deal with the pregnancy the case ended*” (Locker-Forman, 2005; p.78-79). In addition to disclosing earlier (Byrnes, 2001; Fenster, 1983; Locker-Forman; 2005), therapists reflected that future pregnancies could be more effectively managed by being more “*direct*” (Fenster, 1983; p.53), anticipating personal questions (Byrnes, 2001; Kariv-Agnon, 1988) and probable client reactions in advance (Zackson, 2012); alongside ensuring that clients learn of the pregnancy directly from the therapist (Byrnes, 2001).

Subtheme 2: Supervisory Relationships. One conspicuously absent feature across seven studies relates to the lack of supervisory advice regarding pregnancy. Further, where guidance was received this was clinically inauspicious, advocating postponed disclosure. As previously outlined, late disclosure was associated with poorer therapeutic outcomes and therapist regret, emphasising the limited utility of supervision. The non-exploratory approach to pregnancy taken by supervisors was mirrored in therapists’ subsequent client interactions. Therapists’ desire for liaison with formerly pregnant colleagues and supervisors reflects the need for sources of professional identification, especially when supervision does not consider the therapeutic impact of pregnancy.

Even when supervisors were highly regarded and skilled at managing other clinical issues, supervision was largely perceived as inadequate with regard to managing the

therapeutic impact of pregnancy (Bashe, 1989; Fenster, 1983; Kariv-Agnon, 1988; Locker-Forman, 2005). Pregnancy was purported to instigate supervisory role reversals such as reassurance seeking (Fenster, 1983) and trigger personal issues for supervisors (Locker-Forman, 2005; Zackson, 2012). Some therapists expressed regret for following supervisory direction regarding disclosure: *“the supervisor had no advice except don’t talk about it, don’t talk about it, don’t talk about it. Wait for it, wait wait wait. And that was a mistake”* (Locker-Forman, 2005; p.79). Indeed, some therapists who were disinclined to discuss their pregnancies reported high levels of attrition (Fenster, 1983; Locker-Forman, 2005; Zackson, 2012), highlighting possible clinical implications.

Sometimes therapists’ interactions with clients appeared broadly to reflect the tone of supervisory exchanges. For example, one therapist detailed her supervisor’s reluctance to explore her pregnancy: *“I feel her uncomfortableness which makes me want to back away from it”* (Fenster, 1983; p.113), which was in turn mirrored by her own disinclination to discuss the pregnancy with clients. Another therapist who was *“furious”* at her supervisor’s perfunctory response to a client’s threat to kill her baby, described the possible impact of having a similarly cursory exchange with her client: *“the patient’s aggression wasn’t handled well...if she was allowed by me and others to express [hate], the aggression wouldn’t have become this destructive”* (Zackson, 2012; p.94). Others described the same parallel process occurring in reverse, whereby therapists with supportive supervisory relationships reported forging stronger therapeutic alliances with clients during pregnancy (Zackson, 2012). While it is not possible to infer causation, this suggests that pregnancy may enhance therapists’ sensitivity to countertransference, increasing the need for positive supervisory role

models. Indeed, therapists who reported supportive supervisory relationships found that effective containment (Davis, 1997; Lyndon, 2013), alongside having permission to explore how motherhood may affect their therapeutic role, “*made a huge difference*” (Lyndon, 2013; p.102).

Therapists reported discomfort discussing their pregnancies with male or childless supervisors (Bashe, 1989; Fenster, 1983; Zackson, 2012), who were widely perceived as unsympathetic to the therapeutic challenges encountered during pregnancy. Indeed, some therapists chose to disengage from supervision whilst pregnant (Fenster, 1983). Widely, therapists voiced a general preference for female supervisors with lived experience of providing therapy while pregnant (Fenster, 1983; Lyndon, 2013; Zackson, 2012), or liaison with formerly pregnant colleagues (Bashe, 1989; Davis, 1997; Fenster, 1983; Kariv-Agnon, 1988; Zackson, 2012); which may indicate that pregnancy enhances therapists’ need for sources of professional identification. Supervisory self-disclosures made supervisors more “*real*” (Fenster, 1983; p.44) and were perceived as helpful for identifying personal limits and boundaries (Baum, 2010), as was practical advice on how to manage changing capabilities during pregnancy, such as floor-based play therapy (Locker-Forman, 2005). While some trainee therapists reflected on the utility and supportive nature of supervision (Lyndon, 2013), others reported discomfort with the pregnancy taking an increasingly central role in supervisory discussions: “*supervision was actually sometimes an experience of therapy at the expense of supervision*” (Baum, 2006; p.567). While the cause of this discrepancy remains unknown, this may suggest that frequent evaluation alongside a lesser-developed professional identity, may increase trainees’ reluctance to discuss topics perceived as personal.

Attempts to substitute or supplement supervision with literature were reported to be unprofitable (Davis, 1997; Fenster, 1983). Similarly, therapists' core training was considered insufficient at preparing therapists to manage client reactions to pregnancy (Zackson, 2012), leaving some feeling "*lost*" (Zackson, 2012; p.108) and "*completely unprepared*" (Bashe, 1989; p.74). Indeed, therapists reported that study participation either represented the first opportunity to explore the impact of pregnancy (Kariv-Agnon, 1988) or a more intensive examination than clinical supervision, identifying outstanding therapeutic issues (Byrnes, 2001; Fenster, 1983; Zackson, 2012). The dearth of available guidance was perhaps best illustrated by one therapist who requested the study researcher's advice regarding a client's request to meet her baby: "*What should I do? What would you do?*" (Zackson, 2012; p.91). Consequently, therapists articulated a need for improved supervisory training (Bashe, 1989; Fenster, 1983) or specialised consultation to address pregnancy related clinical issues (Byrnes, 2001; Davis, 1997).

Key Concept 3: Therapeutic Challenges

Therapists in twelve studies encountered significant and unfamiliar therapeutic challenges. Strikingly, therapists were frequently subjected to highly threatening and emotionally charged material related to pregnancy, increasing therapist vulnerability. Without adequate supervision, therapists lack a forum to emotionally process this material, leading to increased stoicism and the loss of therapeutic curiosity. Conversely, pregnancy also precipitated increased personal questions from clients. For most, fidelity to the blank screen was futile, whereas enhanced personal disclosure was therapeutically advantageous. Pregnancy therefore appears to

necessitate unconventional working practices, which therapists are largely attempting to navigate alone.

In recognition of the therapeutic disruptions caused by pregnancy, most therapists endeavoured to explore clients' affect and references to expectancy (Bashe, 1989; Byrnes, 2001; Fenster, 1983; Kariv-Agnon, 1988; Matozzo, 2000; McCluskey, 2017; Zackson, 2012). Those who were able to facilitate conversations described pregnancy exploration as “*really powerful*” (McCluskey, 2017; p.7) and “*productive*” (Kariv-Agnon, 1988; p.56); which often unearthed new therapeutic material such as clients' own experiences of pregnancy (Davis, 1997; Matozzo, 2000; McCluskey, 2017) and being mothered (Davis, 1997; Fenster, 1983; Kariv-Agnon, 1989). Enhanced openness regarding pregnancy appeared to be related to positive client outcomes (Byrnes, 2001). Conversely, therapists expressed frustration and regret when pregnancy led to the inhibition of client affect (Bashe, 1989; Fenster, 1983; Kariv-Agnon, 1989; McCluskey, 2017; Zackson, 2012) or they were unable to stimulate exploration (Kariv-Agnon, 1989) with some attributing non-exploration to premature dropout and behavioural escalations (Fenster, 1983; Zackson, 2012).

One area that therapists universally left unexplored was threats of infanticide (Bashe, 1989; Davis, 1997; Fenster, 1983; Grossman, 1990; Kariv-Agnon, 1988; Locker-Forman, 2005; Zackson, 2012). Understandably, therapists reported extreme difficulty listening to clients' fantasies of harm and miscarriage, which left them feeling highly distressed, vulnerable and angry for being subjected to such “*dangerous, threatening material*” (Fenster, 1983; p.92). Similarly, therapists reported aversion to themes of baby loss (Bashe, 1989; Kariv-Agnon, 1988; Locker-Forman, 2005), which often

arose spontaneously in response to pregnancy disclosure. Therapists described feeling upset by the insensitivity of clients who recounted tales of miscarriage: *“I just couldn’t handle it... I was mad at her”* (Kariv-Agnon, 1988; p.70). The residual impact of such confrontational content was apparent when one therapist cried recounting a client’s threats towards her unborn baby (Bashe, 1989). Others reported that the pregnancy became a focal point for clients’ anger (Bashe, 1989; Baum, 2006; Byrnes, 2001; Davis, 1997; Fenster, 1983; Grossman, 1990; Kariv-Agnon, 1988; McCluskey, 2017), which left therapists feeling vulnerable and unwilling to explore or challenge the content. Conversely, a minority of therapists expressed frustration when pregnancy led to the inhibition of client anger (Fenster, 1983; McCluskey, 2017). Pregnancy also signaled an increase in sexual issues, and questions from children (Bashe, 1989; Kariv-Agnon, 1988), and especially from male clients (Bashe, 1989; Fenster, 1983; Matozzo, 2000; McCluskey, 2017), for whom pregnancy revealed both the therapists’ sexual unavailability (Bashe, 1989; Fenster, 1983; Grossman, 1990) and fantasies of paternity (Bashe, 1989; McCluskey, 2017). The highly personal nature of these conversations left some therapists feeling objectified (Bashe, 1989) and unwilling to further explore clients’ fantasies, although some came to later regret this (Fenster, 1983). Incongruously, trainee therapists did not report threatening and sexual content, which may reflect reticence to explore clients’ feelings regarding pregnancy or possibly reduced client complexity.

While some therapists feared that self-disclosure constituted a breach of therapeutic fidelity (Bashe, 1989; Grossman, 1990), therapists tended to be upfront in answering clients’ many questions: *“who the father was, who my husband was. Was I going to keep this baby? Did I want this baby? Was it planned?”* (Byrnes, 2001; p.96).

Colleagues were more frequently consulted than supervisors when deciding what information to disclose (Bashe, 1989; Fenster, 1983; Kariv-Agnon, 1988), further highlighting the limited utility of supervision.

While enhanced disclosure was sometimes perceived as “*intrusive*” (Grossman, 1990; Locker-Forman, 2005; Zackson, 2012), the majority discovered that disclosure was “*meaningful*” (Byrnes, 2001; p.193) and “*very conducive*” (Grossman, 1990; p.73) to the therapeutic alliance. Perhaps related to the perceived changes to therapists’ professional identities, increased candour was also reported to facilitate a therapeutic shift whereby therapists felt increasingly “*real*” (Bashe, 1989; Byrnes, 2001; Fenster, 1983; Grossman, 1990; Lyndon, 2013; McCluskey, 2017; Zackson, 2012), enabling clients to see them as “*a person rather than just a therapist*” (Zackson, 2012; p.112). By contrast, relational changes were not reported by therapists who chose to deflect clients’ questions (Byrnes, 2001).

Therapists reported implementing increasingly active and directive approaches during pregnancy (Bashe, 1989; Byrnes, 2001; Davis, 1997; Fenster, 1983; Grossman, 1990; Kariv-Agnon, 1988; Zackson, 2012), describing their new working practices as more “*confronting*” (Fenster, 1983; p.101), “*blunt*” (Byrnes, 2001; p.186) and “*less neutral*” (Kariv-Agnon, 1988; p.51). Therapists also reported reduced flexibility regarding rearranging appointments (Bashe, 1989; Fenster, 1983; Grossman, 1990) and were less committed to retaining clients at risk of disengagement (Fenster, 1983). Some attributed these changes to increased time imperatives (Bashe, 1989; Fenster, 1983; Kariv-Agnon, 1988; Zackson, 2012), creating greater urgency to stabilise clients prior to maternity leave (Bashe, 1989; Davis, 1997; Zackson, 2012). Of note,

therapists tended to retain their active and disclosing position post-partum (Davis, 1997; Fenster, 1983; Grossman, 1990), indicating that pregnancy may lead to marked changes in therapists' working approaches.

Pregnancy also produced other therapeutic challenges including uninvited touching of the therapists' stomach (Byrnes, 2001; Davis, 1997; Grossman, 1990; Locker-Forman, 2005) and the receipt of baby gifts, which were widely accepted despite customary refusal (Bashe, 1989; Byrnes, 2001; Fenster, 1983; Grossman, 1990). Other therapeutic quandaries, such as clients' requests to see the therapist's sonogram picture (Locker-Forman, 2005), to hold a baby shower (Byrnes, 2001) and babysit (Bashe, 1989; Fenster, 1983) were also reported. With the exception of a few therapists who brought their babies into sessions (Byrnes, 2001; Grossman, 1990), there is little indication as to how therapists managed these clinical dilemmas or whether additional guidance was sought.

Key Concept 4: Guilt

Therapists in ten studies described experiencing considerable and unrelenting guilt related to pregnancy. Pregnancy was often viewed as signifying the intentional abandonment of clients, often to the exclusion of other therapeutic interpretations, and was especially pronounced in the accounts of child therapists. The interference of pregnancy symptomatology, such as concentration difficulties, was considered indicative of poor performance, further evidencing therapist beliefs that pregnancy held adverse consequences for clients. Without suitable support and containment, therapists demonstrated an increased propensity to make compensatory therapeutic

changes and; in the case of child therapists, consider resignation, emphasising the unyielding nature of therapists' guilt.

Therapists' accounts indicated that pregnancy was frequently viewed as evidence of their deliberate "*abandonment*" (Locker-Forman, 2005; p.80) of clients. To this effect, pregnancy was widely viewed as a choice that had been "*wilfully, consciously*" (Fenster, 1983; p.89) inflicted upon clients; with therapists readily endorsing the notion that pregnancy was at the "*patients' expense*" (Bashe, 1989; p.69). For some, pregnancy became a physical manifestation of the differences between therapists' and clients' life experiences (Bashe, 1989; Baum, 2006; Fenster, 1983; Grossman, 1990; Locker-Forman, 2005), heightening therapist guilt: "*I have everything and they have nothing*" (Fenster, 1983; p.76). This comparison was exacerbated for therapists working with clients for whom pregnancy was especially confronting, such as those struggling with infertility (Bashe, 1989; Davis, 1997; Grossman, 1990; Kariv-Agnon, 1988; McCluskey, 2017; Zackson, 2012) and looked after children (Locker-Forman, 2005; Zackson, 2012). Resultantly, pregnancy disclosure was sometimes experienced as an admission of guilt: "*The session I told them I was pregnant, I didn't even want to charge them, I felt so bad*" (Matozzo, 2000; p.52).

Therapists working across a range of specialisms described pregnancy guilt. However, the magnitude was especially pronounced in the accounts of child therapists. For some, pregnancy necessitated the revision of omnipotent fantasies of being the client's closest ally, thus generating guilt for "*abandoning this child to a world where nobody cares*" (Locker-Forman, 2005; p.72). This perceived forfeiture of therapists' personal investment caused some to question their professional

commitment and aptitude (Kariv-Agnon, 1988; Locker-Forman, 2005). Therapists' guilt was inadvertently further reinforced by children's attempts to convince the therapist to stay: "*they would be a better child or they would be good*" (Fenster, 1983; p.81), or requests to join the therapists' family: "*do I take foster care, could I adopt them*" (Byrnes, 2001; p.95). Indeed, the intensity of guilt experienced by therapists was reported to impede engagement with children's emotions, increasing the likelihood of client drop out (Locker-Forman, 2005). Additionally, post-partum child work was often perceived as so confronting that therapists sought alternative employment (Byrnes, 2001; Locker-Forman, 2005; Zackson, 2012), culminating in the fulfilment of clients' abandonment fears: "*I just couldn't. It was too painful to tolerate*" (Locker-Forman, 2005; p.83).

Pregnant therapists described experiencing physical sensations, such as nausea and baby movements, that divided their attention during clinical work and contributed to recent self-perceptions of inadequate performance (Bashe, 1989; Baum, 2006; 2010; Byrnes, 2001; Davis, 1997; Fenster, 1983; Grossman, 1990; Kariv-Agnon, 1988; Locker-Forman, 2005; Lyndon, 2013; Zackson, 2012). This was especially pronounced in trainee therapists, who frequently interpreted their preoccupation as signifying their professional failure (Baum, 2006; 2010). Indeed, during pregnancy, therapists tended to berate their clinical prowess: "*pregnant and a bit competent*" (Grossman, 1990; p.68), and questioned whether clients would want to resume therapy following maternity leave (Davis, 1997; McCluskey, 2017), highlighting the consequent impact on therapists' identities as professionals. Pregnancy also stimulated role reversals whereby clients tried to look after the therapist, intensifying feelings of guilt and ineffectiveness (Bashe, 1989; Grossman, 1990; Kariv-Agnon,

1988). Interestingly, multiparous therapists reported guilt less frequently than primiparous therapists. While causation cannot be assessed, it is possible that a therapist's second pregnancy may not evoke the same degree of client reactivity, perhaps because therapists are able to demonstrate their continued availability post-partum (Bashe, 1989; Zackson, 2012).

Therapists reported making therapeutic changes in attempts to alleviate pregnancy guilt, including acquiescing to requests for personal information (Fenster; 1983; Kariv-Agnon, 1988; Zackson, 2012), withstanding verbal tirades (Bashe, 1989; Baum, 2006; Davis, 1997; Fenster, 1983; Grossman, 1990; Kariv-Agnon, 1988; McCluskey, 2017) and going “*overboard*” (Grossman, 1990; p.62) to meet clients’ needs. Occasionally, therapists’ efforts to prioritise client care were detrimental to their own health, such as conducting sessions whilst feeling faint (Baum, 2006; Locker-Forman, 2005), fearing miscarriage (Byrnes, 2001) or during premature labour (Davis, 1997). Therapists also attempted to negate the impact of pregnancy during maternity leave by arranging surplus interim cover (Byrnes, 2001; Davis, 1997; McCluskey, 2017), maintaining client contact (Bashe, 1989; Byrnes, 2001) or opting for brief leaves of absence (Bashe, 1989; Baum, 2006; Byrnes, 2001; Davis, 1997). Therapists additionally utilised various protective strategies to alleviate pregnancy-related guilt, including minimising clients’ difficulties (Grossman, 1990), repressing memories of confronting cases (Locker-Forman, 2005) or denying the impact of pregnancy on clients’ treatment (Bashe, 1989; Kariv-Agnon, 1988). The latter approach was notably described by trainee therapists (Baum, 2010; Lyndon, 2013), who tended to “*ignore*” (Baum, 2010; p.724) their pregnancies and avoid

pregnancy exploration with clients; precluding opportunities to gain contrary evidence.

Discussion

Owing to the considerable proportion of the therapeutic workforce who are female and of childbearing age, this meta-synthesis explored and detailed the widely unreported experiences of pregnant therapists. A meta-ethnographic analysis led to the development of four key concepts, which indicate that pregnancy creates a multitude of novel personal and therapeutic challenges. The meta-synthesis demonstrated that while therapists' clinical experiences were largely congruent, the emotional burden of pregnancy was most pronounced in the accounts of primiparous, trainee and child therapists.

Although pregnancy reflects a brief transitional stage in the careers of therapists, the meta-synthesis indicates that many of the therapeutic changes derived during pregnancy may lead to long-term clinical changes, such as enhanced self-disclosure. While this may be viewed as an assimilative process of identity reformation or reappraisal of job role, it may also be the result of insufficient support during a formative chapter of therapists' careers. Indeed, the meta-synthesis suggests that changes to working practices during pregnancy, such as reduced exploration of client affect, emerge (partially) in response to uncontained therapist guilt. Supervisors may therefore need to be especially vigilant for therapist guilt, especially primiparous child therapists, as for some, pregnancy led to resignation. Plainly, these findings highlight

that existing support frameworks and guidelines are insufficient during pregnancy and require urgent attention to promote retention.

In accordance with wider literature (Imber, 1990; Goldberger et al., 2003; Nadleson, Notman, Arons & Feldman, 1974), the meta-synthesis identified therapists' avoidance of highly emotive and threatening material. While this may reflect maternal instincts to protect one's baby, this is incongruent with therapeutic conventions of being receptive to all client experiences. Therapists' reduced exploration has been linked to both increased vulnerability and guilt (Lax, 1969; Raphael-Leff, 2004), enhancing therapist likelihood of responding to clients' pregnancy reactions as indisputable facts. Thus, pregnancy may inadvertently "*blind the analyst*" (Uyehara, Austrian, Upton, Warner & Williamson, 1995; p.117), and contribute to the fulfilment of therapists' fears of clinical inefficacy. Alongside offering much needed emotional support, supervision may help to identify avoidant therapist tendencies and consider ways to incorporate difficult material for therapeutic gain.

Therapists' assertions that late pregnancy disclosure results in premature client terminations, supports views that disclosure should occur prior to the third trimester (e.g., Bassen, 1998; Goldberger et al., 2003; Uyehara et al., 1995). Early disclosure may be especially warranted for clients who stand to be particularly affected by therapist pregnancy, such as those struggling with infertility, allowing sufficient time to explore pertinent issues. Further, emerging research indicates that clients place responsibility for pregnancy disclosure firmly with the therapist (McCluskey, 2017), demonstrating the need for forthright disclosures and the added value of research exploring clients' experience of therapists' pregnancy. Combined, these findings

reveal the futility of supervisory advice issued to therapists in the meta-synthesis to maintain psychoanalytic fidelity during pregnancy. Waldman argues that psychoanalytic practitioners have a “*clinical mandate*” (2003, p.52) to explore the impact of pregnancy and motherhood in therapy. Indeed, the meta-synthesis identified therapists’ concerns that they had not managed pregnancy disclosure and exploration “*correctly*” (Bashe, 1989; p.43), indicating that pregnancy may enhance therapists’ desire for didactic supervisory practices. The lack of pregnancy-specific guidance and supervision is a notable finding that is reflected by professional bodies (e.g., BPS, 2017), highlighting that professional issues relating to pregnancy continue to be overlooked. Indeed, if pregnancy is not regularly discussed in supervision as the meta-synthesis suggests, or if therapists receive explicit instruction not to disclose their pregnancies, it is perhaps unsurprising that therapists report pregnancy-related guilt.

Owing to variation in study demographics, it is not possible to determine how many therapists were in receipt of supervision during pregnancy, although there is some evidence to suggest that some therapists discontinued supervision during pregnancy (Fenster, 1983), calling into further question the utility of supervision. The meta-synthesis indicates that therapists express preferences for supervisors who have themselves successfully negotiated pregnancy and motherhood, perhaps due to increased opportunities for role identification. However, Baum and Itzhaky interviewed mother-supervisors and found that attitudes towards pregnant therapist supervisees were “*consistently critical and judgemental*” (2006; p.33). This may indicate that supervisory difficulties do not diminish through experiential knowledge, highlighting the need for comprehensive training for *all* supervisors (see Goldberger

and colleagues' 2003 guidance for supervising pregnant therapists). Given the potential parallel processes at play during pregnancy (Fenster et al., 1986; Goldberger et al., 2003), it would be advantageous for supervisors to initiate exploratory discussions about pregnancy, which could subsequently serve as templates for therapists' conversations with clients. Indeed, in a book expanding upon Fenster's (1983) clinical dissertation, Fenster, Phillips and Rapoport (1986) suggest that pregnancy exploration should begin in supervision before being extrapolated to the therapy room. However, as the meta-synthesis indicates, it may be beneficial for supervisors to prospectively discuss the clinical rationale for such supervisory modifications, especially with trainee therapists who may otherwise find the introduction of personal content disconcerting.

When considering the meta-synthesis' findings, it is important to remain mindful of the following limitations. Firstly, the breadth of focus of the individual studies varied considerably, impacting how much each paper contributed to the final synthesis, which may have led to some findings being overrepresented. This may be further skewed by the inherent difficulty analysing qualitative studies with small sample sizes, most of which were conducted in North America where maternity leave is often restrictive. Further, the variance in the demographic data provided by studies limits the capacity to draw firm conclusions about the experiences of pregnant therapists, and subsequently to whom the findings may be most applicable. This precludes opportunities for subsequent analyses, such as matched demographic comparisons or exploring the unique contributions of therapist-specific variables. For example, the experiences of group psychotherapists are notably underrepresented. Research exploring the therapeutic experiences of matched pregnant therapist and supervisor

dyads would be particularly informative. Comparative studies exploring the therapeutic impact of other sudden changes, including therapist illness or disability, are also warranted. Finally, many of the included studies are notably dated, which may have influenced the reported findings, i.e., prevalence of psychodynamic working practices. However, many findings such as guilt and identity conflicts are reflected across the wider study corpus, indicating the consistency of therapists' experiences over time and the continued lack of adequate therapist support.

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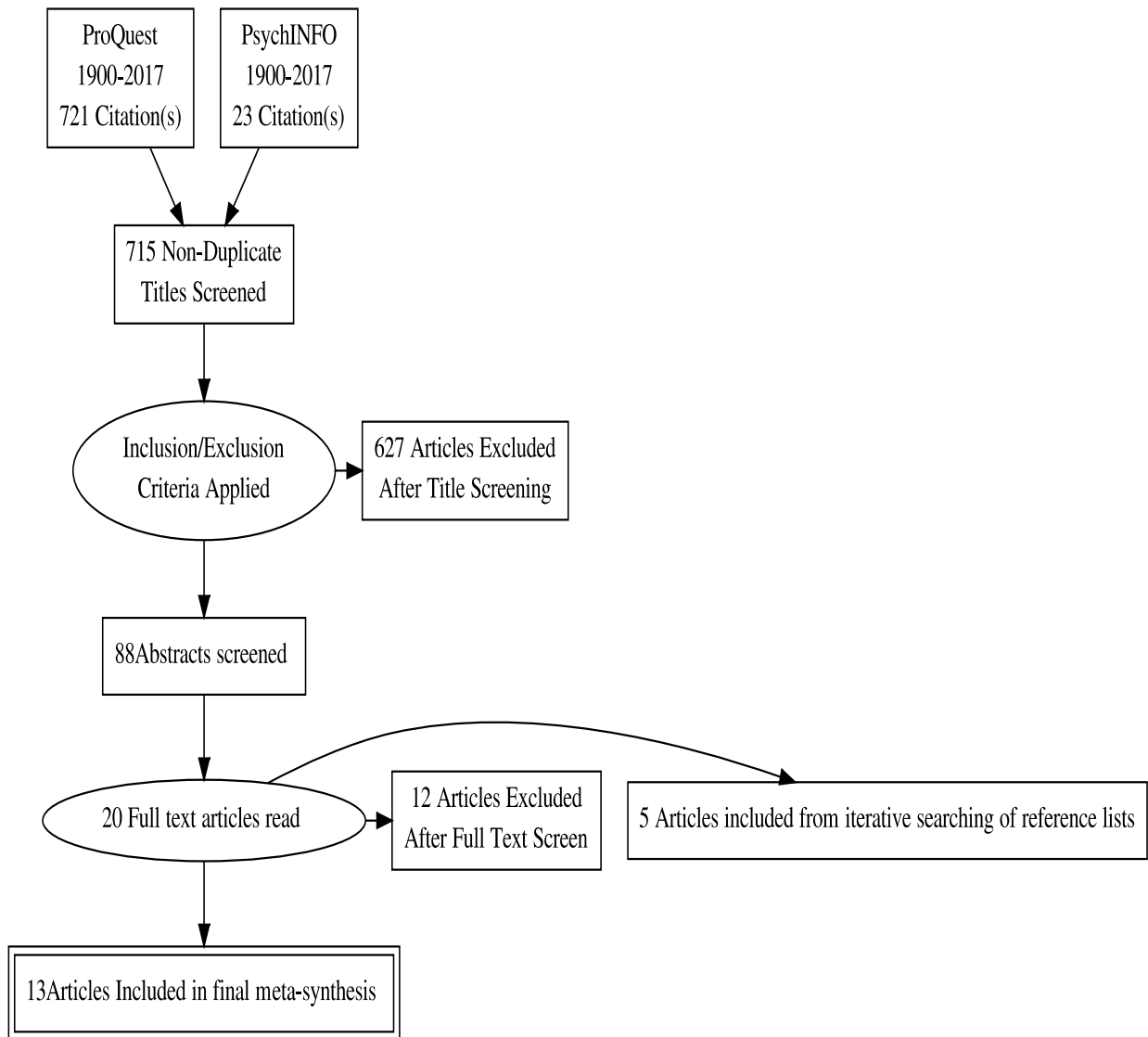
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Appendix 1

Diagram 1: PRISMA Diagram Demonstrating Systematic Study Selection Procedure



Appendix 2

Table 1: CASP Qualitative Checklist for the Meta-Synthesis

Demonstrating how each Study in the Meta-Synthesis addresses the CASP Qualitative Checklist (2017) Quality Measures

	CASP Checklist Questions									
	1	2	3	4	5	6	7	8	9	10
Bashe (1989)	✓	✓	✓	✓	✓	?	?	?	✓	✓
Baum (2006)	✓	✓	✓	✓	✓	X	?	✓	✓	✓
Baum (2010)	✓	✓	✓	✓	✓	X	?	✓	✓	✓
Byrnes (2001)	✓	✓	✓	✓	✓	?	?	✓	✓	✓
Davis (1997)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fenster (1983)	✓	✓	✓	✓	✓	X	?	✓	✓	✓
Grossman (1990)	✓	✓	✓	✓	✓	✓	?	?	✓	X
Kariv-Agnon (1988)	✓	✓	✓	✓	✓	X	?	✓	✓	✓
Locker-Forman (2005)	✓	✓	✓	✓	✓	✓	?	✓	✓	✓
Lyndon (2013)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Matozzo (2000)	✓	✓	✓	✓	✓	X	?	?	✓	?
McCluskey (2017)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Zackson (2012)	✓	✓	✓	✓	✓	✓	?	✓	✓	✓

Key:

(✓) indicates that the researcher has appraised the study as possessing the specified quality aspect

(X) indicates that the researcher has appraised the study as lacking the specified quality aspect

(?) indicates that the researcher has been unable to sufficiently appraise whether the study may possess the specified quality aspect

Appendix 3

Table 2: *Overview of Studies included in the Meta-Synthesis*

Author , Year, Publication Type and Location	Study Focus	Sample Characteristics	Method	Methodology	Main Themes
Bashe, 1989 Unpublished Doctoral Thesis USA	Impact of psychotherapists' pregnancy on therapy	15 psycho-dynamically orientated therapists 28 – 39 years (average age 33.3 years) average 6.8 years professional experience (1.5 – 14 years range)	Interviews during 3 rd trimester	Not stated, themes corresponding to interview schedule identified	5 key research areas emerged: <ul style="list-style-type: none"> • Pregnancy recognition • Therapist Technique • Practical decisions and logistics • Transference themes • Countertransference themes
Baum, 2006 Journal article Israel	Sources and triggers for the emergence of guilty feelings	10 primiparous trainee social workers 25 – 32 years (average 28.3 years)	Semi-structured interviews Conducted either at 9 months pregnant (n=5) 2-12 months post delivery (n=5)	Content Analysis	Article focuses on the 4 following types of guilt feelings: <ul style="list-style-type: none"> • Guilt for clients • Guilt for leaving the baby to pursue professional ambitions • Guilt for supervision becoming therapeutic • Personal guilt

Author , Year, Publication Type and Location	Study Focus	Sample Characteristics	Method	Methodology	Main Themes
Baum, 2010 Journal article Israel	Focuses on themes of dual transitions between becoming a mother and developing professional identity.	10 primiparous trainee social workers 25 – 32 years (average 28.3 years)	Semi-structured interviews Conducted either at 9 months pregnant (n=5), or 2-12 months post delivery (n=5)	Content Analysis	Article reports findings on 2 themes: <ul style="list-style-type: none"> • Trainees’ distress in direct client work • Trainees’ determination to fulfil work obligations
Byrnes, 2001 Unpublished Doctoral Thesis USA	Child psychotherapists’ perceptions of the impact of pregnancy on child psychotherapy	24 child psychotherapists experience 1 – 13 years (average 5.4 years)	Prospective structured interviews: during 3 rd trimester (n=24) and 2-7 months postpartum (average 4.5 months) (n=23)	Not explicitly stated, <i>‘response categories for each question or group of related questions was developed... other categories were established which appeared to have face validity’</i> . Quantitative data derived from counting frequencies in interview data.	Qualitative and quantitative findings reported in relation to 10 research questions exploring following areas: <ul style="list-style-type: none"> • Child client reactions • Therapist reactions • Pragmatic Issues • Overall impact of therapist pregnancy

Author , Year, Publication Type and Location	Study Focus	Sample Characteristics	Method	Methodology	Main Themes
Davis, 1997 Unpublished Doctoral Thesis USA	Comparative study exploring differences in how pregnant and adopting therapists’ balance personal and internal experiences of expectant motherhood with professional roles	5 therapists: 3 clinical psychologists 2 clinical social workers average age 35.6 years average 9.9 years clinical experience integrative, systemic and psychodynamic approaches	Interviews during 3 rd trimester	‘five modes of analytic procedure’	Reports 4 core themes: <ul style="list-style-type: none"> • The experience of expectancy • Awareness of changes in the sense of self • Patients’ reactions • Other emergent issues
Fenster, 1983 Unpublished Doctoral Thesis USA	Impact of therapists’ first pregnancy on patients, supervisors and sense of self	23 primiparous psychoanalytic therapists 29 – 41 years old (average 34.5 years) 22= psychoanalytic 2= gestalt 2= family therapy	Prospective semi- structured interviews: during 3 rd trimester (n=23), 2 months – 1 year postpartum (n=22) (1 baby stillborn) (average 6.5 months)	Examined for ‘repetitive themes’ codes that did not fit other categories grouped into ‘other’ category frequency of responses expressed as percentages	Pregnancy interview themes: <ul style="list-style-type: none"> • Patient reactions to pregnancy • Therapist reactions to therapy and changing self concept Post-partum interview themes: <ul style="list-style-type: none"> • Adaption to motherhood & work, retrospective views of pregnancy • Supervision

Author , Year, Publication Type and Location	Study Focus	Sample Characteristics	Method	Methodology	Main Themes
Grossman, 1990 Book Chapter USA	Therapists' experiences of pregnancy and transition to motherhood	16 psychotherapists: 9 psychologists 6 social workers 13 primiparous mothers 14 in training or supervision in psychodynamic orientated psychotherapies Does not state ratio of pregnant/ post-partum therapists	Prospective open ended individual and group interviews over 12 month period Group 1 = 9 members Group 2= 6 members (researcher participated in each group) Additional individual interviews during final trimester and 3 months post-partum(n=3), 3 year follow up (n=9)	Themes identified, analysis method not reported.	Initially coded for 'themes of power and nurturance'., additional 3 themes: <ul style="list-style-type: none"> • Guilt: responsibility vs selfishness • Changing personal and professional identities • Fluctuating boundaries
Kariv-Agnon, 1988 Unpublished Doctoral Thesis USA	The effect of pregnancy on the therapists' feelings towards and perceptions of the therapeutic experience	9 primiparous pregnant psychotherapists 29 – 39 years old 2-12 years experience different theoretical orientations	Individual semi-structured interviews 3 rd trimester n=7 2 nd trimester n=1 1 st trimester n=1	Exploratory qualitative approach, appears consistent with thematic analysis – 'central themes were extracted'.	Data organised into four categories: <ul style="list-style-type: none"> • Impact on the way patients are experienced • Impact on patient work • Impact of physiological and emotional changes • Exploring ones pregnancy with patients

Author , Year, Publication Type and Location	Study Focus	Sample Characteristics	Method	Methodology	Main Themes
Locker-Forman, 2005 Unpublished Doctoral Thesis USA	Explores child psychotherapists' experience of pregnancy on themselves and their physicality, and child clients	9 primiparous pregnant psycho-dynamically orientated play therapists	Prospective open-ended interviews during 3 rd trimester and again within 6 months post-partum	Not specified, reports ' <i>patterns and themes that emerge as most salient</i> '	The following seven themes emerged from the findings: <ul style="list-style-type: none"> • Telling • Parent work • Moving Away • Supervision • Outcome • Renegotiation of roles • Facilitative?
Lyndon, 2013 Unpublished Doctoral Thesis USA	Explores how therapists negotiated completing doctoral clinical psychology training whilst becoming first time mothers	8 clinical psychologists	Semi-structured retrospective interviews and demographic questionnaire	Interpretative phenomenological analysis	The following eight themes emerged from the findings: <ul style="list-style-type: none"> • Maternal desires • Professional ambition • Internal struggles • Impact of career on motherhood • Impact of motherhood on clinical work • Limits & limitations • Family of Origin • Support

Author , Year, Publication Type and Location	Study Focus	Sample Characteristics	Method	Methodology	Main Themes
Matozzo, 2000 Unpublished Doctoral Thesis USA	Comparative study exploring the impact of therapists' and physicians' pregnancies on clients	10 psychologists; 10 physicians pregnant within past 3 years average 4.3 years post- training experience	Semi-structured interviews & questionnaires	Unspecified method, data 'coded and transformed'. Chi-square analyses to make comparative comparisons of psychologists' and physicians' qualitative interview data	Areas explored: <ul style="list-style-type: none"> Differences between psychologists and physicians Similarities between psychologists and physicians
McCluskey, 2017 Journal article USA	Explores the clinical dynamics that emerge when a therapist becomes pregnant during treatment	8 primiparous postpartum therapists: All utilise psychodynamic or psychoanalytic approaches Experience 3-14 years (average 8.4 years)	Semi-structured interviews conducted post-partum: Within 6 months of pregnancy (n=6) Within past year (n=1) Within past 5 years (n=1)	Constructivist Grounded Theory	Article reports 6 key findings: <ul style="list-style-type: none"> Pregnancy rules and self- disclosure Trust, identification and deepened connection with therapist Bad timing of pregnancy Maternity leave Life and desire, or loss and regret Role reversals

Author , Year, Publication Type and Location	Study Focus	Sample Characteristics	Method	Methodology	Main Themes
Zackson, 2012 Unpublished Doctoral Thesis USA	The impact of Primary Maternal Preoccupation on the therapist and therapy following return from maternity leave	20 psychotherapists who returned to work within 6 months of giving birth All therapists utilise multiple therapeutic approaches Years qualified 0-13 (average 5.15)	Mixed methods: primary maternal preoccupation questionnaire (Moulton, 1991) and semi-structured interviews. Brief follow up call 3 weeks post interview to capture any additional content that may have been difficult to articulate during the interview.	Thematic analysis. Compares qualitative findings between the highest (n=10) and lowest scoring (n=10) therapists on the primary maternal preoccupation questionnaire.	Organised around the four domains of the primary maternal preoccupation questionnaire (boundaries, distractability, affect, autonomous ego functioning) with one additional emergent category, self esteem.

Appendix 4

Table 3: *Study Endorsement of the Key Concepts Expressed in the Meta-Synthesis*

	Study												
	Bashe (1989)	Baum (2006)	Baum (2010)	Byrnes (2001)	Davis (1997)	Fenster (1983)	Grossman (1990)	Kariv-Agnon (1988)	Locker-Forman (2005)	Lyndon (2013)	Matozzo (2000)	McCluskey (2017)	Zackson (2012)
Key Concept 1 Identity Changes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓
Key Concept 2 a) Telling	✓			✓	✓	✓	✓	✓	✓		✓	✓	✓
b) Supervisory Relationships	✓				✓	✓	✓	✓	✓				✓
Key Concept 3 Therapeutic Challenges	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Key Concept 4 Guilt	✓	✓	✓			✓	✓	✓	✓	✓	✓		✓

SECTION 3: Empirical Paper

***“A dangerous thing to go throwing about”*: Trainee Clinical Psychologists’ Views
and Experiences of Touch in the Therapeutic Relationship.**

Counselling Psychology Quarterly Submission Guidelines:
<https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=ccpq20>

***“A dangerous thing to go throwing about”*: Trainee Clinical Psychologists’ Views
and Experiences of Touch in the Therapeutic Relationship.**

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Abstract

There remains a dearth of research exploring clinicians' experiences of touch in therapy. Trainee clinical psychologists (trainees) represent a distinct group of emerging professionals training within the current risk-averse healthcare context. This qualitative study explored trainees' views and experiences of touch in therapeutic work. Nine U.K. trainees participated in individual semi-structured interviews. Transcripts were analysed using interpretative phenomenological analysis (IPA) through which three super-ordinate themes emerged: secrecy to confession; fear of the external monitor; and conflicting identities. It is proposed that greater emphasis on formal instruction on the uses of therapeutic touch may help to alleviate widespread fear and encourage greater dialogue. The influential role of clinical supervisors in supporting trainees' professional development relating to touch is also outlined.

Keywords: touch, trainee clinical psychologists, IPA, fear.

Introduction

A controversial topic in psychotherapy (Smith, Clance & Imes, 1998), touch represents a clinical 'grey area' (Sheret, 2015) without clear consensus regarding its value or place within the therapeutic relationship. Despite being incorporated into healing and healthcare practices for centuries (Smith, 1998), the appropriateness of touch within psychotherapy has become contentious since Freud amended his position to one of abstinence (Bonitz, 2008). The primary concerns are that touch may impede therapeutic fidelity and lead to a 'slippery slope' of sexual misconduct. The potential

for therapeutic harm also forms the basis of wider objections to touch, including possible misinterpretation (Smith, 1998) and re-traumatisation (Hunter & Struve, 1998), loss of therapist objectivity (Durana, 1998) and disempowerment of clients via the enhancement of ever present power differentials (Alyn, 1988; cited in Kertay & Reviere, 1998).

Within an increasingly cautious healthcare context, clinicians may be concerned that touch could be subject to allegations of misconduct (Stenzel & Rupert, 2004). Fears of personal culpability and admonishment may be inadvertently perpetuated by the lack of a definitive professional position on the use of touch (British Psychological Society Professional Guidelines, 1995; section 2.1.2.2).

Research demonstrates that while clinicians may be reticent to publicly acknowledge their use of touch (Tune, 2001), it remains a facet of many therapists' practice (Pinson, 2002), with many clinicians considering touch an appropriate and even essential part of clinical practice. Proponents assert that therapeutic touch represents an authentic expression of care, imbued with the possibility to convey emotions that are not easily expressed in words. Westland (2011) synthesises different functions of therapeutic touch including affective soothing and grounding, increasing clients' awareness of physiological responses, deepening emotional processing and enhancing therapeutic rapport. Regarding the detrimental effects of touch deprivation (i.e.; Harlow, 1958), for some the exclusion of touch represents a professional transgression which may impede therapeutic progress (Sponitz, 1972) and emulate the cold and rejecting parenting many clients may have experienced (Bowlby, 1977).

Initial research investigating touch utilised questionnaire and survey methods to ascertain the frequency, function and typology of therapeutic touch. Pope, Tabachnick and Keith-Spiegel (1987) determined that psychologists most frequently used handshakes and hugs, with handshakes considered ethically sound by the majority of respondents (93.6%). There was less consensus about whether hugs were ethical. Ninety percent of American psychologists (Stenzel & Rupert, 2004) working in adult psychotherapy practice reported rarely offering touch to clients, a higher proportion than reported in previous studies using similar methodologies (i.e. Pope et al., 1987; Holroyd & Brodsky, 1977).

In qualitative research using grounded theory to explore decision-making processes of experienced psychotherapists in the United Kingdom (U.K.), Tune (2001) found that touch was most likely to occur at therapy termination, with touch mainly used to convey nurturing and containment. The therapists were highly ambivalent about disclosing their motivations and practices relating to touch.

Four American psychoanalytically orientated psychotherapists (Pinson, 2002) reported that their decisions to incorporate touch were based upon assessment of client need rather than clinicians' therapeutic or personal perspectives of touch. They reported mixed views regarding the appropriateness of touch in therapy, leading to delayed or absent supervisory disclosures.

Burkholder, Toth, Feisthamel and Britton (2010) conducted focus groups to capture the touch experiences of 16 American counselling trainees and faculty members. Utilising a constructivist phenomenological approach, trainee counsellors identified

potential risks of touch, including misinterpretation and blurring of professional boundaries, and indicated insufficient training opportunities regarding touch. Considering the taboo on touch, a focus group format may have unintentionally inhibited participants' responses.

To date, two qualitative studies have explored the practices of qualified clinical psychologists working in National Health Service adult mental health settings. Harrison, Jones and Huws (2012) interviewed six clinical psychologists regarding their decisions to use touch in therapy. Using interpretative phenomenological analysis, they found that instinctual reactions to touch clients were frequently inhibited, keeping the incidence of touch encounters low. Touch was reportedly infrequent due to psychologists upholding professional boundaries, and concerns that touch could lead to misinterpretations, client dependency and damage to one's professional reputation. Certain client presentations further suppressed psychologists' propensity to touch (borderline presentations and opposite gender of client), whereas contextual factors such as the termination of therapy increased the likelihood of touch encounters. Although clients' abuse histories, social isolation and heightened affect increased psychologists' inclination to use touch, this did not result in higher frequency of touch for all psychologists.

Sheret (2015) explored 11 U.K. qualified clinical psychologists' touch experiences alongside their underlying decision-making processes. Using grounded theory methodology, some touch behaviours were classified as entirely acceptable (handshakes) or unacceptable (sexual and aggressive touch); the appropriateness of other forms of touch was more ambiguous (hugs, touching arms, hands or shoulders

to communicate reassurance), reflecting wider study findings (Pope et al., 1987).

Sheret (2015) determined that psychologists' touch decisions were extremely idiosyncratic, highlighting the perceived complexity of therapeutic touch.

Previous research exploring therapeutic touch has been restricted by methodological limitations (Stenzel & Rupert, 2004) or lacked analytic rigour and subsequent interpretation (Pinson, 2002; Burkholder et al., 2010). Qualitative studies researching touch have primarily focussed upon decision-making processes relating to touch (Tune, 2001; Harrison et al., 2012), with comparatively little known about clinicians' lived experiences of touch in therapy. Research has focussed on highly experienced clinicians working within adult mental health settings only (Harrison et al., 2012; Sheret, 2015). The present study therefore aims to extend existing research by exploring how trainee clinical psychologists (trainees) make sense of their experiences of touch in the therapeutic relationship. The use of interpretative phenomenological analysis permits engagement with trainees' narratives and enables greater conceptual understanding of their training experiences relating to touch in therapy.

Method

This study utilised an interpretative phenomenological analysis (IPA; Smith, 1996) methodology. IPA was selected due to the experiential focus on 'giving voice' (Larkin, Watts & Clifton, 2006) to participants' experiences of subjective phenomena of interest, especially those that have been under-researched (Smith & Osborn, 2007).

IPA employs a double hermeneutic of interpretation, whereby an understanding of participants' 'lived' experiences (Smith & Osborn, 2007) is sought and constructed

through the researcher's interpretation of participants' narratives. The central role of the researcher in the analytic process is explicitly recognised within IPA, thus increasing transparency. As a final year trainee clinical psychologist, the first author holds a broad position: simultaneously considering that touch may enhance therapeutic gains or lead to therapeutic ruptures.

The current study presents the combined analysis of nine trainee interviews.

Participants

Nine trainee clinical psychologists aged between 27 and 32 years (average 29 years, SD 1.97) served as study participants. Trainee clinical psychologists represent a homogenous group of professionals, beginning to establish their careers within the current healthcare context.

Participants were all enrolled on British Psychological Society accredited doctoral level clinical psychology training courses in the U.K., and came from across all three years of clinical training (Table 1), reflecting the full training experience.

Table 1: *Number of Trainee Participants from Each Year of Clinical Training*

	Year of training		
	1	2	3
Number of trainees	2	4	3

Eight female and one male trainee volunteered to participate in the study. While it is recognised that this may affect sample homogeneity, this reflects the wider gender

distribution in doctoral clinical psychology programmes in the U.K. (Clearing House for Postgraduate Courses in Clinical Psychology, 2016).

Recruitment

After obtaining ethical approval from Bangor University, three clinical psychology training courses in the U.K. consented to provide access to trainees. However, owing to a high response rate, recruitment was only necessary from two training courses.

Although twelve trainees contacted the first author to take part, due to pragmatic restrictions the first nine responding were interviewed at their respective Universities.

Interview Participation

Trainees were reminded that their participation was voluntary and that they were free to withdraw from the study at any point without repercussion. Following assurances of confidentiality, written informed consent to audio-record interviews was obtained.

Basic demographic and training information was collected. A semi-structured question schedule was devised based on the study aims. In keeping with IPA guidance (Smith, Flowers & Larkin, 2009) additional enquiries were made as required, facilitating a deeper understanding of trainees' experiences.

Interviews lasted between 44–116 minutes (average 82 minutes) with all trainees reporting at least one touch encounter (average= 3.67, range 1-6). All trainees were fully debriefed.

Analytic Process

Owing to the larger corpus (Smith et al., 2009), pragmatic restrictions and IPA advice issued to the first author (P. Flowers, personal communication, February 10, 2017), it was determined that analysis would primarily focus upon a subset of transcripts with a view to developing provisional superordinate themes. Research team consensus (C.W, C.L & R.R) led to the selection and close examination of five transcripts chosen for the richness within, and variation between trainees' accounts. Idiographic analysis comprised of noting descriptive, linguistic and conceptual features of trainees' narratives, following which potential sub and emergent themes were recorded. The remaining four transcripts were then analysed to establish congruence and divergence with the provisional themes, with the identification of additional themes leading to revision of original themes. Subthemes that lacked sufficient depth were removed (e.g., the function and timing of touch).

The final superordinate themes were developed with consideration to both the richness of trainees' accounts and the recurrence of themes across transcripts (Yardley, 2000; cited in Smith et al., 2009). Identifying the presence of themes across participants is useful to demonstrate the rigour and validity of analysis (Smith et al., 2009), whilst still permitting for individuality between accounts reflecting the same superordinate theme. As Table 2 demonstrates, the final superordinate themes were highly endorsed by all trainees, with no qualitative differences emerging between the accounts of female or male trainees.

Table 2: *Trainee Endorsement of Superordinate Themes*

Superordinate themes	Trainee								
	Libby	Martha	Izzy	Theo	Olive	Grace	Chloe	Daisy	Robyn
Secrecy to Confession	✓	✓	✓	✓	✓		✓	✓	✓
Fear of the External Monitor	✓	✓	✓	✓	✓	✓	✓	✓	✓
Conflicting Identities	✓	✓	✓	✓	✓	✓	✓	✓	

In order to establish analytical validity, transparency was achieved by the explicit ownership of the first author's perspective and assumptions (Elliot, Fischer & Rennie, 1999). This process was supplemented via a reflective diary. Further reflexivity was shared with the second author during post-interview debriefs. Initial themes were assessed for credibility by the second and third authors.

Results

Three superordinate themes were apparent across trainees' narratives: Secrecy to Confession; Fear of the External Monitor and Conflicting Identities. Transcript excerpts are presented verbatim to convey trainees' attempts to make meaning from their experiences, supporting quotes from other trainees are displayed in "*italics*". The constituent themes demonstrate the level of confusion and fear experienced by trainees when considering touch, rendering it important to consider the themes in reciprocal and reinforcing relationships with each other.

Secrecy to Confession: a frightening dialogue

The majority of trainees acknowledged a collective secrecy surrounding the use of therapeutic touch, whereby touch was rarely if ever acknowledged by qualified Clinical Psychologists. Although trainees reported a preference for open dialogue that could offer greater clarity, trainees described being recipients of “*implicit messages*” (Libby) and “*inherent rules*” (Olive) that touch was largely unacceptable conduct:

“I feel like there’s a blanket rule though not to touch” (Olive)

“My sense is that touch isn’t something we talk a lot about as psychologists
it’s not something we routinely think about a lot as psychologists” (Robyn)

Olive and Robyn illustrate how in the absence of explicit dialogue, the prohibition of touch is intuited “*I feel*”, “*my sense*”. Trainees also noted how tuition on touch was largely absent or minimal in clinical training with many identifying the need for formal instruction and dialogue. For some, the silence was interpreted as meaning that there was no remit within the profession for touch:

...the absence of something does feel sometimes like a kind of barrier to using it really, or the idea that if it was that big a deal that it would be talked about, that you’d hear about it? So the fact that you’re not hearing about it says something, erm, in itself. (Libby)

Here Libby demonstrates inductive reasoning: touch must have minimal value because it lacks a designated platform. Others reflected how secrecy contributed to

continued uncertainty regarding what forms of touch may be considered acceptable:

you tend to just listen to little snippets of what other people say and watch what other people do [...] sort of gauging what everybody else does and okay that person doesn't do it all, that person does it quite a lot. [...] if you're somewhere in the middle then that must be okay but it's always guesswork I think cos nobody really talks about it. (Daisy)

Daisy portrays herself as external to others' conversations and actions. By expressing that she only catches "*little snippets*" of others' discussions, Daisy depicts touch as a clandestine subject to which she is not privy. Daisy attributes her uncertainty to the lack of dialogue "*nobody really talks about it*", yet this reveals an inconsistency: she acknowledges that others do discuss touch, but not with her.

The prospect of breaking the perceived silence surrounding touch provoked anxiety for trainees, who were largely unwilling to discuss touch openly with clients. However, all trainees described responsibility for initiating touch discussions in clinical supervision. While Libby, Martha and Robyn considered this straightforward, the remaining trainees described how initiating touch conversations left them feeling "*worried*" (Theo), "*really panicking*" (Olive) and "*uncertain*" (Izzy):

there was definitely like I thought of she could just, she could just be like 'what you don't know the rules?' and I'd be like 'Oh no, everyone knows something that I don't know about whether touch is OK or not' (Izzy)

Izzy conveys a discrepancy between the knowledge of her supervisor, whom she regards as possessing salient information regarding touch, and her own relative inexperience. She therefore depicts a power imbalance whereby she is vulnerable to potential admonishment from better-informed superiors ‘*you don’t know the rules?*’ reflecting the perceived vulnerability of the trainee position.

While the outcome of supervisory discussions was largely reported to be favourable and helped trainees to consolidate their own position relating to touch, those who found supervisory discussions very anxiety provoking relied on alternative forums to learn about touch:

These are the sort of conversations that I have had with other people, trainees. But I probably wouldn’t bring it up with a supervisor which is the interesting part I think. I would have to feel very safe with a supervisor to mention that to them (Theo)

Theo’s willingness to talk with fellow trainees reflects the group consensus, indicating that peer discussions may be less threatening for trainees than supervisory discussions. Theo affirms this proposition by emphasising the need to “*feel very safe*” before sharing with supervisors. Despite the comparative safety of peer discussions, these were not reported to influence trainees’ likelihood of incorporating touch in therapy.

The present research provided an opportunity for trainees to openly discuss touch in a dedicated forum. Despite volunteering to take part, trainees' discomfort discussing touch was evident across all narratives, indicating a potential difficulty separating fear of evaluation from the interview process. Indeed, many trainees queried whether their experiences were reflective of other trainees, further emphasising the lack of an overt touch dialogue. Objective discussion of the potential risks of touch was marked:

“if you, if you don't fully understand it and how to use it erm it can be kind of a dangerous thing to go throwing about ha- unless you know what to do with it” (Daisy)

Daisy articulates the need for caution and utilises collective pronouns to create distance from a potentially threatening narrative. Personal disclosures of touch occurred later during the interview process and were infrequent, characterised by losses of fluency and grammatical inaccuracies. Nevertheless, trainees endeavoured to convey their limited contributions to touch encounters, deepening the sense that trainees found discussing their own touch usage anxiety provoking:

“I didn't touch him, he touched me you know and I held my hand out like this” [demonstrates, palm parallel to floor] (Olive)

And what's interesting about having this conversation is that I almost feel compelled now to explain what I mean by physical contact when I say it, to explain to you that it's not something sinister (Theo)

Olive and Theo's extracts have a confessional quality whereby they appeal to the interviewer. It is therefore possible that despite volunteering to take part, trainees experienced the interview as a potential source of incrimination, necessitating the need to articulate oneself unambiguously.

Fear of the External Monitor

Trainees reflected on the lived experience of being highly evaluated across clinical training. In parallel, they described a sense that touch was highly monitored and open to misinterpretation and judgement from others. In consideration of the perceived scrutiny, the majority of trainees described how the trainee role intensified the precariousness of using touch therapeutically:

“I suppose you generally feel yeah under a lot of scrutiny as a trainee so perhaps a little bit more anxious about getting it wrong or using touch”
(Grace)

“it's just part of being on the course isn't it because you're always being evaluated [...] now I'm worrying about whether somebody's going to criticise my actions” (Daisy)

Grace and Daisy's extracts convey that decisions to use touch intensify the ever-present anticipation of external evaluation that is inherent to the trainee role.

A prominent concern for all trainees was that those external to the interchange could surreptitiously observe and scrutinise any touch encounter:

“I think it’s almost like that sort of concern that like the CQC [Care Quality Commission] or something are gonna bust in there and say ‘why are you touching somebody’?” (Theo)

I suppose any situation for an onlooker, a bystander could be misinterpreted because they are not in that situation so, erm. I suppose if you were just trying to comfort somebody and it, somebody else might see that through a doorway and think that’s not appropriate (Chloe)

While Theo names a powerful regulatory body as the enforcing organisation, Chloe’s description reveals that potential judgement could come from inconspicuous sources “*an onlooker, a bystander*”, reflecting other trainees’ concerns of anonymous admonishment from “*other people*” (Martha, Theo, Olive, Daisy) and those who “*watch on cameras*” (Izzy). Both accounts elicit images of covert surveillance, for example “*through a doorway*”, invoking notions of Big Brother-esque monitoring that exacerbate trainees’ continued sense of vulnerability.

While a few trainees named service managers and supervisors as potential critics of touch, uncertainty regarding the identity of potential adjudicators appeared to increase trainees’ concerns of what would be deemed acceptable conduct:

who decides what’s inappropriate and is, is your judgement, your judgement

ever going to be the same as the next person so then they might think ‘well why did you do that?’ So yeah, I suppose it’s worrying (Izzy)

Izzy’s account introduces an interrogative character who challenges her usage of touch “*why did you do that?*” illustrating her anticipated need to defend her decision to use touch. All trainees reported concerns that the intended meaning of touch could be misconstrued:

“...even though I felt like it my judgement was okay on it you know I guess you don’t know how other people might interpret it and erm I guess people will have extreme views.” (Olive)

Olive reflects the overt expectation that outside agents will misperceive trainees’ use of touch, leading to decreased certainty regarding ones own decision-making. Olive also indicates that others may have “*extreme views*”, evoking possible notions of unreasonable and unjust treatment.

Although no trainees reported receiving criticism or repercussions for using touch, many voiced concerns that it could result in personal consequences including “*litigation*” (Libby, Theo), being “*accused of doing something inappropriate*” (Daisy), and “*dragged through the courts*” (Theo). The magnitude of fear is most powerfully captured in the below extract:

I think it would help to know you know that you weren’t going to be immediately kicked off the course and everything like that if somebody found

out that you'd you know, tapped somebody on the shoulder or something
(Theo)

Considering Theo's perception of risk, it is not difficult to understand his abstention from touch: Theo perceives that even a small infraction such as tapping "*somebody on the shoulder*" could result in disproportionately large personal consequences "*immediately kicked off the course*". It is worth considering the notorious challenge of being accepted onto clinical psychology training, which he contrasts with the perceived ease with which he could be unceremoniously dismissed for using touch: further highlighting the perceived vulnerability of the trainee position in comparison to the omnipotent touch adjudicator.

For some, total abstention from touch was conceived as the only option for insuring one's personal safety. Chloe considers the need for a defensive, risk averse position on touch during training, which is emphasised through her repetitive language:

"if you wanted to be really really careful about things you would just never
never touch anybody." (Chloe)

Some trainees described an expectation that the degree of touch scrutiny would diminish following completion of clinical training:

I think as a trainee, you just think you couldn't get away with, with acting like
that, that it would be seen to be unprofessional or, too unboundaried, that kind

of thing but, maybe there's a point where you see the value of it, over the course of a career (Libby)

Libby's extract demonstrates an evolution of touch acceptability across clinical training and post-qualification. She depicts the presence of an external monitor who only evaluates trainee's touch usage "*it would be seen to be unprofessional*" and contrasts this with a perceived capacity to determine the utility of ones' own touch post-training "*where you see the value*"¹. This reflects trainees' wider perspectives that there may be increased scope to utilise touch post-qualification due to an anticipated reduction in external monitoring:

"I could imagine using it more potentially when I'm qualified than as a trainee
I suppose [...] I don't think I'll be so free [laughs] about it as a trainee."
(Grace)

Grace identifies that the trainee position intensifies the restrictions placed upon touch. She perceives greater freedom to use touch post-qualification, reflecting trainees' collective belief that touch monitoring may subside across ones career.

Conflicting Identities

The majority of trainees perceived touch as an intrinsically human quality, imbued with the power to transcend language, increase connection and reduce therapeutic power imbalances. Trainees described touch as an "inherently human" (Theo) and "natural" (Libby, Martha, Izzy, Theo, Grace, Chloe, Daisy, Robyn) process. However,

¹Underlining used to add analytical emphasis

despite emphatic accounts attesting to the clinical value of touch, a direct conflict with the need to conduct oneself in a professional manner, becoming of an aspiring Clinical Psychologist, ran throughout trainees' narratives. This theme is therefore concerned with how trainees negotiate the development of a Clinical Psychologist identity, which is conceptualised as being at odds with one's pre-existing 'human' identity.

With the exception of one trainee who previously worked in a forensic setting prior to commencing training, trainees documented previous job roles including carers, assistant psychologist and research positions where touch was an accepted or even an encouraged element of their work:

I don't remember ever thinking like that when I worked as a carer, should I be doing that? I just did or didn't and it was a lot more natural whereas erm yeah that's a difference I guess is that I get that kind of self-doubt now. (Daisy)

before I worked kind of, properly in psychology I was a support worker and a health care assistant and I used touch a lot in those jobs, it was a very natural part of those jobs, obviously move it into a therapy context it's very different. (Libby)

Here Daisy and Libby demonstrate an emerging awareness that touch is less acceptable within their current remit. All trainees echoed this point, describing a need to "*find your feet*" (Libby), "*test the water*" (Theo) and "*tiptoeing around*" (Grace) within the trainee position as a means to identify what constituted appropriate

conduct.

The majority of trainees described needing to behave with a professional decorum that was perceived as incongruent with touch:

I think when you're trying to maintain those boundaries touch may make that a bit- how you set out those boundaries I think is tricky, erm, and then touch may make that a bit more, a bit more confusing what is this relationship about like, you know. Erm which I think is sad as I'm saying it because I think I'd go back to my original point that I think it can be a real human you know, positive connective thing to do. Erm, so it feels a shame errr, to to feel that way about it. (Olive)

Olive captures the relative complexity of balancing her own position regarding the benefits of touch and the need for professional considerations such as boundaries, reflecting trainees' wider concerns that incorporating touch could "muddy the waters" (Libby). Her account is peppered with indecision and hesitations that emphasise her confusion regarding the ideal course of action. Trainees described different ways of managing this conflict: for Libby, who strongly identified with the need for professionalism, greater clarity was achieved by abstaining from touch entirely:

"And for me a part of that is not using touch, I find that one of the easiest ways of keeping that boundary in place" (Libby)

Others concurred, describing how the addition of touch made therapeutic relationships

additionally “complex” (Martha, Olive, Chloe, Daisy) and “confusing” (Olive), leading some trainees to purposefully omit touch in order to streamline the therapy process. Theo likewise refrained from using touch, however did not find the choice straightforward. Instead, he laments prioritising professionalism over clients’ immediate needs:

And when I don’t, it almost feeling a little bit kind of, yeah like I say, apologetic, like I know that this would be the right thing to do but I’m not going to do it. And as I said before, almost a bit inhuman, almost like I’ve kind of, ‘now I’m professional’, when throughout the whole of the therapy what I’ve been to you is a human, somebody trying to, kind of make metaphorical contact with you and understand you, where you are and now you’re here, and I’m not doing it. (Theo)

Theo’s account has a confessional quality: he describes feeling apologetic and letting the client down in their moment of need. He describes various collaborative steps of therapy, detailing a shared journey before intentionally sidestepping a perceived responsibility, “*I’m not doing it*”. This excerpt also utilises a change from past to current tense, indicating that his sense of guilt is sustained, further emphasised by directing his speech towards the client as opposed to the interviewer. By withholding touch, Theo describes a shift in position to “*now I’m professional*” indicating that he perceives humanity and professionalism as mutually exclusive. Theo describes feeling “*almost a bit inhuman*”, conjuring ideas of being heartless, robotic and disconnected from his client’s suffering. This fits with Theo’s unresolved internal conflict: he feels unable to touch and be professional, yet by not touching he feels unable to fulfil his

professional responsibilities towards his client.

Many trainees shared Theo's conflict, describing how rebuffing or failing to initiate touch was "*uncaring*" (Theo), "*unnatural*" (Libby, Grace, Daisy), "*harmful*" (Chloe), "*rejecting*" (Izzy, Grace, Daisy) and "*hostile*" (Theo, Grace). For Izzy, a proponent of therapeutic touch, aspiring to a professional identity necessitated an insular position:

I think some psychologists might want us to be more alien so maybe we're, we're the professionals and we know the answers and we have the power and we should keep certain boundaries [...] but I think for m- I feel quite strongly that we should be giving a message that we're human too (Izzy)

Here Izzy describes a top-down pressure to adopt an increasingly professional position, which is at odds with her human identity. She conceptualises becoming increasingly professional with becoming "*more alien*", evoking ideas of being inaccessible and remote, whilst highlighting her personal disinclination towards the professional identity.

For others, exemplification of a professional identity was preferable. Martha, who was nearing clinical training completion, demonstrates the development of, and preference for a professional identity:

as a therapist and being a profession that have to be really aware of boundaries

and actually that's kind at the core of being aware of how people feel [...] also more of a professional, psychology identity as well. (Martha)

Martha's phrasing "*being a profession*" indicates the internalisation of her professionalism as opposed to this being an aspirational process. For Martha, what constitutes a "*professional, psychology identity*" includes maintenance of therapeutic "*boundaries*", which is aligned with her wider beliefs that touch is incongruent with professional conduct. Several trainees echoed these sentiments, describing how upholding "*professional boundaries*" (Libby, Martha, Chloe) and acting with "*appropriate*" (Olive, Libby, Martha, Theo, Grace, Chloe, Daisy, Robyn) decorum was a professional imperative, necessitating the omission of touch.

Discussion

Utilising an interpretative phenomenological approach, the views and experiences of nine trainee clinical psychologists relating to touch in therapy indicated that touch dialogue was shrouded in secrecy and fear, leading some to query the appropriateness of touch within their remit. For those who attested to the clinical value of touch, an internal conflict between the perceived humanity of touch interactions and the need to adopt a professional identity emerged.

Secrecy to Confession: a frightening dialogue

Trainees described an unspoken 'sense' that touch fell outside the remit of clinical psychology, which was indirectly communicated via lack of wider dialogue. This reflects both Harrison et al. (2012) and Sheret's (2015) findings that qualified clinical psychologists received implicit narratives that touch was incongruent with their

professional conduct. This indicates that across all stages of a clinical psychology career, touch dialogue may be suppressed. Speculatively, trainees may therefore internalise rules that touch is unacceptable, leading to the perpetuation of touch secrecy and avoidance. Consequently, trainees' assumptions regarding touch incompatibility with professionalism may be inadvertently transferred across one's career, inhibiting opportunities for future dialogue.

Inadequate attention to touch instruction during training is a frequently cited concern (Burkholder et al., 2010; Durana, 1998; Zur, 2007). In the present study, trainees reflected on how minimal tuition contributed to perceptions that touch was taboo, perpetuating beliefs regarding its inappropriateness. Lack of instruction has been linked to greater ambiguity regarding touch decisions (Burkholder et al., 2010), which may be partly responsible for trainees' reticence to discuss touch and reliance on covert observation and 'guesswork' to ascertain appropriate practice; exacerbating already present anxiety. Indeed, where specific teaching has been provided, increased confidence in touch decisions has been reported (Milakovitch, 1998; O'Keefe, 2016). Recommendations for incorporating touch into clinical training curricula are discussed below.

In the absence of clear tuition, other sources of instruction may become particularly influential in determining touch acceptability (Milakovitch, 1998). In the present study, the majority of trainees expressed anxiety at the prospect of raising touch with supervisors, citing fears of ridicule and admonishment. Although the secrecy surrounding touch did not prevent trainees from using touch sporadically, supervisory discussions were sometimes impeded or absent, reflecting wider findings that secrecy

surrounding touch pushes conversations further underground (Pinson, 2002). Supporting Milakovitch's (1998) findings, trainees who utilised supervisory discussions reported increased conviction in their touch decisions, indicating that open dialogue may play a mediatory role in alleviating trainee anxiety. Alternatively, gaining a permissive response relating to touch may help trainees to feel less isolated and vulnerable due to enhanced perceptions of professional approval.

Despite the secrecy encompassing touch, study recruitment found considerable interest from trainees, all of whom spoke at length about their views and experiences. Although trainees perceive touch as an outwardly covert topic, there remains great interest in exploring touch within this cohort, perhaps especially when ones' anonymity is assured. Nevertheless, trainees' anxiety during the interviews was marked, with many emphasising that their touch usage was infrequent and professionally appropriate. Trainees appeared concerned about how their experiences may be construed, reflecting how lack of dialogue perpetuates psychologists' concerns that all therapeutic touch may be subject to allegations of misconduct (Stenzel & Rupert, 2004).

In support of Harrison et al.'s (2012) findings, trainees emphasised the infrequency of touch interactions, although all nine described at least one touch encounter. Trainees' accounts of their own touch usage within therapy were characterised by frequent losses of fluency, grammatical confusions and hesitations. Disclosing one's own use of touch may therefore represent a breaking of the collective silence on touch, rendering such discussions highly anxiety provoking. Trainees' discomfort discussing touch extended to clients, with only Martha and Daisy describing holding explicit

conversations. Trainees' reticence to discuss touch with clients is aligned with wider research findings (Stenzel & Rupert, 2004) and may reflect a lack of guidance on how to initiate such discussions, leading to further anxiety.

Fear of the External Monitor

Familiar with high levels of clinical and academic assessment during training, trainees conveyed that touch encounters could also be highly evaluated. While research utilising qualified clinical psychologists identified primary fears of judgement from clients and colleagues (Harrison et al., 2012), trainees in the present study described overarching fears of covert monitoring with all onlookers representing potential sources of incrimination. Trainees' difficulty identifying definitive sources of admonishment may reflect the perceived vulnerability of the trainee role, rendering all touch encounters potentially dangerous.

Trainees reflected on the need to act with appropriate decorum during clinical interactions, but demonstrated confusion regarding what others may constitute as acceptable touch conduct, reflecting research findings with trainee counsellors (Burkholder et al., 2010). Speculatively, the secrecy surrounding touch may contribute to trainees' uncertainty regarding both how touch is regulated, and the potential ramifications. Trainees described how perceived infractions could result in 'litigation' and being 'dragged through the courts', and may reflect awareness of the recent increased reporting of boundary violations in psychotherapy (Zur, 2007). Training within the current healthcare climate may therefore have influenced trainees' cautious approach, necessitating an increasingly defensive position.

Some trainees described beliefs that touch scrutiny would reduce post-training, affording greater opportunity to evolve their clinical practice relating to touch. Sheret (2015, p.140) proposes a dynamic three-stage developmental model of touch confidence, whereby initially, touch decisions are made in ‘blind confidence’ without due awareness of the potential complexities, before later acquiring a deeper understanding of the nuances. The acquisition of new touch perspectives is proposed to heighten uncertainty in one’s usual approach, leading to decreased confidence. Sheret (2015) describes a final consolidation stage whereby clinicians develop an ability to withstand the uncertainties inherent in touch encounters, leading to considered decision-making. Trainee clinical psychologists’ experiences appear to be most closely aligned with the middle stage, as characterised by losses of confidence and uncertainty regarding ‘correct’ courses of action. Trainees’ supposition that touch scrutiny may reduce following qualification may therefore reflect a desire to incorporate touch more flexibly, reflecting Sheret’s (2015) final developmental stage. However, Joshi, Almeida and Shete (2010) determined that clinicians’ touch frequency did not increase with experience, indicating that there may not be additional opportunities to develop the use of touch post-qualification.

Conflicting Identities

Trainees regarded touch largely as incongruent with their professional identity, leading to a binary choice: either touch and remain human, or abstain and be professional. This contrasts with qualified clinical psychologists’ conceptualisation that the human position could be integrated within the professional role (Harrison et al., 2012; Sheret, 2015). The propensity to categorise humanity and professionalism as separate identities may therefore reflect trainees’ desire for a more definitive, clear-

cut position on touch. Indeed, several trainees highlighted how incorporating touch made the therapeutic relationship unnecessarily “*complex*” and “*confusing*”, emphasising trainees’ desire for a more straightforward position.

In contrast to trainees’ previous occupations where touch was accepted practice, clinical training was perceived as requiring more stringent professional standards. Resultantly, all trainees acknowledged the necessity of maintaining professional boundaries, which may indicate that the formation of a clinical psychologist identity requires a particularly discerning position regarding touch. For some this was achieved through touch abstention, reflecting wider concerns that touch may blur therapeutic boundaries and lead to a ‘slippery slope’ of inappropriate conduct (Bonitz, 2008). Although all trainees reported cautious and infrequent touch usage, some trainees lamented the need to prioritise professional boundaries, reflecting Lazarus’ (1994, p. 256) sentiments that prescriptive application of clinical boundaries can be ‘dehumanising’ and constitute ethical violations. Therefore, while boundary maintenance appears to form part of trainees’ appraisal of the clinical psychologist identity, trainees’ willingness to adopt this identity varied, which may indicate that there are multiple ways to conceptualise becoming a clinical psychologist during training.

Study Limitations

Due to perceptions of breaking a professional taboo, trainees may have self-censored their narratives. This potential limitation is afforded to all contentious topics and reflects the need for greater visibility and dialogue to overcome perceived barriers in research. Indeed, trainees were initially reluctant to acknowledge any personal use of

touch, with disclosures gradually occurring as interviews progressed, reflecting wider touch research (Tune, 2001). While this indicates that the interview may have been perceived as a potential source of self-incrimination, the first author's status as a trainee herself provided much experiential overlap with the participants. This may have led trainees to presume a sympathetic audience, permitting more candid and detailed exploration of trainees' touch experiences. Indeed, reflecting the current research findings, touch discussions with fellow trainees may be perceived as less threatening, bolstering study recruitment. Alongside the unexpected ease of recruitment, trainees spoke at great length about their views and experiences, which were found to be highly congruent across trainee narratives despite heterogeneity within the sample (i.e., inclusion of sole male trainee). This may emphasise trainees' desire for a forum to discuss potentially stigmatising subjects such as touch.

Conversely, the first author's shared status may have led to compromised researcher objectivity despite methodological safeguards. While IPA does not look to represent those beyond the research sample, it is unclear whether the present findings are congruent with trainee experiences on other courses. Indeed, despite concerns of significant personal consequences for using touch, no trainee reported unsuccessful touch encounters or repercussions for using touch. It remains unclear whether this is an artefact of trainees fear of disclosing such experiences, or whether trainees with these experiences may have been less likely to participate, further perpetuating the secrecy surrounding touch.

Future Research

Reflecting study findings, the provision of additional touch guidance within clinical training and supervisory contexts may help to inform trainees' touch decisions, enhancing practitioner confidence. Greater exploration of clients' perspectives of therapeutic touch are also warranted and may facilitate greater understanding of when, or for whom, touch may be most beneficial. In turn, this may lead to greater interest in incorporating touch instruction within training curricula (Milakovitch, 1998), the impact of which could be evaluated in future research. Proliferation of research is therefore the primary recommendation as continued interest will help to demonstrate that touch is deserving of a public platform, enabling greater professional dialogue.

Practice Implications

Trainees identified the dearth of clinical and supervisory tuition as perpetuating factors in the continuing uncertainty regarding the appropriateness of touch, highlighting the need for more explicit dialogue between training courses and trainees.

This study therefore advocates for greater instruction and discourse on the various functions and uses of therapeutic touch. Implementing a standardised touch curriculum is not without challenges (Burkholder et al., 2010) considering the nuances inherent in touch encounters. Training courses may benefit from offering a range of teaching methods to highlight the subtleties of touch interactions including case studies (Zur, 2007), role plays (Burkholder et al., 2010), peer led discussions and conversations with experts by experience. Dissemination of key literature is also advisable, including novel research advances such as the effects of imagined touch

(Jakubiak & Feeney, 2016) may be particularly useful for clinicians disinclined to utilise physical interventions. Such instruction may help to promote more flexible and forthcoming dialogue, which may be helpful in alleviating trainees' anxiety and challenging the wider stigma surrounding therapeutic touch.

The study also highlights the influential role of clinical supervisors in informing trainees' touch decisions. To reduce the emphasis on trainees initiating touch discussions, supervisors may wish to proactively state their position on touch (Walker & Clark, 1999) and share personal experiences of touch in clinical practice. Such disclosures have been found to be particularly beneficial for supervisees (Ancis & Marshall, 2010) and may increase likelihood of reciprocal disclosure. However, it is acknowledged that supervisors working within the same touch-averse health contexts may be hesitant to disclose. Further, supervisors may doubt their ability to provide adequate instruction on touch (Burkholder et al., 2010), reflecting the vicious cycles of fear and secrecy that may be perpetuated by insufficient training opportunities. Supervisors may be guided by practice recommendations, including consideration of trainees' motivations and the needs of clients (Kertay & Reviere, 1998), awareness of transference and countertransference issues (Phelan, 2009), seeking the client's permission prior to initiating touch (Fosshage, 2000) and processing the meaning of touch experiences with clients (Stenzel & Rupert, 2004). Such dialogue may also contribute to the professional development of the supervisor (Wilson, Davies & Weatherhead, 2016), indicating the potential for reciprocal benefits that may occur from breaking the silence surrounding touch.

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SECTION 4: Contributions to Theory and Clinical Practice

Contributions to Theory and Clinical Practice

In my personal experience, touch and pregnancy have been inextricably linked. Therefore, this paper begins by detailing my personal reflections before considering theoretical conceptualisations, directions for future research and clinical practice implications.

Personal Reflections

Touch

The process of completing this work over the course of my maternity leave provided extended opportunities to re-evaluate my positions regarding touch and pregnancy. A running theme throughout my pregnancy, which coincided with the writing of the empirical paper, was my recurrent inability to feel my baby's movements. The loss of touch, the only communication I shared with my unborn child, was extremely distressing and set the tone for the analysis of trainees' lamentations of the loss of human connection. Interestingly, one of the most anti-touch trainees who saw touch in therapy as a '*red flag*'; Chloe, was the sole mother-participant. Initially, I experienced her position as uncompromising. Becoming a mother myself has diversified my views on touch: I have grown someone in my personal space, which for a limited period became a public space for others' touch. My daughter's entirely natural desire for constant touch during the fourth trimester and beyond has left me at times feeling 'touched out'. Perhaps for Chloe, as for myself, as I consider my own return to work, therapy may come to represent protected time without touch. In other words, becoming a mother could readjust my views on the inclusion of touch in therapy. This also lends itself to larger, as yet unanswerable questions, such as for whose benefit

touch is incorporated, or excluded, within therapy. Also relevant to the research at hand, I have at times struggled when strangers have benignly touched my child without first gaining my consent. Despite being her mother, a relationship where the power dynamic is heavily weighted in my favour, I have tended to silently withstand this perceived social faux pas despite great ire. This has led me to review the position of clients, who due to the inherent power imbalances of therapy may be even less able to articulate objections. Hypothetically, if clients feel unable to raise this with therapists, could this correlate with the rise in formal complaints over recent years? Professional recommendations suggest gaining client consent prior to initiating touch (Fosshage, 2000). Although some trainees discussed a need to explore the meaning of touch with clients, none of the interviewed trainees reported first seeking permission. However, this may in part be due to trainees' reported preference to receive, as opposed to initiate touch.

When I first set upon touch as a research topic, I was struck by the consternation I received. Indeed, there was a departmental suggestion that it may be prudent to initially omit the word 'touch' from my ethics application in case this caused the review board undue alarm. A similarly hesitant response was received from the People Panel, the Programme's Experts by Experience group. While the trainee clinical psychologists present at the meeting were highly intrigued and asked many questions about the research, the panel themselves espoused the litigious dangers of touching clients and the need for touch abstention to protect myself during training. It was apparent to me that there was difficulty differentiating the discussion of touch via research interview, and the actual implementation of touch in therapy. While I initially perceived this cautious approach as a misinterpretation of my research aims, I

later discovered that the trainee participants struggled with the same distinction: If I talk about it, they must think I do it. Thought-Action Fusion is elevated in the appraisal of threatening stimuli (Thompson-Hollands, Farchione & Barlow, 2013) and may increase avoidant behaviours. Potentially, this may reduce the likelihood of trainees initiating touch discussions with supervisors, which may be further perpetuated by the absence of open dialogue and the omission of touch in training syllabuses.

My own experience of touch during clinical training has been varied, and without definitive conclusion. One client, with whom I worked long term and was witness to her incredible achievements in therapy, asked me for a hug in our concluding session. I experienced the intensity of her emotion and gratitude within her hug, as well as her anxiety about how she would maintain her treatment gains without our weekly sessions. Her hug somehow seemed to be an attempt to hold on to part of me, to bolster her memory of my physical presence. Despite the hug being at her request, and one that I did not hesitate to reciprocate, I later could not shake a sense of panic that I had forsaken my professionalism. Like the trainee participants, I began to fantasise about the possible personal consequences should she decide at some future point that the hug was '*inappropriate*' and raise a complaint against my practice. I continue to be surprised at how much, and for how long, this occupied my thoughts. In reality, I could not have had a stronger therapeutic relationship, yet, my anxiety about touch led to the imaginary unravelling of our work together.

Pregnancy

My elective third year placement was working with foster carers and looked after children, a placement I partly chose due to my own poor fertility prospects. I learned that I was pregnant three weeks into the placement. Despite receiving supervision from an experienced mother-supervisor, I continued to struggle, mostly silently, with knowing how to disclose and discuss my pregnancy with clients. In one instance, my reflex to touch my stomach following an enormous kick, alerted my client to my pregnancy. I remember experiencing profound relief upon learning that the foster-carers I was working with all had biological children, which alleviated some of my pregnancy guilt. However, some guilt seemingly remained as I noted my tendency to explain the cessation of clinical work due to the approaching end of the placement, as opposed to my upcoming maternity leave. Moreover, the insensitivity of my pregnant form was most acute when I presented a suitability report for the adoption of a sibling pair - with the prospective couple present, at 34 weeks pregnant. Needless to comment further, in my personal experience, the extant professional issues related to pregnancy have been deafening.

Theory Development

As there are no established theorems for touch or pregnancy, this section considers how key study findings may be understood in relation to various psychological models and therapeutic frameworks.

Psychoanalytic Conceptualisations

Bion's (1962) theory of Container Contained outlines the mother's role in helping her child to develop self-regulation through affective reflection and attunement. The

parallels to the therapeutic relationship as a containing space are self-evident; however, as the meta-synthesis reports, therapists experienced new difficulties withstanding clients' emotional outbursts and their own guilt, indicating that pregnancy may impede therapists' ability to provide effective containment (Cullington-Roberts, 2004). Arguably, when therapists themselves are not sufficiently contained, there may be increased difficulty providing the required holding space. Both the empirical and review papers highlighted the need for greater supervisory input when encountering novel professional issues. Indeed, trainees' wishes for more definitive rules or guidelines regarding touch may reflect a desire for greater containment and direction from supervisors. Speculatively, could touch be an attempt to physically bolster the metaphorical therapeutic container? Trainees' descriptions detail that touch was often spontaneously introduced when clients' emotions were running high, such as encountering new anxiety provoking situations. If touch is therefore inversely related to clinical expertise, might touch interactions decrease as trainees learn additional methods to convey their support and containment? Indeed, Harrison, Jones and Huws' (2012) research indicates that experienced Adult Mental Health clinical psychologists rarely included touch.

The theory of the Good-Enough Mother may be useful to consider the findings of the meta-synthesis. Winnicott (1949) proposes that an essential task of motherhood is to support the baby's development of personal agency. Mothers who demonstrate 'good-enough' parenting achieve this aim by demonstrating manageable empathic failures that reveal the limits of the infants' (and by extension, the mothers') omnipotence. The therapeutic equivalent would be the 'good-enough' therapist, whose clinical errors and misjudgements are readily salvageable as not to compromise the

therapeutic alliance. Pregnancy may represent a confronting period of accelerated therapeutic deficiencies whereby therapists can no longer fully attend to clients' needs, culminating in the loss of the therapist to maternity leave. Speculatively, the high reported levels of client anger and acting out may be related to clients' experiencing pregnant therapists as no longer being 'good-enough'. Indeed, pregnancy also appears to have been confronting for many therapists and led to revisions of professional identity and surges of guilt, especially for child therapists, for whom pregnancy signalled the loss of professional omnipotence.

Third Wave Perspectives

"[touch] might be useful right now but I'm not going to do it: I'm going to hold out on you; because I'm worried." (Theo)

Compassion Focussed Therapy (CFT) may offer a useful framework to understand how fear of complaints may perpetuate trainees' reticence to discuss or utilise therapeutic touch. Gilbert (2009) proposes that negative emotions including fear and anger, activate the threat system while preventing engagement of affiliative, compassionate drives. Thus, trainees' preoccupation with possible admonishment for using touch may override beliefs about its therapeutic merit. Equally, CFT may provide a useful model to consider whether pregnancy enhanced therapists' maternal perceptions of threat, leading to reduced exploration and empathy. This avoidance, as understood by other third wave therapies, like Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999), may represent 'cognitive fusion' to certain feared outcomes (i.e., fear of admonishment and harm to baby). ACT's emphasis on values may also be useful to consider trainees' difficulty reconciling the need for professionalism over 'being a human being'.

Johari Window

Devised by psychologists Luft and Ingram (1955; appendix 1), the Johari Window provides a framework with which to understand interpersonal communication between oneself and another (person, group or organisation). In the absence of professional guidance on touch and pregnancy, the façade and blind spot quadrants hold greatest relevance to the present research. Trainees' reluctance to discuss touch may reflect use of the façade¹, which is concerned with the deliberate concealment of information due to fears of exposure, humiliation or personal repercussions. Similarly, therapists' tendency to wait for clients to raise the subject of pregnancy (i.e., maintenance of the traditional blank screen) reflects use of the façade. Trainees' inclusion of touch in therapy may therefore represent a potential blind spot, with the majority reporting spontaneous inclusion of touch, either at the clients' bequest or their own initiation. Speculatively, could high levels of client complaints regarding inopportune touch indicate a systemic blind spot, whereby health professionals lack sufficient understanding of when and how to use touch? However, unlike therapeutic touch, discussion of pregnancy has a clear time imperative that prevents long-term use of the façade and forces the subject into the 'open'. Thus, primiparous therapists' (and supervisors') decisions to delay disclosure become blind spots, contributing to poor client relationships and therapeutic outcomes.

Future Research

Missing Perspectives

¹ Although interview participation represents a deliberate lowering of the façade, due to methodological safeguards, trainees' views receive only partial visibility.

While both the empirical and review papers explore issues from the perspectives of the clinician, the parallel experiences of clients are sparse in the wider literature. Only one comparative study to date details the clients' experiences of pregnant therapists (McCluskey, 2017) while the clients' perspective of touch in therapy remains absent from the literature. Indeed, when selecting the focus for the empirical study, I considered interviewing clients who had experienced therapist touch. Early discussions highlighted numerous methodological and ethical concerns, including that clients' experience of touch in therapy might have been fleeting, leaving little to discuss in interview. While the prospect of limited interview data led to the eventual decision to interview trainees; in retrospect, this rationale was potentially short sighted: the modal number of touch experiences discussed by trainees was three, and yet the interviews proved a rich pursuit, emphasising (as one may expect from qualitative research) that quantity does not equate to quality.

Preoccupation with appropriateness of touch appears to be focussed within the Western hemisphere, especially in cultures such as the UK and America. By contrast, the acceptability of touch in non-western cultures has rarely been examined (Joshi, Almeida & Shete, 2010), highlighting the need for transcultural perspectives. Further research should also examine whether clinician gender and clinical specialty influences touch practices.

The meta-synthesis focused upon exploring the professional experiences encountered by therapists during pregnancy. By virtue of the included studies, rather than meta-synthesis design, this analysis centred on the experiences of therapists who carried successful pregnancies while other undesirable pregnancy outcomes were

undocumented. Indeed, although one therapist in Fenster's (1983) prospective study suffered a stillbirth, the experiences of the bereaved therapist were excluded from the analysis. While literature provides a cursory exploration of therapist miscarriage (Cullington-Roberts, 2004) and stillbirth (Korenis & Billick, 2014), these studies focus upon the subsequent impact for clients. Research examining the therapists' management of other adverse pregnancy outcomes (e.g., pregnancy loss, congenital disorders, child disability) therefore warrants further examination.

Methodological Alternatives

Interestingly, both studies detailed a preference to discuss issues with colleagues over supervisors. As the empirical study indicates, emergent subthemes such as trainee inferiority, hierarchical admonishment and supervisory evaluation point towards underlying power dynamics in influencing trainees' touch decisions. Foucauldian Discourse analysis, which considers all experiences as located within wider power structures and practices (Hook, 2007), may offer a useful alternative methodology with which to re-evaluate the present findings, and should be considered for future touch research.

Considering the nascence of meta-synthesis research, it was important to include a study quality measure. However, as the CASP (2017) does not promote the use of a scoring system to assess study quality, this led to the inclusion of a comparatively poor-quality study that did not audio-record or transcribe interviews (Matozzo, 2000), thus questioning the utility of the CASP. Future endeavours could consider the adequacy of such measures or develop more rigorous tools for meta-syntheses.

Clinical Implications

This section touches upon areas of shared (and neglected) clinical importance for both papers: open dialogue, supervision, and teaching. Finally, concluding thoughts are detailed.

Professional Silence

It is worth impressing that the absence of a touch dialogue does not equate to a lack of touch in clinical practice: all nine trainees reported using touch, three of whom reported doing so in the presence of supervisors. This suggests that touch may actually occur at quite a high frequency during clinical training, emphasising the futility of professional silence. Similarly, the reported propensity of pregnant therapists' supervisors to skirt the personal and therapeutic ramifications of pregnancy indicates a lack of awareness, which is likely perpetuated by the lack of professional guidance. Without the development of new frameworks and legislature, these important professional issues are likely to remain taboo; preventing exploration of the potential added value to clinical practice, and precluding opportunities to improve supervision, training and clinical practices.

Supervisory Oversight

The absence of supervisory input is notable across both papers. Trainee descriptions indicated that the concealment of supervisors' own touch perspectives, in combination with fears of admonishment and personal liability, contributed to their reticence to initiate touch discussions. This points towards the potential value of supervisory self-disclosures in enhancing trainees' willingness to initiate and engage in conversations that may feel personally incriminating (Ancis & Marshall, 2010). Indeed, pregnant

therapists reported that the most helpful supervisors detailed their own pregnancy experiences and welcomed exploration of the impact on therapy. It is however acknowledged that supervisory self-disclosures may also mark a departure from usual practice, requiring additional support and guidance. This may be especially necessary for supervisors of male trainees, who may be particularly fearful of discussing touch due to potential allegations of sexual misconduct. However, given the increasing deconstruction of gender stereotypes, it is important for supervisors to remain mindful that these concerns apply to all. Circular and reflexive questioning may be helpful to guide supervisory discussions and inform clinical decision-making (Tomm, 1988; cited in Halpern, 2009).

Training Opportunities

Recent advances in experimental touch research may provide opportunities to incorporate touch instruction within training curricula. Jakubiak and Feeney (2016) found that imagining and describing the supportive touch of a close friend or loved one led to greater state security than visualising the location of the interaction (control). The study used a standardised protocol to manipulate the imagery conditions, and thus holds similarities to other established visualisation techniques such as imagery rescripting (Young, Klosko & Weishaar, 2003) and compassionate imagery (Gilbert, 2009). Alongside enhancing professional dialogue, incorporating teaching on imagined touch may hold several advantages, including: touch remains at the clients' discretion and therefore may bypass conventional risks associated with physical touch. Further, this may create opportunities to offer standardised touch tuition, whilst circumventing possible issues relating to teachers' own touch anxieties. However, whether such paradigms sufficiently address therapeutic power dynamics

and bypass the potential clinical losses associated with touch abstention requires further review.

Pregnant therapists similarly lamented the lack of literature and training available on the therapeutic impact of pregnancy. Seminars that examine issues involved in therapist pregnancy, such as increased client aggression and the need for pregnancy exploration and disclosure should be prioritised, given the composition of clinical training programmes. Further, training co-production with service user representatives offers novel opportunities to gain wider perspectives and ask direct questions pertaining to both issues, and thus should be incorporated within teaching syllabuses and other training organisations.

Concluding Thoughts

Arguably, it is very difficult for individual therapists to initiate conversations when existing professional narratives are either overwhelmingly negative (touch) or where no narrative seemingly exists (pregnancy). In relation to both subjects, there is a compelling need for enhanced professional guidance to support workers who are currently struggling alone. The lack of explicit dialogue only functions to push issues underground, it does not preclude difficulties from arising: trainees (and health professionals in general) continue to use touch and women get pregnant. However, without sufficient support, both risk making poor clinical decisions that jeopardise therapeutic efficacy, fidelity, rapport, and arguably, should things go awry, tarnish the reputation of themselves and the wider profession. What these under-examined issues require, therefore, is a professional renaissance via training, research, supervision and

professional guidance, providing fresh opportunities to discuss, learn and profit from emerging new discourses.

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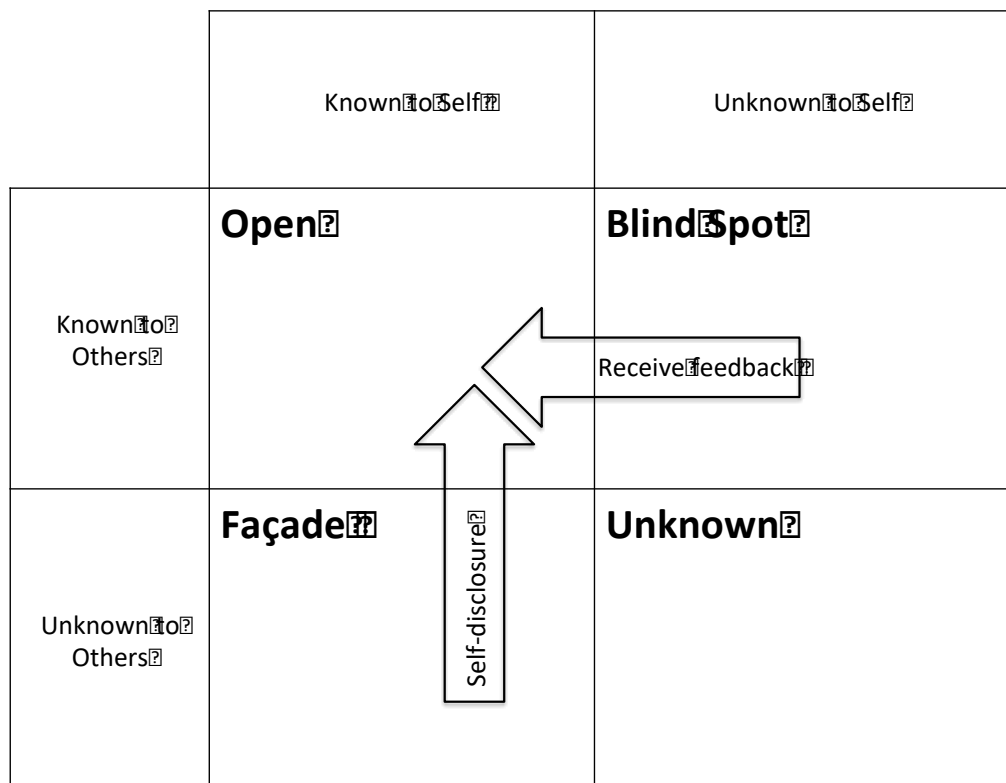
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Appendix 1

Diagram 1: Johari Window



Adapted from Luft and Ingram (1955).

Four quadrants are created based upon what information is known, or unknown, to the self and other:

1. **Open**: known to both
2. **Blind Spot**: known to others, unknown to self
3. **Façade**: known to self, unknown to others
4. **Unknown**: unknown to both

The model holds that information may be communicated directly, or indirectly (e.g. via body language, intonation, omission). The processes of self-disclosure and provision of feedback are proposed to reduce Façades and Blind Spots, respectively, enhancing shared understanding.

SECTION 5: Ethics Appendix

Application for Ethical Approval from School of Psychology, Bangor University

Application for Ethical Approval

Project Title: What are trainee clinical psychologists perspectives and experiences of touch in the therapeutic relationship?

Principal investigator: Way, Caroline

Other researchers: Lamers, Carolien, Rickard, Renee

Pre-screen Questions

Type of Project

D.Clin.Psy

What is the broad area of research

Clinical/Health

Further details: Psychology

Funding body

Internally Funded

Further details: Expenses requested from North Wales Clinical Psychology Programme, as part of the trainee clinical psychologist's research budget.

Type of application (check all that apply)

Study in the area of health and social care requiring sponsorship from BU

Further details: D.Clin.Psy Large Scale Research Project.

Proposed methodology (check all that apply)

Questionnaires and Interviews

Further details: Qualitative study utilising Interpretative Phenomenological Analysis (IPA) methodology and semi-structured interview with supporting brief demographic questionnaire.

Do you plan to include any of the following groups in your study?

Further details: None of the above

Does your project require use of any of the following facilities and, if so, has the protocol been reviewed by the appropriate expert/safety panel? If yes please complete Part 2:B

Further details: None of the above

If your research requires any of the following facilities MRI, TMS/ tCS, Neurology Panel, has the protocol been reviewed by the appropriate expert/safety panel?

Not applicable (the research does not require special safety panel approval)

Connection to Psychology, (i.e. why Psychology should sponsor the question)

Investigator is a staff member in Psychology (including the North Wales Clinical Psychology Programme)

Further details: The main researcher is a trainee clinical psychologist completing the Large Scale Research Project as partial requirement for D.Clin.Psy on the North Wales Clinical Psychology Programme. The study is interested in ascertaining the perspectives and experiences of trainee clinical psychologists. The research is supervised by Dr Carolien Lamers and Dr Renee Rickard, clinical psychologists and staff members of the North Wales Clinical Psychology Programme.

Does the research involve NHS patients? (NB: If you are conducting research that requires NHS ethics approval make sure to consult the Psychology Guidelines as you may not need to complete all sections of the Psychology online application)

No

Has this proposal been reviewed by another Bangor University Ethics committee?

No

NHS checklist. Does your study involve any of the following?

Any change to, impact on or assessment of, NHS treatment.. Use of NHS Staff or resources e.g. recruitment through the NHS, access to Medical records, use of premises etc.

Further details: Trainee clinical psychologists from other University training programmes will be recruited as participants for the present research. By virtue of their position as trainees, trainee clinical psychologists are enrolled as students in Universities that offer the D.Clin.Psy qualification, as well as working in the NHS. Therefore trainee clinical psychologists from several different Universities who are presently reading for the D.Clin.Psy qualification will be invited to participate. Semi-structured interviews are proposed to take place at participants' own University.

Part 1: Ethical Considerations

Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?

Yes

Further details: The purpose of the study will be transparent. Participants will be invited to take part in this qualitative study which will explore trainee clinical psychologists' perspectives and experiences of touch in therapeutic relationship.

Will you tell participants that their participation is voluntary?

Yes

Further details: The voluntary and non-obligatory nature of participation will be explained both in writing and verbally prior to commencing each interview and will be explicitly stated in both the participant information sheet and the consent form.

Will you obtain written consent for participation?

Yes

Further details: Written consent will be sought for all participants and will be a prerequisite for study participation. Both the main researcher and the participant will retain a signed copy of the completed consent form. Participants will be given opportunities to ask all questions that they may have prior to giving consent.

If the research is observational, will you ask participants for their consent to being observed?

N/A

Will you tell participants that they may withdraw from the research at any time and for any reason?

Yes

Further details: The optional nature of the research will be explained both in writing on the participant information sheet, consent form and verbally prior to commencing the interview (see interview schedule document). Participants will be assured that there are no untoward consequences associated with withdrawing from the research at any time, and that this will not affect their D.Clin.Psy training or relationship with the University. Participants will also be informed that should they decide to withdraw from the research that their audio-recorded interview will be destroyed along with all personal data that was collected for research purposes.

With questionnaires, will you give participants the option of omitting questions they do not want to answer?

N/A

Further details: Questionnaires will not be administered. Participants will be asked some demographic information relating to their D.Clin.Psy training experiences as part of the interview schedule. However, as per the whole interview schedule, participants will be told in writing (see demographic information sheet) that all questions are optional.

Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?

Yes

Further details: Participants will be assured that their data will be treated with full confidentiality both verbally and in writing (participant information sheet, consent form and demographic information sheet). Should the research be published, direct quotes may be used to illustrate key themes of the research. In all cases, pseudonyms will be used to anonymously acknowledge which participant contributed the chosen excerpt. Participants will be made fully aware of this prior to participation and will be a prerequisite of participation (see consent form).

Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?

Yes

Further details: Participants will be thanked for their cooperation and invited to ask any questions they may have following participation, which may include a more detailed explanation of the research. All questions will be answered as fully as possible. The main researcher will provide additional study information as requested (e.g. background literature on the topic of study). Following participation all participants will be provided with a debrief information sheet which includes the main researcher's contact details should they wish to gain further information in the future.

Will your project involve deliberately misleading participants in any way?

No

Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort? If *Yes* , give details and state what you will tell them to do should they experience any problems (e.g., who they can contact for help)

No

Further details: The likelihood of participants experiencing distress as a result of study participation is considered low. In the unlikely event that a participant were to become distressed or uncomfortable during the research, the interview would be paused and they would be asked whether they would like to postpone or terminate their participation. All participants will be encouraged to contact a member of their respective D.Clin.Psy teaching staff or University counselling service should they feel distressed (please see debrief information sheet). In the unlikely circumstance that a participant should disclose inappropriately touching a client, or being inappropriately touched themselves, this would be escalated to the project supervisors. In this instance, a member of the research team will contact the participant to inform them of any further action that is required. Participants will be aware of this exception to confidentiality verbally prior to study participation (interview schedule document) and in writing (participant information sheet).

Is there any realistic risk of any participants experiencing discomfort or risk to health, subsequent illness or injury that might require medical or psychological treatment as a result of the procedures?

No

Further details: No risk to health is anticipated as a result of study participation.

Does your project involve work with animals? If *Yes* please complete Part 2: B

No

Does your project involve payment to participants that differs from the normal rates? Is there significant concern that the level of payment you offer for this study will unduly influence participants to agree to procedures they may otherwise find unacceptable? If *Yes* please complete Part 2: B and explain in point 5 of the full protocol

No

Further details: Participants will be offered a £10 gift voucher funded by the NWCPP research budget as an incentive to participate. It is hoped that this will encourage participation in a study where the subject of interest is not widely discussed in the published literature. As the study only seeks to explore participants' existing perspectives and experiences (rather than influence responses), this is not anticipated to affect the study findings or unduly influence participants.

If your study involves children under 18 years of age have you made adequate provision for child protection issues in your protocol?

N/A

If your study involves people with learning difficulties have you made adequate provision to manage distress?

N/A

If your study involves participants covered by the Mental Capacity Act (i.e. adults over 16 years of age who lack the mental capacity to make specific decisions for themselves) do you have appropriate consent procedures in place? NB Some research involving participants who lack capacity will require review by an NHS REC. If you are unsure about whether this applies to your study, please contact the Ethics Administrator in the first instance

N/A

If your study involves patients have you made adequate provision to manage distress?

N/A

Does your study involve people in custody?

No

If your study involves participants recruited from one of the Neurology Patient Panels or the Psychiatry Patient Panel then has the protocol been reviewed by the appropriate expert/safety panel?

N/A

If your study includes physically vulnerable adults have you ensured that there will be a person trained in CPR and seizure management at hand at all times during testing?

N/A

Is there significant potential risk to investigator(s) of allegations being made against the investigator(s). (e.g., through work with vulnerable populations or context of research)?

No

Further details: The research will be fully supervised by Dr Carolien Lamers and Dr Renee Rickard, Clinical Psychologists and NWCPP staff members. Interviews will be audio-recorded and transcribed verbatim and participant consent forms and personal data will be stored securely in line with University policy. These safeguards will therefore provide an accurate record of the present research.

Is there significant potential risk to the institution in any way? (e.g., controversy or potential for misuse of research findings.)

No

Part 3: Risk Assessment

Is there significant potential risk to participants of adverse effects?

No

Further details: No adverse effects as a result of study participation are anticipated.

Is there significant potential risk to participants of distress?

No

Further details: No significant potential of distress resulting from study participation is anticipated. Following participation, a debrief information sheet will be provided that would encourage participants to seek additional support as required.

Is there significant potential risk to participants for persisting or subsequent illness or injury that might require medical or psychological treatment?

No

Is there significant potential risk to investigator(s) of violence or other harm to the investigator(s) (e.g., through work with particular populations or through context of research)?

No

Further details: Participants by nature of their role as trainee clinical psychologists will have full DBS clearance. They are therefore not considered to pose a risk to the researcher. To further reduce the potential for risk, interviews will be conducted on University grounds, during working hours. The main researcher will inform the project supervisors of all meeting times with prospective participants in advance, and will be able to contact the supervisors by telephone. The main researcher will utilise personal supervision as required.

Is there significant potential risk to other members of staff or students at the institution? (e.g., reception or other staff required to deal with violent or vulnerable populations.)

No

Does the research involve the investigator(s) working under any of the following conditions: alone; away from the School; after-hours; or on weekends?

Yes

Further details: Interviews will be conducted within office hours at the convenience of participants. Potential risks include: Conducting interviews at University locations previously unknown to the main researcher. This is considered necessary in order to maximise recruitment. How the risk will be addressed: The main researcher will inform the project supervisors of all arranged meetings with participants in advance, communicating the time and location of the interviews. Should the times of planned meetings change, the main researcher will communicate this to the project supervisors. The main researcher will carry personal identification at all times. The main researcher will endeavour to familiarise themselves with any unknown locations prior to meeting participants. The main researcher will request the support of university administrators in procuring appropriate and safe locations to hold participant interviews. The main researcher will telephone a project supervisor before and after meeting each participant. If the main researcher does not contact the project supervisors by the anticipated finish time of an interview, the project supervisor will contact the main researcher directly. In the circumstance that the main researcher cannot be reached by telephone, the project supervisors will take appropriate action in line with lone worker policy.

Does the experimental procedure involve touching participants?

No

Further details: Touch is not required. Handshakes may be instigated by participants as a formality.

Does the research involve disabled participants or children visiting the School?

No

Declaration

Declaration of ethical compliance: This research project will be carried out in accordance with the guidelines laid down by the British Psychological Society and the procedures determined by the School of Psychology at Bangor. I understand that I am responsible for the ethical conduct of the research. I confirm that I am aware of the requirements of the Data Protection Act and the University's Data Protection Policy, and that this research will comply with them.

Yes

Declaration of risk assessment The potential risks to the investigator(s) for this research project have been fully reviewed and discussed. As an investigator, I understand that I am responsible for managing my safety and that of participants throughout this research. I will immediately report any adverse events that occur as a consequence of this research.

Yes

Declaration of conflict of interest: To my knowledge, there is no conflict of interest on my part in carrying out this research.

Yes

Part 2: A

The potential value of addressing this issue

Further details: The use of touch within the therapeutic relationship is a divisive issue for Clinical Psychologists. Without definitive professional guidance, there remains a lack of consensus surrounding the use of touch and its appropriateness within the therapeutic relationship. Research is beginning to explore the reasons why clinical psychologists and other health professionals chose to implement touch and with whom. Trainee clinical psychologists represent a group of professionals who are beginning to establish their careers. Therefore clinical experience is likely to have been gained from within the current health climate, which may reflect service wide reticence regarding the use of touch (Westland, 2011). To date, research has not explored the perspectives and experiences of trainee clinical psychologists in relation to therapeutic touch. Therefore the present study looks to extend the current literature by capturing the perspectives and experiences of trainee clinical psychologists. Gaining insights from clinical trainee psychologists may provide greater understanding of current perspectives relating to the use of touch in the emerging workforce, and the opportunity to identify potential areas for greater instruction. The reductionist dialogue on the use of touch is reflected in the widespread use of questionnaire and survey methods to assess professionals' views and experiences of touch (e.g. Stenzel Rupert, 2004; Pope Vetter, 1992). Despite this, a few qualitative studies have emerged and shown that touch is something that professionals do want to discuss (Harrison, 2009) and receive supervision on (Phelan, 2009). However, fear of accusations of professional misconduct may lead health professionals to underplay their use of touch in conversations with others (Tune, 2001; 2005), obscuring outstanding training needs and reducing opportunities for constructive discussion with colleagues or supervisors (Westland, 2011). The current research therefore looks to explore the previously unexamined experiences and perspectives of trainee clinical psychologists regarding touch, adding to the existing literature and developing new insights into this important therapeutic area.

Hypotheses

Further details: This research aims to explore how trainee clinical psychologists make sense of their experiences related to touch in the therapeutic relationship. As this research is exploratory, there are not any hypotheses which it seeks to test. Instead, through in-depth data analysis key themes and questions may emerge which in turn may shape the study findings and conclusions.

Participants recruitment. Please attach consent and debrief forms with supporting documents

Further details: The present study looks to recruit trainee clinical psychologists from D.Clin.Psy University training courses. Training courses will be contacted and recruitment will be facilitated with the support of the programme research directors from the respective Universities. A selection of template University contact letters have been compiled to facilitate participants' access and recruitment process (University contact letter, University further information letter, University no response letter, University research packs letter). Trainee clinical psychologists from across all three years of training will be invited to participate, with no further inclusion or exclusion criteria. This is hoped to maximise the recruitment strategy.

Research methodology

Further details: The present study looks to utilise Interpretative Phenomenological Analysis (IPA; Smith, 1996). IPA looks to gain an understanding of how participant's experience or understanding colours their views on a specific phenomena of interest. In this instance, IPA was selected for its appropriateness to the research question, a previously unstudied area that calls for in depth exploration. As with all qualitative analysis, participant feedback is subject to the researcher's interpretation, which is explicitly acknowledged in IPA and considered to be a key feature of the analysis. IPA lends itself well to semi-structured interview methodologies which look to gain an in depth understanding of the lived experiences of participants. From close and detailed engagement with participant's narratives, idiographic insights may be developed, leading to shared themes across participant accounts. A self-constructed semi-structured interview schedule forms the key

study measures. The interview schedule was informally piloted with a fellow trainee clinical psychologist on the NWCPP to ensure that the schedule sufficiently captured rich and meaningful data relating to trainees experiences and views about touch. On the basis of the informal feedback, slight amendments to the interview schedule were made, contributing to its current format. Interview questions are open ended to encourage more detailed responses. Probe (follow up) questions may be used to unearth further views if needed (Kreuger, 2002). Initial demographic information (age, gender) and information relating to training experience (year of study, placement experience, therapeutic orientations used) will also be collected at the time of interview (see demographic information sheet).

Estimated start date and duration of the study.

Further details: 01/03/2016 - 01/09/2017. As this research is being completed as partial fulfilment of the main researchers requirements for Doctorate in Clinical Psychology (D.Clin.Psy), recruitment will be completed by May 2017 at the very latest.

For studies recruiting via SONA or advertising for participants in any way please provide a summary of how participants will be informed about the study in the advertisement. N.B. This should be a brief factual description of the study and what participants will be required to do.

Further details: N/A

Part 2: B

Brief background to the study

The hypotheses

Participants: recruitment methods, age, gender, exclusion/inclusion criteria

Research design

Procedures employed

Measures employed

Qualifications of the investigators to use the measures (Where working with children or vulnerable adults, please include information on investigators' CRB disclosures here.)

Venue for investigation

Estimated start date and duration of the study (N.B. If you know that the research is likely to continue for more than three years, please indicate this here).

Data analysis

Potential offence/distress to participants

Procedures to ensure confidentiality and data protection

**How consent is to be obtained (see BPS Guidelines and ensure consent forms are expressed bilingually where appropriate. The University has its own Welsh translations facilities on extension 2036)*

Information for participants (provide actual consent forms and information sheets) including if appropriate, the summary of the study that will appear on SONA to inform participants about the study. N.B. This should be a brief factual description of the study and what participants will be required to do.

Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)

Payment to: participants, investigators, departments/institutions

Equipment required and its availability

If students will be engaged a project involving children, vulnerable adults, one of the neurology patient panels or the psychiatric patient panel, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

If students will be engaged in a project involving use of MRI or TMS, specify on a separate sheet the arrangements for training and supervision of students. (See guidance notes)

What arrangements are you making to give feedback to participants? The responsibility is yours to provide it, not participants' to request it.

Finally, check your proposal conforms to BPS Guidelines on Ethical Standards in research and sign the declaration. If you have any doubts about this, please outline them.

Part 4: Research Insurance

Is the research to be conducted in the UK?

Yes

Further details: The present research will be conducted at Universities offering the D.Clin.Psy training course. Training courses will be contacted and recruitment will be facilitated with the support of the programme research directors from the respective Universities.

Is the research based solely upon the following methodologies? Psychological activity, Questionnaires, Measurements of physiological processes, Venepuncture, Collections of body secretions by non-invasive methods, The administration by mouth of foods or nutrients or variation of diet other than the administration of drugs or other food supplements

Yes

Further details: The research will utilise qualitative semi structured interview methodology with a brief accompanying demographic questionnaire only.

Research that is based solely upon certain typical methods or paradigms is less problematic from an insurance and risk perspective. Is your research based solely upon one or more of these methodologies? Standard behavioural methods such as questionnaires or interviews, computer-based reaction time measures, standardised tests, eye-tracking, picture-pointing, etc; Measurements of physiological processes such as EEG, MEG, MRI, EMG, heart-rate, GSR (not TMS or tCS as they involve more than simple 'measurement'); Collections of body secretions by non-invasive methods, venepuncture (taking of a blood sample), or asking participants to consume foods and/or nutrients (not including the use of drugs or other food supplements or caffeine).

Yes

Further details: The research will utilise qualitative semi structured interview methodology with a brief accompanying demographic questionnaire only.

Confirmation Email of Bangor University Ethical Approval

Ethical approval granted for 2016-15650 What are trainee clinical psychologists perspectives and experiences of touch in the therapeutic relationship?



ethics@bangor.ac.uk

Mon 04/07/2016 10:16

To: Caroline Esther Naomi Way ^



Reply all | v

Inbox

Dear Caroline,

2016-15650 What are trainee clinical psychologists perspectives and experiences of touch in the therapeutic relationship?

Your research proposal number 2016-15650 has been reviewed by the Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Confirmation of Bangor University Liability Insurance

Hasilwood House
60 Bishopsgate
London EC2N 4AW
Tel: 020 7847 8670
Fax: 020 7847 8689



TO WHOM IT MAY CONCERN

18th July 2016

Dear Sir/Madam

**BANGOR UNIVERSITY
AND ALL ITS SUBSIDIARY COMPANIES**

We confirm that the above Institution is a Member of U.M. Association Limited, and that the following covers are currently in place:-

1. EMPLOYERS' LIABILITY

Certificate No.	Y016458QBE0116A/026
Period of Cover	1 August 2016 to 31 July 2017
Limit of Indemnity	£25,000,000 any one event unlimited in the aggregate.
Includes	Indemnity to Principals
Cover provided by	QBE Insurance (Europe) Limited and Excess Insurers.

2. PUBLIC AND PRODUCTS LIABILITY

Certificate of Entry No.	UM026/95
Period of Cover	1 August 2016 to 31 July 2017
Includes	Indemnity to Principals
Limit Of Indemnity	£50,000,000 any one event and in the aggregate in respect of Products Liability and unlimited in the aggregate in respect of Public Liability.
Cover provided by	U.M. Association Limited and Excess Cover Providers led by QBE Insurance (Europe) Limited

If you have any queries in respect of the above details, please do not hesitate to contact us.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Susan Wilkinson'.

Susan Wilkinson
For U.M. Association Limited



U.M. Association Limited
Registered Office: Hasilwood House, 60 Bishopsgate, London, EC2N 4AW
Registered in England and Wales No. 2731799

Email Correspondence Clarifying Ethical Approval Requirements



Caroline Esther Naomi Way

Mon 25/01/2016, 17:11



Dear **Rossela**,

My name is Caroline Way, I am a trainee clinical psychologist on the North Wales Clinical Psychology Programme. I was hoping to ask you some further questions with regard to clarifying which ethical boards I require approval from in order to undertake my large scale research project. I understand that you may have had a conversation with Mike Jackson on my behalf, however I was hoping to ask you directly in the hope that I could include your reply in an appendix of my thesis.

My project is a qualitative study, looking at trainee clinical psychologists experiences and perspectives on the use of touch in therapy. I plan to utilise semi-structured interviews, supplemented with a brief demographic survey to document their training experiences to date. I hope to recruit trainee clinical psychologists from various university training courses in England (in the first instance, Manchester and possibly Lancaster). I plan to recruit via the Universities and conduct interviews on their premises.

Would it be possible for you to please comment on which ethical committees this project will require approval from. I am happy to provide further information should you require it.

I look forward to your response.

Kind regards,

Caroline

Advice regarding ethical board approval



Rossela Roberts

Tue 26/01/2016, 16:20

Caroline Esther Naomi Way



Inbox

 Action Items

Hello Caroline

I think I remember the project and all you need is the school ethics committee approval, no NHS

Regards

Rossela

Research Forms and Materials

Participant Information Sheet

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SCHOOL OF PSYCHOLOGY

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Participant Information Sheet

Project Title

What are trainee clinical psychologists perspectives and experiences of touch in the therapeutic relationship?

Information about the study

You are invited to participate in this study as you are a trainee clinical psychologist. Trainees are being invited to take part in the study from several training courses in England.

It is important that you are provided with all the necessary information to make an informed decision about whether you wish to take part in this study. Therefore before consenting, please read the enclosed information sheet carefully. If you have any questions regarding this study, please do not hesitate to contact the main researcher, Carrie Way, Trainee Clinical Psychologist (psp4f0@bangor.ac.uk).

Project Background

The use of touch as a therapeutic tool dates back to Freud. One of the most controversial topics in psychotherapy (Smith, Clance & Imes, 1998), decisions about when, how and with whom to use touch in therapy are confusing at best. Literature identifies that dialogue and instruction on the use of touch is a largely overlooked element of most therapists' core training (Phelan, 2009), leading therapists to 'intuit' when it may be most helpful (Harrison, Jones & Huws, 2012).

The British Psychological Society (1998) indicates that "*touch can be acceptable and beneficial, but should be considered carefully*" (Professional Guidelines, section 2.1.2.2). This flexible position towards the use of touch therefore enables clinicians to use their professional judgement to determine whether touch may enhance clients' experience.

Clinical psychologists' personal perspectives on the use of touch vary greatly. For some, the use of touch is never appropriate, whereas for others touch represents an authentic expression of care, with the possibility to convey emotions not easily expressed through the medium of words. Large-scale surveys indicate that touch is generally used sparingly by therapists (Stenzel & Rupert, 2004). However while most therapists initially deny using touch, later probing unearths that touch did occur, mostly during spontaneous interchanges (Tune, 2001; 2005). A recent qualitative study explored the views of qualified clinical psychologists surrounding the use of touch in therapy (Harrison et al., 2012). Participants reported varying degrees of comfort using touch in therapy, with touch primarily occurring between therapists and clients of the same gender.

What is the purpose of this study?

The aim of this study is to explore trainee clinical psychologists' experiences of, and views surrounding the use of touch within a therapeutic relationship. To date, no study has investigated the views and experiences of trainee clinical psychologists on this topic. It is hoped that this study will increase understanding of trainees' experiences and decisions surrounding touch, and identify nuances that are relevant to clinical psychology training.

Research Team

Carrie Way, Trainee Clinical Psychologist
Dr Carolien Lamers, Clinical Psychologist (North Wales Clinical Psychology Programme and Betsi Cadwaladr University Health Board)
Dr Renee Rickard, Clinical Psychologist (North Wales Clinical Psychology Programme and Betsi Cadwaladr University Health Board)

This study forms part of the large scale research project of the main researcher, conducted as part of the Clinical Psychology Doctorate at the North Wales Clinical Psychology Programme (NWCPP).

What does the study involve?

If you decide to participate, you will be asked to sign a consent form and answer a brief demographic questionnaire. You will then be invited to take part in an individual interview about your views and experiences, which will be recorded on a digital audio recorder. The length of the interview will differ from person to person, but on average this takes between thirty minutes and one hour. The interviews will take place in a private room at your University during working hours. You will be given the opportunity to ask any questions you may have about the study. You will also receive a summary of the study findings in due course, should you wish.

Do I have to take part?

No. Your participation is entirely voluntary. You may decide to start the process and withdraw during or following the interview without providing any reason.

What will happen if I do not want to take part?

There will be no untoward consequences if you do not wish to participate, or choose to withdraw at a later stage. Your decision will not affect your training, or relationship with the University.

What are the benefits and risks of participating?

This study provides an opportunity to discuss important professional issues and reflect on your own clinical practice. You will be given a £10 Amazon gift voucher as an incentive for participating. You will receive this voucher regardless of whether you later withdraw from the study.

By participating, you will be contributing to an emerging body of research that has specific relevance to trainee clinical psychologists and therapy training. This research may help to identify areas where trainees could benefit from additional support or guidance in the future. However, there is no guarantee that any suggestions offered will influence current working practice.

There are few anticipated risks of participation. It is possible that discussing views and experiences of touch may be distressing for some participants. Therefore participants will be encouraged to make use of available support services within the University. If a disclosure of inappropriate behaviour towards an NHS patient is made (e.g. sexual behaviour), or if you report that a patient had inappropriately touched you, this would be shared and discussed with the project supervisors to review if further action is required. In this circumstance, a member of the research team would contact you to discuss this in greater detail and determine the appropriate course of action.

What will you do with my personal information?

All personal information will be held in the strictest confidence. A pseudonym will be created for your interview, to avoid using your actual name. If you would like to receive a summary of the study findings, you will be asked to provide contact details prior to commencing the interview. You will not be contacted for any other reason.

Your interview will be transcribed and anonymised. The transcription of your interview will be stored securely using encrypted software on a University laptop. The data will be stored for five years in accordance with Bangor University policy to allow for further analysis and post publication scrutiny.

What will happen with the study findings?

The findings may be submitted to a journal for publication. Findings will be anonymised so that it will not be possible to identify trainees.

Who do I contact if I have any concerns about this study?

If you have any concerns or complaints about this study, or the conduct of the investigators, please contact Mr. Hefin Francis; school manager, School of Psychology, Adeilad Brigantia, Penrallt Road, Bangor, Gwynedd, LL57 2AS. Alternatively, you can email h.francis@bangor.ac.uk or telephone 01248 388339.

Who can provide further information about this study?

Further information is available from the main researcher:

Carrie Way Email: psp4f0@bangor.ac.uk

Trainee Clinical Psychologist
North Wales Clinical Psychology Programme
School of Psychology
Bangor University

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SCHOOL OF PSYCHOLOGY

Gwynedd
LL57 2AS

Alternatively, you may contact the project supervisors:

Dr Carolien Lamers
Clinical Psychologist
NWCPP
School of Psychology
Bangor University
Gwynedd
LL57 2AS

Email: c.lamers@bangor.ac.uk

Dr Renee Rickard
Clinical Psychologist
NWCPP
School of Psychology
Bangor University
Gwynedd
LL57 2AS

Email: r.rickard@bangor.ac.uk

If you would like to take part in this study, please contact the main researcher either by completing the attached opt-in form and post using the freepost envelope enclosed, or email Carrie at **psp4f0@bangor.ac.uk** to arrange a suitable time for an interview.

Thank you for taking the time to read this information sheet. Please keep hold of this information sheet for future reference.

Opt In Form

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Opt-in Form

Thank you for your interest in participating in this study looking at trainee clinical psychologists perspectives and experiences of touch in the therapeutic relationship.

Please complete the following sections and return this form to Carrie Way, main researcher using the pre-stamped envelope provided. Carrie will then contact you to answer any further questions you may have and if you are willing, arrange a suitable time for an interview.

Name: _____

Email address: _____

Telephone number: _____

Preferred contact method (If you would prefer to be contacted by telephone, please state the best times and days to reach you): _____

Can we leave a voice message? Yes/ No

University: _____

Please be assured that if you later decide that you do not want to take part in the study that your personal details will be destroyed and that you will not experience any untoward consequences. Your decision will not affect your training, or relationship with the University.

Participant Consent Form

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Participant Consent Form

Project Title: What are trainee clinical psychologists perspectives and experiences of touch in the therapeutic relationship?

Researchers: Carrie Way, Dr Carolien Lamers & Dr Renee Rickard

Please read the following information and initial each statement as appropriate.

		Please initial
1.	I have read and understood the Participant Information Sheet dated 31.01.2016 (version 1). I have had the opportunity to ask questions and I have received satisfactory answers.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any point without providing notice or reason.	
3.	I agree to my interview being audio recorded for the purposes of transcription and analysis.	
4.	I agree to the inclusion of direct quotes from my interview in the final study findings and any published papers that result from this study. All information will be anonymised as not to compromise confidentiality.	
5.	I agree to take part in the above study.	
6.	When the study has been completed, I would like to receive a summary of the results. I agree to provide my contact details below for this purpose. I understand that following receiving a summary, the researcher will destroy my details.	

Print Name.....Date.....

Signed.....

Contact details:

One copy for the participant, one copy for the researcher.

Version 1 31.01.2016

1

Demographic Information Sheet

COLEG IECHYD A GWYDDORAU YMDDYGIAD
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Demographic Information

This information is being collected as part of the research study. Your personal information will be kept confidential. All questions are optional; please ask Carrie, the main researcher if you have any questions.

Age:

Gender:

Year of DClin Psych study: Year 1 Year 2 Year 3

What placement/s are you currently undertaking:

What placements you have completed so far, if any:

What therapeutic models have you used whilst training:

What therapy training have you completed prior to starting training, if any:

Thank you.

Version 1 31.01.2016

1

Interview Schedule

COLEG IECHYD A GWYDDORAU YMDDYGIAD
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Thank you for agreeing to participate in this study exploring trainee's experiences of touch in therapy. As you are aware, the British Psychological Society (1998) acknowledges that touch can be beneficial to clients. From the published literature, we know that therapists do use touch in therapy, although little is known about when therapists may be most likely to do so or for what reasons. You will therefore be invited to reflect and share your own views and experiences related to touch during your time as a trainee clinical psychologist.

Your interview will be audio-recorded for transcription and analysis. Everything you say will be held in confidence, with the exception of risk to or from a patient. I would like to remind you that your participation is entirely voluntary and that you are free to withdraw from the study at any point, without repercussion.

Do you have any questions?

Interview Schedule

1. What does touch in a therapeutic interaction mean to you? (could touch cover anything else?)
2. What are your views on the use of touch in therapy?
3. Has touch ever occurred between yourself and a client during therapy?
(Could you tell me a bit more about it, what was that like) ('no' → Q6)
 - a. What prompted the touch, if anything?
 - b. Who initiated touch?
4. What was your experience of touch with your client like?
 - a. How did it feel to touch/ be touched by/ your client?

- b. For you, what did that touch mean, if anything? (what did it convey, was anything transmitted or communicated via touch; or was it just a perfunctory behaviour)
 - c. From your point of view, was there any impact of using touch? (prompt: therapeutic relationship, view of self as clinician) (Could you tell me a bit more about it)
- 5. Did you discuss the decision to touch with anyone? (what was that like for you? Did it affect your feelings on using touch?)
- 6. Have there been any times that you wanted to touch a client but didn't? (what stopped you? What was that like for you? Did that create any emotions or thoughts for you?)
 - a. Do you think that not using touch had any impact? (in what way? Rapport, view of self)
- 7. Has anything influenced your views on touch? (teaching on touch, supervision, client response, media)
- 8. What might affect your decision to use touch in the future, if anything? (client group, supervisor, therapeutic relationship, being a trainee)
 - a. Would you feel more or less inclined to use touch with a specific client group?
- 9. Do you have any other examples/ thoughts surrounding the use of touch that you would like to share? (if described a positive experience, have you ever had a less positive experience? Or vice versa)

COLEG IECHYD A GWYDDORAU YMDDYGIAD
COLLEGE OF HEALTH & BEHAVIOURAL SCIENCES

YSGOL SEICOLEG
SCHOOL OF PSYCHOLOGY

Thank you for your participation, do you have any questions?

Study Debrief Form

COLEG IECHYD A GWYDDORAU YMDDYGIAD
COLLEGE OF HEALTH & BEHAVIOURAL SCIENCES

YSGOL SEICOLEG
SCHOOL OF PSYCHOLOGY

RHAGLEN SEICOLEG CLINIGOL GOGLEDD CYMRU
NORTH WALES CLINICAL PSYCHOLOGY PROGRAMME



Study Debrief

Thank you very much for taking part in this study exploring trainee clinical psychologists' experiences of touch in the therapeutic relationship. This research welcomes all trainee views and perspectives on the subject of touch and holds that all perspectives are equally valid. Thank you for sharing your experiences today. Your participation is appreciated and will help to extend knowledge of this under-researched topic.

The audio recording of your interview, along with those of the other participants will now be analysed to synthesise the views and experiences of trainee clinical psychologists. If you indicated prior to taking part that you would like to receive a summary of the key study findings, this will be sent to you in due course.

Should you have any further questions relating to the study, please do not hesitate to contact the main researcher:

Carrie Way
Trainee Clinical Psychologist
North Wales Clinical Psychology Programme
School of Psychology
Bangor University
Gwynedd
LL57 2AS

Email: psp4f0@bangor.ac.uk

We hope that you found participating an interesting and agreeable experience. However, if following taking part you feel in any way distressed we would encourage you to discuss this with your University tutor or supervisor. Alternatively, please contact your University student counselling service.

Thank you for your participation. Please keep this information sheet for your records.

SECTION 6: General Appendices

General Appendix 1: Example of 1st order data analysis for Meta-Synthesis key concept “Therapeutic Challenges”

Removed due to copyright

General Appendix 2: Examples of annotated original study material to demonstrate 2nd order data analysis for Meta-Synthesis

Removed due to copyright

General Appendix 3: Meta-Synthesis Personal Reflexivity Statement

Firstly, it is important to acknowledge that my interest in, and perhaps even my awareness of, the matters involved in providing therapy whilst pregnant would not have come about without my own personal experience of pregnancy.

The meta-synthesis therefore offered otherwise largely unavailable opportunities to vicariously learn from the experiences of others who have been in similar situations, and attempt to bypass some of the therapeutic challenges addressed herein. However, I tried to remain mindful throughout this piece of work, to separate the findings within from those which I personally identified.

As this piece of work was produced across two trimesters of my pregnancy and my maternity leave, my personal interest in various elements of the therapists' experience also varied. For example, in my early post-partum experience when I suffered from mastitis, I was captivated by therapists' descriptions of how client work could require as intensive nourishment as breastfeeding, and could leave them feeling "*like a huge boob*" (Zackson, 2012; p.99). It took significant effort to personally detach myself from this content that I was heavily invested in and refocus on the intention of the meta-synthesis: pregnancy.

One feature of the original study findings that particularly captured my personal experience was that of identity issues. I found many studies to articulate these conflicts very articulately, giving voice to my own experiences. In contrast, my experiences of expressing these most interesting findings to my supervisors left them underwhelmed and disconnected from the meaningfulness I perceived. This gave way to discussions of relevance and subjectivity, leading us to determine that my interest in identity was repeatedly reflected in the literature, which in combination with my own pregnant interest made it worthy of inclusion. Further, it was considered that identity issues were no longer personally salient for my supervisors, thus decreasing their interest.

Remaining connected to the experience of pregnancy was somewhat more challenging when I was post-partum, almost as if the many challenges inherent in pregnancy had already passed me by and had been replaced by new challenges of motherhood. However, this also provided me with a new objectivity, and ability to engage with the material that I found myself consciously distancing myself from during pregnancy. Even the act of reading about baby loss while pregnant felt heavily threatening while the status of my own pregnancy hung in the balance. To this end I found myself prioritising writing methodological and theoretical aspects of the meta-synthesis over engaging with the findings. Further, while every finding seemed highly intriguing during pregnancy, such as therapists struggling to balance demands or the proposed length of maternity leave; these points lost relevance for me overtime, revealing instead the more salient features which formed the basis of the final key concepts.

General Appendix 4: Personal Communication with the British Psychological Society regarding Pregnancy Disclosure

RE: query: self-disclosure

Ethical Enquiries <Ethical.Enquiries@bps.org.uk>

Wed 30/08/2017 13:56

To: Carrie Way <caroline.way@hotmail.com>;

Dear Caroline

I'm afraid we do not issue any guidance on self-disclosure and therefore suggest speaking to your supervisor for information on this.

With best wishes

Ethical enquiries

From: Carrie Way [mailto:caroline.way@hotmail.com]

Sent: 18 August 2017 15:48

To: Ethical Enquiries <Ethical.Enquiries@bps.org.uk>

Subject: Re: query: self-disclosure

Dear Kajal,

Thank you for your response. I apologise if my email was unclear: I am wondering if there are general society guidelines on self disclosure for psychologists - my query is very much a hypothetical one, as I was unable to find any guidance on the bps website myself. Is this as you have suggested, because there is not a specific position on therapist self disclosure held by the BPS? Your clarification would be most appreciated.

Kind regards,

Caroline

On 18 Aug 2017, at 15:39, Ethical Enquiries <Ethical.Enquiries@bps.org.uk> wrote:

Dear Caroline Way

Thank you for your email below.

We would suggest that as you are a Clinical trainee, you speak to your supervisor/line manager for advice as we don't have any guidance on this. Your supervisor/line manager would be the best source of information on this, as they will be able to advise on self-disclosure which is relevant to your work context.

Best wishes

Kajal

From: Carrie Way [<mailto:caroline.way@hotmail.com>]

Sent: 12 August 2017 18:37

To: Ethical Enquiries <Ethical.Enquiries@bps.org.uk>
Subject: query: self-disclosure

Good afternoon,

I have been searching the BPS website and policies for the society's position on therapist self-disclosure, but I am struggling to find any documentation pertaining to this. More specifically, I am looking for guidance on the disclosure of therapist pregnancy - but I imagine this is too specific and not covered by guidelines?

I would be very grateful if you could please direct me to the relevant guidelines or policies which discuss therapist self-disclosure.

With kind regards,

Caroline Way
Trainee Clinical Psychologist
North Wales Clinical Psychology Programme



The British Psychological Society
Promoting excellence in psychology



Ethical Enquiries | Policy Team
St. Andrews House, 48 Princess Road East, Leicester, LE1 7DR
t: +44 (0)116 254 9568 m:
w: www.bps.org.uk

Visit PsychSource, the Society's gateway to a host of online resources for research, teaching and practice in psychology.

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General Appendix 5: Transcript examples illustrating IPA development of superordinate themes:

Secrecy to Confession (transcript examples 1-3), Fear of the External Monitor (4-6) and Conflicting Identities (7-9)

Emergent Themes	Transcript - Izzy p.36	Descriptive Comments	Linguistic Comments	Conceptual Comments
Questioning own hesitation to discuss touch, increasing awareness of silence	And interesting now thinking back how, cos I think often generally in therapy I will like name the stuff that's going on in the room and now I'm thinking back to stuff like that it might have been helpful for me to say "Oh I've noticed that today you're letting me help you with your helmet and I, I, that means I've got to touch your face and I wonder if we would have done that in the first session?" and sort of like saying that outloud and it's just making me think now about how I could like, talk about touch in session a bit more instead of it feeling like, it's always working out whether it's OK and whether it's not and erm, it, avoiding acknowledging it cos it feels like it's not something I've talked about with clients.	Has not been having explicit conversations about touch		Reflecting on what she could do differently – Questioning if she could be more explicit with client about the meaning of touch
Trying to navigate alone			Looses fluency	Is it anxiety provoking thinking about discussing touch more openly? Why? Would being more explicit mean it could be more confronting? for who?
Interview as new opportunity		Considering how she could start to talk openly about touch	'always working out' – perpetual state of uncertainty?	Being explicit may help to reduce uncertainty for everyone – everyone is uncertain about touch? Not just her? Touch is confusing – is it easier to admit if we think everyone is confused by it?
Touch silence			It becomes effortful not talking about touch, purposely absent → why?	Does she worry about how the conversation might go? Reactions of client increased accountability / liability

Emergent Themes	Transcript – Robyn, p.7	Descriptive Comments	Linguistic Comments	Conceptual Comments
Touch tuition limited	Erm I suppose, [exhales] it's something that we spoke about once on training in a communications skills class I'd say somewhere in the first six months of first year erm and it was very, kind of normalising but vague erm advice around kind of obviously it's what you feel comfortable with, it's what you feel might be comfortable in the moment, we would certainly never advocate for what might be deemed socially as inappropriate touch in a therapeutic context but you know it will have to be taken on a case by case basis and always kept open in conversation with you supervisor. Erm and I'm paraphrasing there because it was a while ago now but it felt like a very kind of "okay so this is an issue for psychologists and obviously one we need to think about carefully and you should get time to do that if you want to", but then we never talked about it again [laughs], err as a course and as a in a supervisory capacity on my placements it's certainly not anything that was brought up by any of my supervisors. If I wanted to talk about it then it was something I brought up and in fairness I didn't bring it up a lot because I think there was a, there was a sense that for the most part psychologists don't touch. It's just not my understanding of what's expected of us as a profession.		'Erm' X 3 – talks about need to feel comfortable, is she feeling comfortable?	Mixed messages – touch is important, but we don't talk about it. Why not? What inferences could you draw from this – that it is too large an area to get to grips with, that it is not important for psychologists, that the course doesn't consider it important?
Touch needs to be appropriate				
Trainee onus to discuss with supervisor		Course acknowledges that touch is a complex area but does not provide space to explore it		Could this give impression that touch does not have a place in a clinical role?
Supervisors do not discuss touch		Trainee needs to raise touch with supervisors; supervisors do not discuss touch otherwise.	Laughter – recognises irony	Major sources of teaching and instruction for trainees (course and supervisors) rarely discuss touch, if at all. What messages does this send about the acceptability of receptivity to discuss touch? Could infer that touch cannot be talked about, contribute to a silence and lack of dialogue- teaches trainees that touch is not part of their role.
Psychologists don't touch			There was a sense for the most part psychologists don't touch → "sense" → inferred, invited – not explicitly told	
Professionally unacceptable				

Emergent Themes	Transcript - Martha p.36	Descriptive Comments	Linguistic Comments	Conceptual Comments
Touch anxiety provoking	CW: and what was it like for you when this lady hugged you? Um. It was fine, I think it was, you know, it was, we kind of understood why that was important for her. Erm, and I think I probably felt OK	Lots of hesitance describing experience of touch. Touch as fine. Looses fluency	Says touch is 'fine', but does not seem certain	Stating that touch was fine, but loss of clarity in speech - discussing touch as anxiety provoking?
anxiety discussing use of touch	I don't think, I mean I guess, I'm just trying to see if I felt any, if my mind kind of jumped to 'did I feel uncomfortable about it' and I	Could it be bad if she looked forward to touch? Could this indicate an ulterior motive → worried how it may sound / come across to others?	Loss of fluency – anxiety 'we' → sharing responsibility? Lots of uncertainty and doubt about how she feels	Is it important to say that she wasn't looking forward to touch? For my benefit? Or another reason? Fear that if said otherwise that this could have repercussions?
awareness of touch monitoring?	didn't it just, yeah just OK really. I suppose is how I would describe it. Just um, not something that I was kind of looking forward to I would say, or something that with any form of touch I don't-	Disclosing touch is fear provoking → fear of how touch may be viewed – need to justify position.	Loss of clarity of speech	
Professes not to enjoy touch – not professional to enjoy?	you have to think about it carefully.	Touch needs to be carefully considered.	Emphasises that touch is not gratifying for her in any way	Returns to a stricter narrative – that touch needs to be used sparingly – is it important to state this? Concern about how touch will be construed

Emergent Themes	Transcript – Daisy p.12 – 13	Descriptive Comments	Linguistic Comments	Conceptual Comments
Touch as connective, symbolic	Erm so I guess, I guess it's almost a little bit of a confirmation that what you think about how the client has managed they actually feel that as well erm so that that was quite nice I was kind of pleased to know that our work had been helpful and really pleased for her that she felt that way if that kinda makes sense so in that sense it was really like really positive. Erm and I suppose then what crept in was more like I suppose like doubt [laughs] like self doubt maybe erm, yeah. Yeah not even like kind of criticism of myself like I'd done something wrong I didn't feel like I had but erm like doubting whether someone else would agree [laughs] I suppose yeah. CW: Right right [quietly] And whether somebody in a position to tell me that I'd done the wrong thing would agree yeah	Receiving touch affirms that client found therapeutic work helpful	'I guess, I guess' – not entirely certain.	Still trying to work out the meaning / significance of touch
Touch communicates positive feeling			'what you think' → distancing language to describe touch encounter	Confronting to talk about first hand touch experiences? Why?
Anxiety discussing own use of touch		Self-doubt regarding appropriateness of touch	focuses on clients experience of therapy / touch as opposed to reflecting on what it was like for her receiving touch	Therapist prerogative to focus on client experience, is that easier than discussing own lived experience
Touch is monitored			'crept in' → creeping, sneaky, stealthy, covert, unexpected experience laughter – anxious?	Negative affective reaction to touch – unexpected
Touch as wrong		Concern about what others would think about touch encounter in therapy	Somebody – who? Unclear, unknown external monitor	Uncomfortable considering that others may judge her decision to accept touch –
Expectation/fear of admonishment		Expect to be told by others that touch is wrong	'in a position' → what position? Something about power / status? Are some people more able to pass judgement than others?	expectation of judgement – touch is unacceptable fear of external judgement
			'wrong thing' – touch as bad	

Emergent Themes	Transcript – Chloe p.6	Descriptive Comments	Linguistic Comments	Conceptual Comments
	CW: when you use touch. Could you say a bit more about that Chlöe?	Touch needs to be used carefully		Is it more comfortable to talk hypothetically about touch?
Touch intended may not be touch received	Yeah I suppose careful in terms of errr the effect it could have on a person recipient but also careful in terms of erm well the effect it could have on them and as a result of that	Touch can effect therapeutic relationship	‘person recipient’ - talking about who she could touch – very non-specific – keeps things very hypothetical	What would it be like to talk about touch directly?
Others judge use of touch	the effect it could have on your therapeutic relationship but also if somebody saw you you I suppose	Others may consider use of touch inappropriate	‘somebody’ – who? unknown? Vague, couldn’t it be anybody? ‘you you’ - emphasises self as vulnerable	Touch possesses the power to influence therapeutic relationship – in which direction?
Fear of external monitor	it’s important to, for it not to be deemed inappropriate so you wouldn’t touch someone	Touch could be misconstrued	‘deemed inappropriate’ – expectation of judgement	Others have the power to pass judgement regarding touch
Fear of judgement	inappropriately anyway in an inappropriate place but if somebody	Touch can be taken out of context	‘inappropriate / inappropriately ‘ repeated → emphasising awarene of how touch could be misconstrued	
Touch as inappropriate	witnessed you using touch therapeutically and didn’t know the context that could be misconstrued	Need for caution		Fear that others would say she was inappropriate for using touch - fear of repercussions?
Defends own touch use	so that’s what I mean about being careful not to over step it, being careful, I don’t know how you are careful.		‘witnessed’ → a witness, used in a court of law, able to take a stand and be a reliable informant	Touch as dangerous uncertainty about the ‘rules’ for using touch
Need for self-protection via touch abstention			careful x3 = emphasises need for caution	

Emergent Themes	Transcript – Olive, p.28	Descriptive Comments	Linguistic Comments	Conceptual Comments
Desire for overt guidance	I guess maybe then, maybe that in the rise of complexity sometimes we like rules to make things a bit easier or you know less complex because you know so maybe people take a rule about appropriate boundaries and just apply that across the board cos to have I guess to have this con- this level of conversation about every individual, or think about it in that way that if you've got a lot of people that you work with maybe because that, I'm saying that like about other people but I'm talking about myself perhaps then I apply a rule to make that a bit clear- or a bit easier to manage that touch isn't errr, touch blurs things for everyone [laughs] because it's more complicated to think about it maybe for each individual or the therapeutic relationships' super complex and therefore maybe I give myself some rules erm to make me feel a bit more contained within thinking about therapy, I don't know.	Rules make things simpler so they can be applied universally	Touch blurs things for everyone, touch as opaque	Not using touch makes it easier to navigate different identities → does not blur the boundaries – also for clients – can stick to identity as client, not friend or potential lover
Questioning what is appropriate			Sentences incomplete, reflects lack of clarity/ lack of guidance	This amount of time discussing touch is rare
Touch needs careful consideration				touch is confusing, especially without clear guidance, abstention is safer?
Anxiety?			Language 'you', 'people' distancing techniques, but owns it. Acknowledging that this is what she does	Penny dropping
Touch abstention makes therapy easier for her		It could be overwhelming if considered each case individually – easier for her to implement a blanket rule that applies to everyone	Answer reflects my earlier question	Touch is complicated and therefore easier not to have to consider on an individual basis. Acknowledges applying 'appropriate boundaries' without consideration is a shortcut for her. Requires less mental exertion. It's like having a snap judgement or a stereotype, timesaving – prevents mental exhaustion.
Touch abstention gives her safety				

Emergent Themes	Transcript – Theo p.47	Descriptive Comments	Linguistic Comments	Conceptual Comments
Touch deprivation as therapeutically harmful	And in not doing the touching part of it I have I sometimes felt like ‘and this is exactly how your mum would have reacted when you were crying’, which is just to sit here and almost felt a bit kind of like impotent in a way, like I could, I feel like you know, I may have something which helps, which may, which might be to you know, put my hand on your shoulder and say “yeah it’s rubbish isn’t it” or whatever. And that might be useful right now but I’m not going to do it I’m going to hold out on you; because I’m worried. Which feels pretty rubbish as somebody’s who’s employed to be a helping, caring person.	Equates not touching with early relationship patterns	Be passive. Without power, prowess, feel helpless–takes a passive position. Belief client is aware ‘you know’	Awareness that touch neglect could be recreating feelings and experiences of rejection in client
Touch as valuable/helpful				
Trainee prioritises self over client	And that might be useful right now but I’m not going to do it I’m going to hold out on you; because I’m worried. Which feels pretty rubbish as somebody’s who’s employed to be a helping, caring person.	touch on shoulder	Hold out on, be rejecting, not meet needs, be selfish. Shame?	Feels like he has no choice – but acknowledges it does exist – remorse at lacking courage
Guilt for touch abstention	You know it almost feels so weird to kind of not go through with that. Like I’ll be caring up to a point, but I won’t. And obviously there are ways that you can interpret that which I’m sure there are very good reasons for these sort of strict lines and whatever but, but I feel like it’s too far over the safety – risk side at the moment. Erm, so yeah I’ve felt like I’ve, I’ve been letting people down I guess, erm, so.	Conscious decision not to touch	Details what touch would look like – fear of misinterpretation?	Awareness that fear of personal accountability is overriding responsibility to client
Touch is a professional red line		Limits to Helping	Awareness of status does this make it worse? Feeling that he is not meeting his occupational responsibilities?	Aware of the conflict, paradox
Touch dialogues as too risk-averse – loss of humanity		Professional guidelines risk averse	‘to be’ → to play – does not feel is living up to role. Backwards, odd, peculiar, Nonsensical	
Laments lack of touch			Letting people down – unable to do job without touch?	

Emergent Themes	Transcript – Grace p.27	Descriptive Comments	Linguistic Comments	Conceptual Comments
Withholding touch unnatural	You know, she'll be like that with them but they're not going to be like that with me you know cos I'm a different kinda like person like I'm not as tuned in or something I'm some other kinda you know I'm going to interpret it in the wrong way or you know I'm not I'm thinking about how is she going to see that other people could have read her you know I'm putting myself in the mind of like some one who could feel yeah it could feel quite isolative and that sense of I'm not of course you know I'm mad so they're not gonna you know give me a hug because obviously if if they give me a hug I'll think it's something way more than what it is you know it's kinda so I think there's also if you're not being kinda just natural with someone then you're like you're leaving you're showing them you're not there is a difference here do you know like erm either you're not deserving of my touch or you're not it's not you can't handle it[laughs] do you know? You're going to do something weird with it you know you're gonna erm yeah you're gonna somehow make it not, yeah I think it really can increase that sense of I'm stuck on the other side of the you know of the wall do you know certainly with that lady so yeah I guess that's what.	How she envisages client would feel if she were to withhold touch	Collective pronouns used to illustrate how client may feel that lack of touch is symbolic of their difference.	Lack of touch indicates difference between trainee ad client
Touch intended not touch received			'not as tuned in' – on a different wavelength – some things being lost in communication?	The absence of touch may be as harmful for the therapeutic relationship and the clients' self-concept
Withholding touch in therapy amplifies power differentials in therapy		Withholding touch may be stigmatising or make the client feel ostracised	Very strong inferences being made from lack of touch – 'you know I'm mad...obviously'	The omission of touch may have as many implications and ramifications as its inclusion?
Not touching therapeutically damaging, rejecting		Not touching perceived by clients as sign that they are different – cannot be trusted with touch.	Not being natural – withholding touch unnatural?	Not touching increases power differentials
Client judgement		Not touching can enhance power differentials	You're not there – withholding touch prevents relating to clients – connection Something weird – misinterpret touch in someway? Make it not – what? Appropriate? 'the wall' – not touching creates a barrier, something unscaleable – makes additional obstacles in therapy	Touch transcends language Touching represents having a respect for the person, measure of equality As many risks that touch may be misinterpreted if withhold as if you give - touch as powerful considers that not touching can increase therapeutic distance – so would touching enhance therapeutic connection?

Emergent Themes	Transcript – Libby p.44	Descriptive Comments	Linguistic Comments	Conceptual Comments
Developing a professional identity during training	Erm, thats an interesting one, like I say LD for me is that area erm, but then I don't know if that's because that was the area I was kinda most competent in before I came to training so maybe my professional identity in that sense is more developed than for other areas that I've found my feet in what I feel is appropriate and comfortable in that sense, whereas I guess things like erm, more traditional adult therapy I hadn't had a lot of experience in before starting training so my identity in that sense is still very much developing, erm and influenced by the limited number of supervisors I've had and the way that they work I guess. Erm... probably it I think.	Professional identity develops at different paces	'kinda most competent' doubting degree of competence?	Is competence important? Does competence form part of professional identity?
Professionalism means being appropriate		Professional identity related to appropriateness and competence	Professional identity – how many senses / identities are there? Found my feet – need for a secure grounding and developing from the roots up	Does professional identity emerge as becomes more competent?
Possibility of multiple identities		Professional identity less developed in other specialisms	My identity – owned, personal, self-concept, view of self	Own definition of appropriate – what is that? Professional identity includes concepts of appropriateness and being comfortable in own decision making. Is touch not appropriate? Or not professional because doesn't feel competent?
Developing own concept of professional identity		Supervisors' working styles influences development of own professional identity	Language emphasises lack of experience – 'hadn't had a lot'; 'limited number of supervisors' → recognising limits of own experience / competence?	How does ones' identity develop? Via which processes? Identity is shaped through supervisory modelling – how she sees herself as a professional is heavily influenced by supervisor's conduct – vicarious learning experiences – does this include views on touch?
Supervisors highly influential in development of identity and perception of professional conduct				

General Appendix 6: Researchers' a priori Touch Assumptions

- Touch is valuable and has the potential to be powerfully facilitative in therapy
- Touch could be misconstrued by clients and lead to complaints
- Supervisors ultimately take responsibility for trainees' clinical decisions during training, therefore trainees have an additional safeguard surrounding their clinical practice
- Trainees will endorse a full spectrum of perspectives on touch, ranging from abhorrence to full endorsement
- Not everyone will have used touch, or be willing to acknowledge it if they have
- Touch is symbolic in therapy
- The clinical setting and client group may influence decisions to use touch
- Touch occurs more frequently than clinicians acknowledge
- Not all touch is equal: touch may serve different purposes, such as functional touch or affective touch
- Touch provokes clinician anxiety
- Touch is a 'grey area' where straightforward 'blacks and whites' of therapy do not apply
- Qualified clinical psychologists may have more consistent working practices regarding touch compared to trainees, who maybe more willing to experiment with different approaches regarding touch

General Appendix 7: Excerpt from Reflective Diary

Reflections on Interview

Friday 19th August 2016

- Initially I felt nervous – surprised at what the rooms looked like, no windows, quite like a cell – did not feel therapeutic at all (hard for me to separate therapy and research) – so I set up two seating stations – one at a table, one just chairs opposite each other
- Went to collect the trainee participant, surprised by how tall she was, very well put together, air of confidence, competence, professionalism
- Discussion of shared places and people, I felt taken aback – this is not an insular process
- She opted for the interview across a table – felt like an interview – I found this uncomfortable, tried to reduce the formality by hiding the pad and pen under the table
- Initially I thought her scope was quite narrow about touch, but also not clearly defined, not fully thought through. Sense that I repeated questions to try and prompt her to give more which perhaps she would not have done otherwise
- Eye contact just to the side, slightly disconcerting, but friendly
- Some touch is ‘natural’, but the rest is? What? Wish I had thought to ask this at the time...
- Very compliant. I wonder if I led her to consider touch more for my benefit, rather than accepting the scope of her views as they stood (however, I suppose that this helped to flesh out the parameters of her thinking process, and see what she had considered and what were new concepts)
- Sense that I did not want to make notes (or that I could not make them without this being obvious? That this would make me look deskilled?) Felt that she talked in quite long sound bites – what did I miss?
- She shook my hand upon meeting me – seemed perfunctory, proper – not something that we were sharing the significance of – I was already thinking of what it must be like to shake her hand if I was her client... professional, cold?
- Belittling of some touch, frightened of other touch. Does this make touch insignificant, or powerful?
- When discussing AMH she noted awareness that touch could be re-traumatising, but when discussing more generally my sense was that she was afraid for the repercussions for her as primary – could touch not be beneficial? Not just natural but humane?
- Thinking that I do not have the restraint and foresight that she does about long-term impact, or is this just a excuse?
- She had not had her own therapy- therefore role of clinical teaching much more important, or intimates the lack of it to mean that it is not OK to use touch
- Not spoken about means not OK. Interesting what implicit messages are taken away without courses being aware of this. What else might trainees

be drawing conclusions about without being expressly discussed? Would the same implicit messages be heard if they had positive connotations?

- ‘I had no problem discussing with the supervisor’ – my gut reaction is that this is not the full truth – I couldn’t imagine being so forthright and not feel scared, certainly not “fine”. Could this be to do with my own use of touch? Or her compass to do things by the book (from her perspective) removing any potential grey areas
- I have no idea how it may have felt for her clients to be touched or not touched – interview schedule does not cover this. I experienced her touch as an extension of how I experienced her: proper, conservative, distanced. Quite GP- like (not meant as an insult!) ... and then following the interview she sends me a paper on GPs use of touch!!! Is this her working model for touch? Paper shows that GPs who have to touch to do their job are still worried about personal repercussions – if this is the template for her understanding of how professionals should view touch (especially in the absence of clinical teaching on touch), as perfunctory? Could I expect her to draw any other conclusion? Published literature and supervision may both be formative (in the absence of teaching) – but only if they go looking for it – what does it mean that she knew about this? Was she looking because she was worried about touch? Or because she wanted to be helpful to the research and me? Perhaps if she had no interest at all in finding out more than she would not have participated.
- Is it possible that different peoples’ touch feels different because of the person? Perhaps only people that believe in the value of touch ought to be using it, it transmits how they feel. Perhaps whatever added value touch may bring (if any) is lost if it is communicated by someone who doesn’t really want to/ doesn’t believe in it? Perfunctory is not the same? Not all touch is equal?
- Could her touch usage reflect attachment styles? Her own? Awareness of clients?
- She was married. She must touch others outside of therapy. How might this differ to touch within therapy?
- What will become of this research if everyone is so hesitant and reserved in both discussing and using touch? I think this could be boring (both in terms of findings, and for me personally – am I in the minority?).

Word Count Statement

<u>Thesis Component</u>	<u>Word Count</u>
Thesis Abstract	292
Literature Review	8,062
Empirical Paper	7,044
Contributions to Theory and Clinical Practice	3,031
Word count excluding tables, figures, reference lists and appendices TOTAL:	18,419

Figures, Tables, Reference Lists, and General Appendices

Literature Review References	1,056
Literature Review Appendix 1 (PRISMA Diagram)	11
Literature Review Appendix 2 (CASP Checklist)	245
Literature Review Appendix 3 (Study Information Table)	1,203
Literature Review Appendix 4 (Key Concept Endorsement Table)	114
Empirical Paper References	939
Empirical Paper Tables	12
Contributions to Theory and Clinical Practice References	439
Contributions to Theory and Clinical Practice Appendix 1 (Johari Window)	112
General Appendix 1 (Meta-Synthesis 1 st Order Data Analysis)	19
General Appendix 2 (Meta-Synthesis 2 nd Order Data Analysis)	21
General Appendix 3 (Personal Reflexivity Statement)	460
General Appendix 4 (BPS Personal Communication)	13
General Appendix 5 (IPA Transcript Examples)	3,421

General Appendix 6 (Researchers' Assumptions)	167
General Appendix 7 (Reflective Diary)	870
Appendices including figures, tables and reference lists, excluding ethics appendices TOTAL:	9,102
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Total Word Count	27,521
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