

INTERNATIONAL JOURNAL  
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*In This Issue:*

**CAN MEDICINE BE PRACTICED  
WITHOUT TOUCHING  
THE PATIENT PHYSICALLY?**

**A NEW LOOK AT  
PSYCHOTHERAPY**

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## A STATEMENT OF PURPOSE

This Journal is part of the general program of The Bar-Levav Educational Association (BLEA) to advance the science of psychotherapy and the understanding of the hidden forces that shape individuals and societies. Such an understanding is derived from our clinical work and is useful in the on-going treatment of patients. Additionally it has been found to have wider implications in practically all areas of human endeavor.

Learning to think critically requires first that we make room for it by diminishing the domain of feelings. Feelings have the power to bend thinking and to distort one's view of reality.

The ability to think critically develops only in the absence of fear and with freedom from the dictatorship of other feelings. This Journal is dedicated to examining psychotherapy and human behavior and motivation with the yardstick of critical thought.

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All articles reflect the point of view of the respective writers. They are not necessarily those of the Bar-Levav Educational Association. We invite readers of any ideology bent to participate in the discussion of topics presented in this Journal. Subject to the availability of space, we will publish all thoughtful comments.

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Please see page 29 for subscription information.

## INTRODUCTION TO THIS ISSUE

### Can Medicine Be Practiced Without Touching the Patient Physically? A New Look at Psychotherapy

Why even ask the question? Was it not established long ago that in psychotherapy touching a patient physically will muddy the transference, and may even give rise to its erotic form?

We are reexamining this issue because the answers have been so well established and so long ago. They are generally accepted as firm fact. But many old answers and solutions become invalid. In light of new understanding some certainties always have to go. This is the nature of progress. Scientific knowledge is not exempt.

The rise of the biologic approach in psychiatry is not only the result of a better understanding of the microstructure of the brain and pharmacological discoveries. It also comes from the widespread disappointment in the outcomes of psychoanalysis and psychotherapy. They remain imprisoned by long established ideas that were a scientific breakthrough at the end of the 19th century, but not at the end of the 20th. Now many of these are anachronistic and wrong.

We are at the verge of a true revolution in our ability to treat emotional illnesses. Everyone prefers, and is more comfortable with, evolutionary change. Revolutions disturb us and the status quo. But there really is no better word to describe what is already happening in our field. The mere asking of the question we are posing here is a part of this revolution, and thus we raise it out of a sense of obligation to advance psychotherapy knowledge and competence. The science of psychotherapy that was so brilliantly fathered by Freud demands that we all join hands in the effort to improve our results. This can only be achieved by examining relevant issues with as much objectivity as we can muster. The welfare of our patients demands no less.

The Editors

# A RATIONALE FOR PHYSICAL TOUCHING IN PSYCHOTHERAPY

by Reuven Bar-Levav, M.D.

Our patients in the 1990's are not really sicker than those of the 1890's. But the pace of our life is faster. Our moral and behavioral codes are looser. Our families sustain the individual less well. And we have much more freedom to act out. Vienna of 100 years ago was tight-lipped and straight-laced. The emotional illnesses today are more blatant. We are not treating nice neurotic patients.

It is much clearer now that the basic source of their anxiety is not Oedipal trauma but the preverbal experiences they had as newborns and infants. For almost two years each of us lived in such darkness before consciousness or memory existed. We had many frightening physical experiences during that time, but no ability to understand any of them. Most of these were objectively safe, but we could not know it. The nerve fibers of our cortex were not yet fully myelinated, and this part of our brain was not yet functional (Bar-Levav, 1988).

But nothing is lost in the universe. We survived, and within us survived traces of those early experiences. For the rest of our days each of us lives with the same chance physiologic response patterns that were associated with our survival. In adulthood we often react as if we were in danger, when in fact no danger exists. Similarly, old hurt and preverbal rage are easily stimulated in adulthood by mildly hurtful or annoying experiences. Our body reacts in the present to signals from another age, long ago. The messages are wrong, but our body does not know it. Such "incorrect" responses are the cause of most adult difficulties and failures. These wrong messages are not sent by the cortex, the organ of understanding. They are issued instead by the sub-cortical brain, the one that controlled the autonomic nervous system at the very beginning and which sustains life thereafter.

Explanations to the cortex are therefore useless. It is not the source of the trouble and not in charge here. Patients understand, gain insight and agree with our interpretations and reconstructions, but they do not change as a result. Even in "talking" therapies the body and its physiologic patterns must be altered. Not our thinking.

Until recently this appeared to be an impossible task. How can we ever know what happened before the patient had any memory and any consciousness? We cannot know it from what the patient says. But we can deduce it from what the patient is, and what he or she shows characterologically and characteristically. Our new knowledge of early infant development is also useful.

The basic human experience is universally the same. Individual differences exist only in the details. We know, for instance, why Spitz's babies died in England, even though they never told us. They were not mothered properly. They were carefully attended to, fed and changed, but this was not enough. And how were

they not mothered properly? They were not held and touched enough, and not well enough (Spitz, 1957). They literally wilted and died.

Everything that newborns and infants know about the universe they learn through their physical sensations. Orality is only one route. And not always the most important one. Our sense of safety comes from the softness, firmness, consistency and steadiness of the mothering body. Most commonly this refers to the biological mother, but not necessarily.

If Mother is immature and anxious the baby knows its world as jerky and jumpy, or as stifling and crushing. Such mothers typically hold their babies either too loosely, lest they be crushed, or too tightly lest they slip and fall. Or Mother might cling to her baby to lessen her own anxiety. Either way, the young organism "knows" the world through such experiences. And this remains its "knowledge" for life, unless it is modified by good, long-term psychotherapy that addresses and changes such physiologic expectations.

But how do we address and change such preverbal "knowledge"? Surely not by talking from our cortex to the patient's. It is done by repeatedly establishing exquisite contact with the distrustful and scared infant within the adult patient. We persist until the fragile inner baby begins to feel safe in the therapeutic setting. Only then do patients drop their socially acceptable ways of being and of behaving. The affects and physical reactions of early preverbal experiences then bubble up and come to the surface.

This also happens in marriages and this is what often destroys them. The expectations that result from the feelings that bubble up are not satisfiable in any reality. And such affects come up in real-relationships with compassionate, consistent and competent psychotherapists who earn the patients' trust over time. But only if a strict non-acting contract is in place. Such primitive and powerful affects remain in hiding unless the environment is experienced as totally safe. The emerging affects represent emotional experiences from the period of normal autism soon after birth and, strictly speaking, they are therefore not transference.

Experiencing such affects early in life or many years later is obviously not the same: only the adult patient is in a position to observe the panic, the deep hurt and the extreme rage even while they are bubbling up. This is the critical difference. It makes resolution of the earliest autistic horrors possible. It becomes clear even to very disturbed patients that the enormously powerful storms of affect are not a function of the therapist or of the therapeutic setting. Here it's safe. All is well in reality.

Although propelled by powerful wishes to escape, to withdraw or to lash out, none of these in fact occur as long as the non-acting contract holds. In the meantime the body's musculature, physiology and sub-cortical brain are slowly "trained" to recognize that the information imbedded in them is wrong. Not having the powers of observation of the cortex, they are slow learners.

Patients must repeat such affective hurricanes many times before the wrong messages are no longer sent and received. The feelings finally change too. This is the essence of psychotherapy that heals depression. No wonder that such a process is tedious and takes a very long time. But real personality and character change are now an achievable goal. Living essentially without anxiety and depression is possible.

Physical touch with the explicit permission of the patient each time anew is the most reassuring intervention when the body undergoes such hurricanes. They are often experienced as literally life-threatening. Every patient naturally always wants to avoid them, or to escape from them as soon as possible. Verbal reassurance is not always enough.

A firm but gentle touch at the right moment allows a patient to endure such experiences of extreme panic and pain without bolting. It intensifies the deep sobbing of hurt. It allows patients not to limit their powerful expressions of rage. These are always very frightening, and especially so for patients who have never had room to express any protest openly. Many people, including professionals, confuse the verbal expression of rage with acts of violence or aggression. They fear losing control. Patients sometimes need a hand, literally, not to curb such safe expressions of rage. Repressing affects cripples effectiveness in general.

The laying-on of hands was always considered to be helpful in medicine. It is not hocus-pocus. It is not magic. The scared infant within the sick adult patient was always reassured by the touching hands of a physician. This often saved lives when no specific treatments existed.

Forbidding touch on the basis of the possibility of stimulating an erotic transference essentially reflects the fears in the therapist. Though it is often expressed as a generally accepted fact, such an assumption is also theoretically incorrect. The yearning of a patient for the therapist's love is not sexual. Such yearnings for affection are not even embarrassing when seen for what they really are: yearnings of the panicky infant to be mothered safely and perfectly.

We must make room for such yearnings and welcome their open and full expression. They are a necessary step on the road to self-mothering. Proceeding on this road often requires a gentle, obviously non-sexual, touch on the forearm or on the shoulder. More than any number of wise words, it speaks louder, more clearly and more directly to the patient's confusion and fear.

#### References

1. Bar-Levav, Reuven. (1988). *Thinking in the Shadow of Feelings*. Simon and Schuster.
2. Spitz, R.A. (1957). *A Genetic Field Theory of Ego Formation*. International Universities Press.

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Reuven Bar-Levav, M.D., is a psychotherapist, teacher and author of *Thinking in the Shadow of Feelings*, Simon and Schuster, 1988 and of over two hundred other articles. He is also the father of Crisis Mobilization Therapy, the founder of the Michigan Group Psychotherapy Society, and a contributing editor of *VOICES*.

## WHAT IS THE BLEA TUESDAY SEMINAR?

A BLEA post-graduate clinical psychotherapy seminar has been held in Detroit every week for over fifteen years, always from 12:00 Noon to 2:00 P.M. Practical issues of patient management have been supplemented by theoretical examinations of the nature of psychotherapy and human behavior in general. The Socratic method of teaching has usually been used. Seminar participants have been challenged to think critically and to examine afresh their own, and everyone else's, opinions and statements. We have grown together in our expertise and in our ability to understand and to enunciate the rationale, techniques, and methods of our clinical work.

The BLEA Tuesday Seminar has thus been and is a laboratory in which new ideas are tested. Carefully prepared assignments are presented by seminar participants from questions handed out the week before. The answers are read aloud, discussed, critiqued, and sometimes heatedly debated.

There is now a chance for you, the reader, to also benefit from this stimulating experience. Each issue of the Journal, devoted to one Tuesday Seminar topic, will bring to you the questions asked and some of the responses. In this our first issue, we examine the highly charged issue of physical touch in psychotherapy. What follows are the assignments and some of the answers which were presented over a four-week period. Your thoughtful responses in 250 words or less are welcome and, if suitable, will be published in a future issue. The deadline for responses to this issue is February 1, 1994.

# BLEA TUESDAY SEMINAR

## Can Medicine Be Practiced Without Touching the Patient Physically? A New Look at Psychotherapy

### ASSIGNMENT FOR TUESDAY, MAY 26TH:

1. Psychoanalysis and psychotherapy in general exclude any physical touching between therapist and patient and consider it to be wrong. Consult the literature and write a concise statement that supports this position.
2. Throughout the history of medicine, physicians often had very little to offer patients besides the reassurance that came from their "fatherly" presence. This often was most effectively expressed by the "laying on of hands." Find older people to tell you of the subjective meaning of such an experience and add whatever you know personally from your experiences as a child or as an adult on this subject.

The total of your answers should not exceed 250 words.

### ASSIGNMENT FOR TUESDAY, JUNE 2ND:

1. Why touch and why not touch?
2. When to touch and when not to touch?

The total of your answers should not exceed 250 words.

### ASSIGNMENT FOR TUESDAY, JUNE 9TH:

1. How and where to touch?
2. How and where not to touch?

The total of your answers should not exceed 250 words.

### ASSIGNMENT FOR TUESDAY, JUNE 16TH:

1. What does physical touching do to the:
  - A. Levels of experienced anxiety?
  - B. Levels of expressed anxiety?
  - C. Levels of experienced pre-verbal yearnings?
  - D. Levels of expressed pre-verbal yearnings?
  - E. Continuation and outcome of therapy?

The total of your answers should not exceed 250 words.

# BLEA'S TUESDAY SEMINAR

## ASSIGNMENT FOR TUESDAY, MAY 26TH:

1. Psychoanalysis and psychotherapy in general exclude any physical touching between therapist and patient and consider it to be wrong. Consult the literature and write a concise statement that supports this position.

In 1910, Freud wrote, "The patient should be kept in a state of abstinence or unrequited love...the more affection you allow him, the more readily you reach his complexes, but the less definite the result." Physical touch compromises the analyst's personal neutrality, interrupting the blossoming of the transference. Transference gratification interferes with the working through and it supports an indefinite continuation of treatment.

Marcia B. Stein, M.S.W.

Successful analysis of the transference and of the infantile yearnings which fuel it depends critically upon the strict non-gratification of those yearnings. Physical contact of any kind is likely to gratify those yearnings, which then become unavailable to work with. As Robert Langs declares emphatically, "...there will be no physical contact...other than the handshake with which the patient is greeted at the time of the initial consultation, and perhaps a handshake at the time of an extended vacation or at termination" (Robert Langs, *Psychotherapy: A Basic Text*, p. 429). Violation of this "essential point [will] without fail [lead] into areas of unconscious collusion" (p. 307) and contaminate the therapeutic neutrality of the analyst.

Paul P. Shultz, M.S.W.

2. Throughout the history of medicine, physicians often had very little to offer patients besides the reassurance that came from their "fatherly" presence. This often was most effectively expressed by the "laying on of hands" Find older people to tell you of the subjective meaning of such an experience and add whatever you know personally from your experience as a child or as an adult on this subject.

My mother welcomed the doctor's visit to her sick child as her mother had, shaking his hand at the door. Even the towel he touched was special. The child was expected to politely accept all touches and pokes from the revered personage. Following the examination, the doctor and my mother spoke in low, serious tones. My previously worried mother would return to my room seeming to have had a burden lifted from her. The doctor's reassurance had transferenceal meanings of a good mother or father soothing her fears.

Pamela Torracco, M.S.W.

The year was 1902, the patient was ten and the diagnosis, diphtheria. Before antibiotics and immunizations this disease often meant death, especially for children. The family doctor made a house call when the child worsened and his prescription was two teaspoons of whiskey every two hours to keep her throat open.

What was most remembered were his daily visits; his reassuring bedside manner, the gentle hand on her forehead to check her temperature and his cool hand to check her pulse and breathing.

The year was 1941 and I was seven; still no antibiotics and the diagnosis, trench mouth. My throat and mouth were covered with sores and a foul smelling substance. Isolated from my family, the only treatment was hourly mouth washes and visits every few days to my doctor's office. There he examined me and prescribed more mouth wash. I remember his firm but gentle hands as he held my sore mouth open. After three more weeks of no resolution with a steady hand on my chin, the doctor swabbed a burning solution in my mouth. It stung but the sore, foul smelling disease went away. I remember the burning solution but the steady hand which applied it has equal weight in my memory.

Victor R. Stoeffler, M.S.W.

"Laying on of hands" has been much discussed as beneficial and "possibly curative" during my training as an Osteopathic physician. I spent many hours in training sessions, both touching and being touched in a medical setting by fellow classmates while learning the various physical manipulative techniques. Though in theory, the procedures were involved with spinal and bone structure misalignment, the "laying on of hands" was in itself, a powerful influence on "the treatment." I noticed it in myself during these training sessions and others stated they noticed the same phenomena too. I was not surprised to see the relaxed and satisfied appearance of an older established practitioner's patients after such treatments with him.

Lester Potempa, D.O.



#### ASSIGNMENT FOR TUESDAY, JUNE 2ND:

##### 1. Why touch and why not touch?

Touch is one of the earliest means of communication available to human beings after birth and therefore is often capable of reaching the "visceral brain" of patients more immediately and successfully than words or visual cues. It is also one of the first means by which primitive boundaries between self and other are developed. Physical touch can therefore be a powerful tool for helping a patient regain a sense of self and reality when fear temporarily overwhelms the integrity of patients' ego boundaries. Touch is indicated for the patient who is in a temporary state of heightened fear, inaccessible to contact through verbal and visual interventions and, nonetheless, also observant of being involved in a therapeutic process. Touch at such times can lessen the fear enough to allow the patient to make or regain contact with themselves and therefore others.

Leora Bar-Levav, M.D.

##### Why Touch?

An obvious conclusion from the Harlow monkey experiments is that touch more than feeding, has a profound effect on infants. The fearful infant needs physical

contact for reassurance and maturational advancement. Left to his own body he will "opt" to seal off contact with others and with his own feelings as a method of emotional survival.

For some this becomes a "hardening" of their personality. Others appear more depressed and resigned, the physical defense being less rigid, more lethargic. Still others become loose-bounded and spew their impulses. Well-executed touch can settle the anxious body which is in the way of meaningful contact.

#### Why not Touch?

1. Because it will be confused by the dependent personality as a reward for regression.
2. Because it can confuse those with weak boundaries to such an extent that it becomes an unmanageable situation.
3. Because the therapist has many occasions to feel impotent and at such times will unconsciously want to use this powerful tool for his own relief and not for the patient's benefit.

Ronald J. Hook, M.S.W.

A psychotherapist should not physically touch a patient if he lacks either a theoretical model that provides a tool for deciding when and why to touch, or if the therapist's own personal boundaries are incompetent to the task. Physical contact should never be used by the therapist to provide comfort to a suffering patient, or to satisfy infantile yearnings. Nor should it be used if the patient is likely to interpret touch that way, regardless of the therapist's intent. Only when there is in place a real relationship, based on a solid therapeutic contract, is it appropriate to touch.

Paul P. Shultz, M.S.W.

#### 2. When to touch and when not to touch?

Only experienced therapists should use physical techniques and only after they have mastered non-physical "holding" techniques and have a clear understanding of physiologic memory.

A clear contract separating feelings and thoughts must be in effect. No action, including physical touching, must ever be permitted based on emotional reactions but only on rational thought processes. Permission must always be requested and granted before any touch occurs.

Touching should generally occur in the therapy group where the experiencing and integration of such experiences can be done with peers present.

Touch is only one of many possible interventions an experienced therapist has at his disposal at any one moment. Before it is used, its value should be weighed along with other possibilities. Since all people harbor yearnings to be touched and held, even experienced therapists can momentarily over-identify with a patient and hold him or her at the wrong time for the wrong reasons. Touching must never be used to gratify infantile wishes. It is never indicated because it

"feels good" to either patient or therapist or because the therapist does not know what else to do.

Pamela Torracco, M.S.W.

#### When to Touch?

Touch when several conditions are met:

1. The therapist is freed from his own need to touch or be touched.
2. When all other valid interventions are determined not to be effective.
3. When the alliance is secure and the boundaries are clear enough.
4. When it is evident that early character defenses are operating beyond the capacity of self-observation and the will to affect them.
5. Only when the patient has granted permission.

#### When not to Touch?

1. When the patient is regressed.
2. When the patient's character presentation is of the dependent type.
3. When the therapist is feeling powerless or needy.
4. When the therapist is momentarily unable to provide adequate scientific rationale.
5. If there is sexual confusion on the part of the therapist or the patient.

Ronald J. Hook, M.S.W.

If in doubt, better not to touch. Other means to reach a patient are safer when the therapist is not sure. A patient with abuse in his/her history, especially sexual abuse, should not be touched. With a patient likely to read supernatural powers into the therapist's touch, physical contact should be avoided.

Annikki M. Kurvi, M.S.W.



#### ASSIGNMENT FOR TUESDAY, JUNE 9TH:

1. How and where to touch?

Where and how, where not and how not to touch a patient can be determined in each situation given an adequate theoretical model, correct diagnosis of the patient's needs, and competent personal boundaries of the therapist. Thus equipped, the therapist is ready to face the ever-changing clinical situation with its many surprises, adjusting his interventions accordingly. Generally speaking, physical manipulation or contact should be used to work directly with muscular armor defending against feelings the patient can usefully experience more strongly.

Physical manipulation or touch, only with the patient's consent, should always be with the patient's immediate needs clearly in mind, firmly but gently allowing him to go beyond the block by providing both the mothering reassurance of physical touch, and the forceful fathering encouragement to "let go" of muscular tension.

Physical contact should always avoid sensitive body parts, such as the eyes, and any place on the body which is typically associated with sexual longings. Care must be given to the idiosyncratic meanings certain areas of the body may have for a patient. It must never resemble either a lover's caress or an enemy's physical assault to either patient or therapist, yet be neither too gentle nor too forceful to allow the block to release.

Paul P. Shultz, M.S.W.

The therapist's touch must always be deliberate, not casual, and he or she should be able to clearly describe, before touching, the specific purpose of that particular kind of touch at that particular time. Tentative or stroking touches feed the transference rather than awakening dormant affects in the presence of an observing ego. Obviously, no touching of the genitals or breasts is ever permitted.

The therapist's hands, like those of the surgeon, are the most versatile organs of touch. They can be finely manipulated to calibrate placement and pressure. The deliberate nature of the planned movements of experienced hands and fingers is likely to encourage physiologic safety while maintaining the real relationship.

The therapist's arms and lap are the most powerful parts of his or her body which can come into contact with the patient's body. Strong physiologic memories of safety or danger are easily evoked when an adult body is actually held, due to the similarity to infancy thus evoked. Such interventions must be carefully timed and not overused.

Since breathing is essential to full expressions of feeling, touch can be helpful in blockages to full inhalation and/or exhalation. A firm hand pressing on the upper chest or back with the other hand holding the mouth open often helps the patient breathe more fully, thus making room for the experiencing of powerful emotions.

Pamela Torracco, M.S.W.

## 2. How and where not to touch?

When touch is the indicated intervention, the therapist should proceed by first obtaining the patient's explicit consent. Touch should never be spontaneous or sexual in nature and is best done in a group setting where others (patients and co-therapists) are present, reducing the possibility for confusion and lending weight to the observing ego. Touch should be firm and deliberate, never tentative, on head, shoulders, arm, neck or back.

It is both unethical and harmful to touch a patient for the conscious gratification of the therapist's yearnings or reduction of the therapist's anxiety. The patient should never be touched on breasts, genitalia or buttocks.

Marcia B. Stein, M.S.W.

How?

Touch to lend safety so that layers of disturbed and tense physiology can relax.

Touch with all parts of your personality, voice, eyes, manner and timing.

Where?

Touch in areas that are least confusing to therapist and patient. The shoulders and forehead are most often associated with comforting and are the locations of choice. For technical reasons, hopefully understood by the patient, one might also touch the jaw or upper chest to encourage uninhibited respiration, since the breath is held to suppress emotion.

How not?

Not with continuous motion or stroking since this only reflects the emotions of the therapist. Not faintly. Not tentatively. Not harshly. Not for the therapist.

Where not?

Not in eroticized areas. Not in sensitive areas which might result in agitation rather than settling. Not in individual sessions.

Ronald J. Hook, M.S.W.

Touch should be firm, assured, respectful of the patient and always in response to a patient's current emotional need. This assumes that a therapist has worked sufficiently with him- or herself to be quite clear that the touch serves the patient rather than the therapist. This also assumes a clinical model that recognizes emotional needs distinct from wants and employs touch as an intervention specific to particular clinical assessment. By contrast, touch should not be used when a therapist simply does not know what else to do. Touch should not be tentative, obviously not hard, but also not too soft; i.e., caressing, which increases the risk of boundary confusion. Generally speaking, touch should be used only in a group setting where extra sets of eyes can witness and help identify any distortion that may exist on the part of the patient or therapist to the manner, timing, or possible motivation for the touch.

Leora Bar-Levav, M.D.



#### ASSIGNMENT FOR TUESDAY, JUNE 16TH:

##### 1A. What does physical touching do to the levels of experienced anxiety?

Physical touch can, and most often does, serve to reassure the anxious person's body and thus reduce the total amount of experienced anxiety in it. In some cases where serious mishandling had taken place in infancy, physical touch may raise the level of experienced anxiety in the short-run since this type of body expects danger connected to physical touch. At the same time, reality testing should begin to take place as a person's body can begin to re-open to touch as reassuring.

Ronald J. Hook, M.S.W.

When properly timed, touching lowers the patient's level of experienced anxiety. This makes it possible to use the therapist's touch as a reminder of current reality. From this position the patient can temporarily distance himself from his usual fears, examine them, and put them in perspective.

Pamela Torracco, M.S.W.

1B. What does physical touching do to the levels of expressed anxiety?

Muscle tension, mental and/or verbal busyness, and other expressed elevated levels of anxiety are lowered by touch. The lessened fear and increased feeling of safety that accompanies a properly timed and executed touch has a relaxing effect which allows emotions previously masked by anxiety to surface.

David B. Fogel, M.D.

The level of expressed anxiety goes down as anxiety diminishes at first, but then it increases as the patient reaches deeper levels of fear. Properly timed touch increases the expression of anxiety as the physiologic defenses give way to the shaking or crying of preverbal fears.

David A. Baker, M.S.W.

Properly timed and executed physical touch temporarily reduces anxiety. But with an increased visceral sense of safety defenses are relaxed and the freedom to sob deeply therefore increases. Anxiety is then more fully expressed also.

Marcia B. Stein, M.S.W.

1C. What does physical touching do to the level of experienced pre-verbal yearnings?

The level of experienced pre-verbal yearnings is heightened as physical touch reminds the body physiology of feelings that were numbed early in life. Lessened anxiety associated with a proper "therapeutic touch" can also allow yearnings close to the surface to be experienced.

David B. Fogel, M.D.

If a patient is already experiencing pre-verbal yearnings, physical touching is likely to gratify them, reduce anxiety, and make it less likely for the patient to observe and talk about his feelings. This retards therapy.

Paul P. Shultz, M.S.W.

Physical touching stimulates and increases the intensity and frequency of experienced preverbal yearnings. Patients often report disturbing memories of deprivation, isolation, and abandonment. Sometimes after touching, patients with "tightly wrapped" preverbal yearnings act out with spouses and therapists; they wish for more contact to gratify their emerging preverbal yearnings.

Natan HarPaz, M.S.W.

1D. What does physical touching do to the level of expressed pre-verbal yearnings?

Touching, over time in therapy, often increases the expression of these pre-verbal yearnings. In conjunction with a strong therapeutic alliance and real relationship the yearnings stimulated by touch eventually can become an acceptable and openly expressed part of the therapeutic relationship.

David B. Fogel, M.D.

Touch, properly timed and executed within the context of a real relationship, reduces anxiety and encourages both a sense of safety and the awakening of pre-verbal yearnings. Given a therapist with secure boundaries who does not fear being the focus of intense feelings, the awakened yearnings are then more fully and directly expressed.

Marcia B. Stein, M.S.W.

1E. What does physical touching do to the continuation and outcome of therapy?

Properly administered touching settles patients, enhances the real-relationship, stimulates pre-verbal yearnings, and reaches the physiology in a way which other methods often do not. The infant within the adult body has an increased sense of safety and this allows a patient to remain observant while experiencing profound fears. Such deep levels of fear, unreachable in verbal therapy alone, can thus be successfully worked through.

David A. Baker, M.S.W.

Used properly, touch stimulates pre-verbal hunger and reassures at a depth far beneath cognition. It is a significant component in the physiologic working through of characterologic difficulties and therefore of the outcome of therapy.

Marcia B. Stein, M.S.W.

# SOME HISTORICAL COMMENTS ON THE ROLE OF TOUCH IN HEALING

Victor R. Stoeffler, M.S.W.

Folklore, folk medicine, the medical profession and other forms of healing throughout history have all used touch in the treatment of sick people. From anthropological studies, we learn that physical and emotional illnesses often have been treated by touch. Eskimo shamans treated injuries by lapping with the tongue. A Navajo singer would touch the sufferer, saying "May he be well" (Brown, 1984). A simple touch by Aboriginal witch doctors was regarded as curative. The father of medical science, Galen, used applications of heat and massage to treat hysteria in women. At his Paris clinic, German physician Franz Mesmer used touch and a form of hypnosis to treat his patients, especially those with hysteria. All of these "cures" probably had much to do with the fact that the laying on of hands by a trustworthy person lowered the patient's anxiety.

Before the emergence of psychotherapy and psychoanalysis as we know them today, psychiatrists treated emotional illness with strictly physical procedures. Until recent years, hydrotherapy and wet packs were standard practice in most hospitals for emotional illness. Freud, who began his career as a biologist and neurologist, treated severely disturbed patients in his early practice by using touch. For seven weeks in 1889 he treated Emmy von N. for severe anxiety neurosis, the symptoms being pain and coldness in her leg. He used hypnosis and massage of her entire body twice a day, reporting that she became calm and quiet and could then speak clearly and directly about herself. Freud also developed a specific technique in which he touched a patient's forehead and applied pressure between the eyes. At other times he would hold the patient's head between his hands. Both techniques, he claimed, helped a patient free associate and get beyond certain unconscious obstacles (Breuer and Freud, 1956).

Since those early years, the traditional psychoanalytic position of having no physical contact with patients has evolved, with Menninger and Wolberg among the more vocal opponents. Menninger (1958) believed that "Transgressions of the rule against physical contact constitute ... evidence of the incompetence or criminal ruthlessness of the analyst," while Wolberg (1977) viewed any physical contact as "absolutely taboo" since it "may mobilize sexual feelings in the patient and therapist or bring forth violent outbursts of anger." Frieda Fromm-Reichmann, on the other hand, holds that there are times when touching is appropriate and therapeutic:

"At times it may be wise and indicated to shake hands with the patient, or in the case of a very disturbed person, to touch him reassuringly or not to refuse his gesture of seeking affection and closeness. However, it is always recommended that one be thrifty with the expression of any physical closeness in one's psychotherapeutic contacts." (Bullard, 1959)

The traditional methods of psychoanalytic psychotherapy were challenged significantly with the advent of the so-called "touching therapies" of Gestalt and

Transactional Analysis in the 1950's and 60's. While Eric Berne, the founder of TA, did not condone touching patients, his followers and students, including Jacqui Schiff, introduced touching as a therapeutic measure. Essentially they believed that physical touching was crucial to intimacy and since it was also part of a "total life experience," needed to be integrated into psychotherapy (Barnes, 1977). Intrinsic to the philosophy of Gestalt therapy developed by Fritz Perls is the view that the body and the self are a unity (Kepner, 1987). With these two therapeutic approaches, touch was brought into the mainstream of modern psychotherapy.

Wilhelm Reich and Alexander Lowen also made important contributions. Reich, originally a student and colleague of Freud, believed that by breaking down the "body armor" and relieving muscle tension, one is freed from the influence of archaic emotions in the body. Lowen, Reich's student, developed Bioenergetics which also uses "body work" and exercises, including touching, to free the body from the influence of repressed emotions.

The debate about touching and not touching has continued through the years. Goodman and Teicher (1988) believed that certain "emotionally and intellectually arrested" patients need to experience the therapist's presence through a judicial touch. They urge restraints, however, for the regressed patient who must use verbal communication in order not to live out his regression. Kertay and Reviere (1993) maintain that not enough attention has been paid to ethical and therapeutic considerations in touching and they list specific guidelines focusing on patient needs and therapist countertransference. Bar-Levav and Kelley have been innovators in the purposefully designed use of touch with patients. Their positions are presented elsewhere in this issue.

As a component in the treatment of emotional illness the issue of physical contact has raised considerable controversy. As responsible practitioners we must continue our search to determine its proper use.

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## Background Points of Theory

### MAN'S EARLIEST BEGINNINGS

- 1. A vague but powerful sense of impending doom in the face of the unknown that was us and everything about us is every person's first experience after birth, always completely out of consciousness. Since we exist in that situation before we have any comprehension of anything, including time, it is a timeless experience. It is felt as eternal. The entire experience has absolutely no meaning for us, no direction, no framework, only dread.
- 2. The sense of dread is the direct and unavoidable result of the newborn's suddenly being thrust into an altogether new environment. After many months of living in a relatively constant and finely regulated setting, it abruptly finds itself under radically new conditions, without any time for transition. It must suddenly adjust to a gaseous environment, totally different from the liquid one in which it existed before. Its physiology must suddenly function in a totally new way.
- 3. Dread or irrational fear is therefore the earliest and often the most persistent companion of every living person. This was not obvious in the past because realistic dangers were much more prominent. Only in modern affluent societies living in peace has Man's physical survival not been constantly under threat. Large and powerful animals do not devour humans anymore, death from hunger or exposure is less common, the Black Plague and other scourges have been wiped out, and lesser illnesses are being treated better than ever. Dread is much more evident these days, since it is no longer so obscured by real danger.

From *A Unified Theory of General Human Motivation and Behavior*  
Chapter 8 of  
*Thinking in the Shadow of Feelings*.

# TOUCHING IN RADIX WORK<sup>1</sup>

Charles R. Kelley, Ph.D.

Radix Education is a program of personal growth involving work with the body. In this it is like Alexander work, Yoga or Feldenkrais work, though it customarily evokes far more feeling. It has always been done in both individual and small group sessions. The student dresses lightly for the session, commonly men in shorts, women in bathing suits, so that the Radix teacher sees and can handle directly most of the student's body. Handling the body is so much a part of Radix work that Radix trainees are asked to take a course in massage to better gain experience as to how different bodies feel. The Radix teacher must understand with his hands the difference between tense, normal, and flaccid muscles. Radix Education is not psychotherapy, but with its special emphasis on freeing tensions in the body that relate to the emotions, is a useful adjunct to it. The presence of so much body contact in Radix work, often of a nature that evokes emotion, makes it worthwhile to examine how it is used and how problems occasioned by it are dealt with, and thus serves as a guide to the use of touching in psychotherapy.

The two central concepts of Radix work are, 1) that there is a life force, a real, natural force and, 2) that there are chronic patterns of muscular tension in the body, the muscular armor, that block the natural activity of the life force, particularly the discharge of emotion. These two concepts derive from the work of Wilhelm Reich, my most important teacher (Reich, 1942). They remain as fundamental to Radix as they were in Reich's own work. Skillful freeing of a pattern of armor in a Radix session results in the release of the blocks and completion of the process that was blocked. Physical touching is usually involved. I give each Radix student this specific instruction regarding touching in their first Radix session:

"I will touch and handle your body freely and sometimes strongly in your Radix session, with the understanding that I have your permission. This is a permission you can withdraw at any time by telling me, or by taking my hand away. I will always respect your ownership of your own body."

This final sentence expresses an underlying principle governing body contact in Radix work. The teacher's attitude should convey respect for the student's ownership of his or her body in every possible way, since the student may have never really learned that he or she is indeed the owner of that body. There is much in our culture that teaches the opposite. The growth of a person's experience of ownership, of autonomy over his body, is sabotaged not only by sexually and physically abusive parents and siblings or parent surrogates, but also by invasive and intrusive toilet training, health care, and educational practices. This concept is also maintained by the archaic but still widespread view that the wife's body is the husband's property.

The opposite side of the coin from the body disrespected by abuse and invasion is

1. From an article published by the author. The excerpts appearing here were selected and edited by him for this Journal. Copyright © 1988 by Charles R. Kelley. All rights reserved.

the untouched body, where body contact is rare, inhibited and uncomfortable. Students from families where touching is rare may not respect their bodies for quite a different reason—they have not had enough experience of body contact to become comfortable with it, to learn the easy, pleasurable give and take of the friendly embrace, the affectionate non-sexual touch, the nonformal clasp of the hands, rumpling of the hair, etc. The lack of normal touching, holding and being held, is a problem as serious as the now more fashionable problem of invasive and abusive body contact. Consider the appalling effect of extreme touch deprivation in Rene Spitz' classic studies of neglected institutionalized children (Spitz, 1957). Body contact is an important, and in our culture, often unfulfilled human need. While the need itself cannot be satisfied by the Radix teacher, the blocks and inhibitions that interfere with its satisfaction are a legitimate subject of the teacher's skill. Such blocks are anchored in the chronic patterns of tension in the body that Reich referred to as the "muscular armor".

The following are typical Radix interventions and exercises involving body contact between teacher and student:

- The student's head posture is adjusted to make eye contact with the teacher more direct.
- The teacher presses and holds the student's upper lip down, to discourage a defensive smile, and to encourage the feeling the smile defends against, e.g., anger or pain.
- The teacher touches and works under the student's lower jaw to help free tensions in the floor of the mouth that are blocking crying.
- A student, suddenly very fearful in the session, is asked to reach out and touch the teacher's face, staying in eye contact, breathing, allowing and accepting any feelings the exercise evokes.
- The teacher asks a student on the verge of crying, "Will you let me hold you?" With the student's assent, the teacher embraces the student, encourages him or her to return the embrace and to surrender to the sobbing, to cry out loud.

These characteristic Radix interventions can take place in individual or group Radix sessions. Group sessions add a dimension to body contact in Radix work, in that the teacher can intervene through group members. Thus another group member might hold the student or be a partner in other exercises involving touch, given the consent of both parties. Group members are often used as "additional hands" for the teacher, to compress a student's ribs on the exhalation, loosen a tight scalp, massage a tight back, etc. The strict rule is that all such interventions are under control of the teacher. Students do not improvise any intervention without going through the teacher for approval.

I teach Radix teachers that they should be clear and matter-of-fact in exercises involving touching, and not excessively careful. If the teacher is comfortable, considerate, and professional in doing his work, and includes body contact in a relaxed and natural way, touching will not create problems unless the student is quite disturbed in regard to body contact. The basic rule that the student is touched only by permission, which can be withdrawn at any time, helps the student protect against touching that is felt as threatening or too stressful.

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Charles R. (Chuck) Kelley, Ph.D. developed Radix work in the late 1960's. He has trained 150 Radix teachers, who practice the work world wide. His home is in Vancouver, Washington.

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## Background Points of Theory

### THE BASIC WANTS OF INFANTS AND OF ADULTS

■ 65. All the newborn "wants" is to feel safe. This is primitive pre-knowledge, obviously physiologic and not cognitive. Observations of infants allow us to deduce what each of them typically "expects":

1. It wants to be held firmly and tenderly for as long as it wants it, and no longer.
2. It wants to be touched.
3. It wants to be fed well and in time. It expects always to be satisfied and full.
4. It wants to be "seen" and immediately recognized and served.
5. It wants to be taken care of and unconditionally loved at all times.
6. It wants what it wants now, without delay.
7. It expects all its wants to be fulfilled not only instantaneously but also perfectly.

Since all adults are grown-up infants in various stages of maturity, at least traces of these wants normally continue to be present in everyone.

■ 67. All these wants of infants and of adults serve but one purpose: to minimize fear. No one is totally exempt from such irrational yearnings, since we are all human. We become more content when we are treated in a way that satisfies many of these primitive wants. Our muscles are less tense or less jerky then, and we relax more easily. We feel safer.

■ 69. The basic wishes of the newborn as described in Sections 65 and 66 are referred to collectively as "preverbal hunger." When it is not satisfied or not satisfied quickly enough, the healthy infant expresses its demands loudly and powerfully, totally disregarding time and circumstances.

From *A Unified Theory of General Human Motivation and Behavior*  
Chapter 8 of  
*Thinking in the Shadow of Feelings*.

## CASE PRESENTATION

*Clinical observation and experience have always been the way knowledge in medicine was transmitted to the next generation of practitioners. Physicians were mainly taught by apprenticeship in the past, and even now observing experienced clinicians is still the backbone of medical education. Though many of us are psychologists and social workers and not psychiatrists, we also wish to utilize this effective way to teach psychotherapy. This is one of the major goals of this Journal.*

*A standard feature in each issue will be a clinical case presentation. The primary therapist will summarize his or her diagnostic impressions and plan for major clinical interventions, and this will be followed by specific comments of other experienced psychotherapists, each giving his/her own clinical impressions and treatment plan. We invite and will subsequently publish responses from our readers, and may offer the patient an opportunity to anonymously express his or her reactions to the entire group of discussions.*

*The following case is presented by Ronald Hook. You, the reader, are invited to actively participate in this clinical discussion. Please give your own clinical impressions, treatment plan, and rationale for recommendations. Clearly written presentations will be published subject to the availability of space. All responses must be received by February 1, 1994.*

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### THE CASE OF MR. K

Mr. K, a 36-year-old married businessman, presented with chronic anxiety and frequent panic attacks. After nine years of monthly visits to an adjacent university's anxiety clinic where his treatment was routine prescriptions of Xanax (often without physician contact), he was still deeply disappointed and very depressed. A beta blocker was also prescribed for his high blood pressure (170/110) during this period. For all these years the patient, fearing a possible panic attack, never took a vacation nor drove far from home.

He reported experiencing his first panic attack on his honeymoon nine years earlier. His Catholic parents had opposed the marriage because his wife, "a used woman," had been previously married.

Mr. K is tall, clean-cut, muscular and very alert, though somewhat preoccupied. His thoughts are generally coherent, and he is well-oriented x 3. A university graduate, he is bright and perceptive, though he speaks through a tense jaw in a clumsy, unsophisticated way. Visibly anxious and tense, his other affects are submerged by massive anxiety. He does not complain freely.

Mr. K used to work out every evening, and could press 300-plus pounds. His

blood pressure problem was his only presenting physical symptom, though in the past he had had six knee surgeries due to athletic injuries. He has a high tolerance for pain.

Mr. K identifies with his father who is described as tall and strong, a high achiever who progressed from relative poverty to extraordinary wealth. He demanded very high achievements from Mr. K who is the fourth child and the fourth son in a sibship of six.

He reports that his mother, at his birth, was disappointed because she didn't have a daughter, but that his father was delighted to have another son and made him his namesake. He says he is not, and never has been, close to his mother. The maternal grandfather died when Mr. K was one, his only sister was born when he was two. The maternal grandmother died when he was three, and his mother became ill, near death, when he was four. Following this the mother became depressed, at which time she lay in a darkened room and often told him to get out when he came to be near her.

Mr. K was the closest of his sibs to his father who had emigrated as a boy from Eastern Europe. Although limited in his ability to mother, the father was the patient's primary source of nurturance. Since the mother was not dependable, Mr. K appears to have defended himself against his needs by identifying with his father and engaging in continuous self-strengthening practices from body-building to wealth-building. Denial, projection, isolation of affect, intellectualization and rationalization are prominent in his defensive structure.

He has remained married and is very involved with his only child, a seven-year-old son, born prematurely with many complications, but now a remarkable over-achiever like his father.

Mr. K arrives at work at 5:00 A.M. and often finishes work at about 1:00 A.M., leaving 3-1/2 to 4 hours for sleep. He claims that he is 5 to 7 times as productive as any business peer. He is already beyond any real financial need, but worries about such things as the Japanese buying up America, the burgeoning non-white population, and the possible collapse of the Social Security System.

He never listens to music, only to educational tapes. He has never been to a symphony concert or a museum, and has had no desire to do so. Vacations or driving long distances are still generally avoided because of the fear of panic but also because of an urge to return to work. In his business life his reliability and judgment are good. At home he also tries very hard to be a good father and provider. He coaches little league baseball, hunts occasionally, and wishes he had the patience to play golf again. His judgment is poorest when it comes to the appropriate care of himself, and to human relationships that involve intimacy. Mr. K is sensitive, but he sounds like an Archie Bunker and seems proud to be this way.

## DISCUSSION

Mr. K has a conspicuous involvement of his body in his character defense. His great self-sufficiency is also a sign, by contrast, of denied underlying dependency needs.

I assume that at his core he has a powerful sense of abandonment, or painful rejection (note his acquired high tolerance for pain), or both. He remembers his mother telling him to get out of her room, but now he is fortified "to endure anything". Since it meant separating from his parents in more ways than one, he probably restimulated his abandonment fear and/or his denied sense of rejection at the time of his marriage.

Mr. K powerfully identified with his father in a way that ruled out being anything like his mother. I suspect the father was the mothering parent insofar as he provided basic emotional nurturance to the young Mr. K, and he became demanding of excellence as Mr. K grew.

His battle with intense anxiety over many years is causing his system to give out. He seems unable at this time to enjoy anything, or to be passive and restful at all. His main preoccupation seems to be with survival and survival preparations. He is depressed, somewhat paranoid, his functioning being handicapped by constricting intense anxiety.

I think treatment for this patient requires intensive involvement in therapeutic relationships with the hope of creating an emotional home for him. Combined individual and group therapy are required so that unconscious affect will be stimulated over time and worked through with enough intensity so that his fortified physiology will be affected. Without this level of change, the results will not be significant. He will need an individual therapist who is very sensitive (in order to find the openings in his character armor) and yet secure and straightforward (so that the reality of the relationship will not resemble the one with his mother, and so that the rough seas ahead can be navigated in a workable alliance). Because of his heavy defenses I think he will need the therapist to be sensitive and active in getting him to relate emotionally just beyond his defenses.

His involvement in the group will be difficult because he will be sitting in a matrix of emotional troubles resembling his own early mothering. He is likely to keep his fortifications there for some time. Meanwhile he can deepen his relationship with his individual therapist in preparation for the emergence of the pain and anger around deprivation that will eventually come up in the group. Once he is secure enough in this situation for these affects to emerge, to be expressed in their full intensity, and to be worked through, his physiology ought to change.

As the therapy commences I believe he should be evaluated regularly as to his actual need for medication. With medical consultation he should be withdrawn from the medication as his security in the actual therapy increases. He will also have to be sensitively weaned from his excessive exercising and other busyness

as he learns to deal with his emotions directly in the therapy.

At first, he will need to become "at home" in the therapy. I believe it will be important for him to complain verbally, and to be educated about the difference between verbalizing feelings and acting them out. I would establish a firm contract that restricts acting out. This will be necessary so that his affects will be "forced" into the therapy.

Touch along with freer breathing can produce an inward flowing awareness. Having a securely felt presence, a *physically* felt presence, can produce a new level of holding environment within which previously frightening affects can begin to release for working through.

I also think this patient will need to be physically touched from time to time in a careful way. This intervention is essential for a body like his which gives such clear indications of feeling unsafe. No amount of talking will reach his "gut" as effectively as a sensitive and secure hand. This may also bring to life the dormant yearnings which are so strongly denied.

Ronald J. Hook, M.S.W.

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Ronald Hook practices individual and group psychotherapy in Detroit and has had training in Neo-Reichian body work through the Radix Institute. He serves on the faculty of The Bar-Levav Educational Association.

#### COMMENTS IN RESPONSE TO THE CASE OF MR. K

From the data supplied, I believe that this male patient, when 27 years of age, began to experience panic attacks while on his honeymoon with a woman who his parents opposed for religious reasons. The use of medication was the main clinic treatment and not helpful.

The patient had a very poor connection with his mother. The only person in early life who he seemed close to was his father, a tall and strong high-achiever who originally was poor but amassed extraordinary wealth. His father demanded high achievements from his children as well as from himself.

The history suggests that the patient suffers from rigid, constricted standards and demands for achievement and success. The patient's story fits the descriptions of the Adorno-Frenkel-Brunswick study about authoritarian personalities. Such persons identify with parents who appeared to them to be strong and powerful. The parents denied any weakness or vulnerability and displayed considerable contempt for any sign of weakness or failure in their children. It looks as though this patient did not receive nurturing maternal qualities to soothe and reassure him.

Instead, his only available caretaker was a father who encouraged idealization, and manifested a sense of the importance of power, money, and strength to gain acceptance and self-worth. The patient went along with this pressure and has lived his life in a very similar way. Usually in cases of overachieving, there are longings for nurturance and a dread of failing to live up to the "victories" demanded by the father. Usually there are strong unconscious feelings of worthlessness and vulnerability in such patients who develop a veneer of pseudo-adequacy all based upon the success they desperately strive for and often succeed in attaining without really feeling secure and successful within. One prognostically positive factor relates to how, despite all this pressure to identify with impersonal strength, this patient is very tender towards his vulnerable son.

My orientation is an object relations-developmental psychoanalytic framework. My treatment program for such a patient is to listen carefully, maintaining a respectful appreciation of his distrust and need for distance. I empathize with the patient's anguish, anxiety, and suffering and when appropriate, acknowledge the reasonable fears of vulnerability and the defensive nature of overworking and straining. I attempt to provide a "holding environment" without imposing a value system. Whenever appropriate, I acknowledge the patient's phobic qualities within a solid therapeutic alliance. I have seen people like this patient overcome anxiety through communication in a talking-relating interaction during regularly scheduled sessions. Signs of discomfort and resistance are acknowledged and appreciated without subjecting the patient to criticism or pressure. A person who received little nurturance and acceptance would be reluctant to trust and "open-up" to the therapist. With this patient, I would explore his overachievement in business and finance and his anxieties about the danger of outsiders encroaching upon his security. I would probably not call any attention to his lack of recreation or avoidance of vacations until he shows awareness. I think his panic reactions and the satisfaction he needs by returning to work and trying to feel better through perfectionism are an attempt to live up to his father's almost impossible standards. Gradually patients with this kind of background develop a transference to a therapist who does not have the kind of attitude of his dreaded father. The old destructive, exaggerated identifications are replaced by an internalization of the nurturing therapist, and the patient's inherent value and real potential are reinforced.

Saul Tuttmann, M.D.

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