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JEAN'S LEGACY

On the Use of Physical Touch in Long-Term Psychotherapy

Pamela Torracco

It is impossible to address the issue of physical touching without first examining nonphysical "touching." For all of us in the helping professions—physicians, the clergy, nurses, psychotherapists—it is our job to "touch" those who come to us, to make contact with them in a way no one else has. It is our job to provide a sense of safety and holding by using our very being. Physical touch is only one of the many avenues open to us.

For those of us who are therapists, our aim is to "touch our patients' souls"—to provide temporary but real relief from basic, early-life fear. "I am not afraid of what terrifies you so much," we must somehow communicate. "Your fear poses no danger to either of us. It is safe to expose it here, and together we will examine it." Words alone are insufficient. They address only the cerebral cortex, whereas the fear resides in the basic physiology, where it affects both autonomic functioning and idiosyncratic emotional reactions to normal, everyday events. Real contact can occur only when a therapist can "reach in and touch" a patient on such a deep level.

Two of the five senses routinely come into play in any face-to-face human interaction: the sight of the other person, and the sound of his or her voice. A kind face, a firm yet gentle voice, an ability to listen to

the hidden meanings beyond the words and to articulate what the patient can find no words for—these are all part of the “holding” environment of therapy sessions, in which the patient should feel touched, welcomed, and safer than before. Ideally, every patient should leave each therapy session (whether group or individual) with a sense of having been “touched” in some nonphysical way that reassures even when it is also experienced as frightening.

JEAN

Apparently I succeeded in this regard early in my career with a patient named Jean, though largely for the wrong reasons. When I was still a young, idealistic social worker who believed that perseverance and good will ought to save the world, I worked in a public health clinic for children. A usually calm pediatrician sounded alarmed one day when he buzzed my office and urged me to see Jean and her 2-year-old son, Mitchell, immediately.

Mitchell was well dressed, bright-eyed, cute, and physically healthy. Jean, age 28, looked 45 and deeply troubled. She was unkempt in appearance, walked unsteadily, had scaly protuberances on her face and arms, and had a look of deep sadness in her eyes. Several missing teeth had been replaced with pieces of metal in some crude attempt at dentistry. Her messy hair and frightened demeanor gave her a wild appearance. She smiled in a somewhat contorted way, and it was clear from the first moment that she was working very hard to be present and to be socially appropriate.

Her interaction with her child was firm, loving, and sensitive to his needs, in marked contrast to what one might expect from her appearance. As she became less frightened of me in my position of authority, her eyes darted less, and she studied me carefully; eventually, she accepted my invitation to tell me about herself. Her presentation was confused and rambling at times. Occasionally she would stop talking and gaze into space. But often she made real contact with me with her eyes as she spoke sensitively about herself. The story that emerged touched me deeply—too deeply, since I must have overidentified with her from the beginning.

I no longer remember the details of her very troubled origins, but she had spent most of her adolescence and young adulthood in a state hospital. She cried about her family members, who had not wanted her, and recalled various social workers and nurses she had known over the years. She also spoke about a strange but meaningful relationship she had developed with a male patient who was much older. Reluc-

tantly, she had agreed to have sex with him under a stairwell, although she had been terrified. During her pregnancy, contact with him was prohibited; after Mitchell was born, she was discharged from the hospital with her infant. Her heavy doses of medication were supposedly regulated during her 10-minute, monthly visits to a psychiatrist. She said that her skin condition was a reaction to her many years on psychotropic drugs.

Jean and Mitchell became one of the families I followed on a long-term basis, and I saw them in the clinic or made a home visit every week or two. I and other clinic staff members were amazed at Mitchell's relatively healthy development and the quality of mothering he seemed to receive from this strange woman. We expected serious problems to develop with the boy as he got older. Since other staff members were afraid of Jean and her odd mannerisms, they were glad to lend support to the social worker who was eager to follow her.

I also became acquainted with Jean's roommate, Sharon, who had also survived the state hospital system. She, too, had those odd metal teeth. They both welcomed me, and Jean was genuinely grateful for my presence in her life. I liked and respected Jean and she knew it. She was masterful in her ability to budget her welfare check and creative in her attempts to decorate the meager apartment I had helped her get in a housing project. She was charming in her childlike eagerness to learn about the world she had been shut out of for so long, and she seemed devoted to her son without smothering him. As she felt safer with me she was less careful in her speech, and her confusion, poor ego boundaries, and paranoia became more evident. She sometimes became annoyed when I was busy with other mothers in the clinic and was deeply hurt when I politely declined the food she wanted to cook for me. She apologized profusely for a few angry outbursts directed at me. She refused my offers to try to find a psychotherapist for her.

One day after returning from vacation, I received a desperate call from Sharon, begging me to come over. I found a trembling Jean, who tearfully told me she was determined to withdraw from the heroin her boyfriend had been giving her. Sharon had vowed to stand by her, and indeed had the loyalty to do so. I promised to help her, too, and I visited every day for a week or so until the crisis passed. My presence alone was usually comforting to Jean, but one day her body could find no peace. I recall the scene clearly: Jean was sitting on an old sofa, shaking and crying, her teeth chattering; Sharon sat on one side of her and I sat on the other, each of us holding one of her hands. Apparently I found her painful struggle intolerable, and I put my arms around her and held her. Wrapping her arms around me, she buried her head and sobbed deeply. The trembling slowly subsided, and she was moved and

amazed that I was willing to hold her and to touch her "ugly" scaly skin. After that, she seemed to succeed in her withdrawal from heroin. She was thrilled with her victory and grateful to me for my help.

Several months later, I left the clinic to expand my private practice of long-term intensive psychotherapy. I wished Jean could be my patient in that setting—sick as she was, she had so much health and determination. Maybe she could really get well, I hoped, although I knew my wishes were unrealistic. Of all the people I had worked with at the clinic, it was most difficult for me to tell Jean I was leaving. She first cried and wished me well, then withdrew in hurt; she refused to say good-bye and told me I was a bad social worker. After my departure, she located my home phone number and called several times, either crying about how she missed me or threatening to hurt me, now that she knew where I lived. Nothing ever happened, and I never heard from her again. That was over 20 years ago.

Since I was not afraid of Jean's gross pathology, she took more chances with me, exposing more aspects of both her health and her illness. When she began making her threatening phone calls, I was scared, hurt, and angry. How could she treat me this way when I had been so devoted in my work with her? Certain by then that I had done everything wrong, I was too embarrassed to seek the counsel of friends, attorneys, or more experienced therapists. I just heaved a sigh of relief when the phone calls finally ceased.

Jean's behavior makes excellent sense to me now. Her severe ego boundary deficits and concomitant body image distortions are clearly evident. So are her lack of adequate mothering and fathering, and the resulting panic and inner turmoil she experienced most of the time. It is obvious now why she was tremendously confused about herself as a person and as a woman. She was a survivor; her health allowed her to function outside the hospital (a near miracle), and, beyond that, to cling to me and trust me in spite of all her previous experiences. I encouraged her to lean on me as a precondition for treating her illness. But at that time I did not understand well enough the infantile yearnings I was inadvertently stimulating.

My holding Jean physically only further thickened her unworkable transference involvement with me. It was unworkable for three reasons:

1. I was not experienced enough then and did not understand how to work with such primitive and powerful infantile wishes for mothering.
2. The setting was not right for such work, even if I had known what to do.
3. Jean probably did not have enough emotional health to sustain

the emotional turmoil that is an unavoidable by-product of such surgery-like interventions.

Remembering Jean and learning from my errors with her have helped me, however, with other patients in settings more conducive to working through such early damage. We are all Jeans in one sense, even though many of us have been less damaged in our psychological development and our life experiences have been more fortunate. Even 20-plus years ago, I knew that people could not move beyond themselves and their character limitations without being touched on a level much deeper than that of the rational brain. I did not then understand the power of such involvement, but Jean's legacy is my continuing search for better ways of using myself to help others like her out of the emotional prisons in which they live.

NANCY (AND LAURA)

I became acquainted with Nancy several years after my final encounters with Jean. By then, I was working with several other therapists in a private practice where all our patients had regular, alternating individual and group sessions. Each patient also had the advantage of being involved with multiple therapists—both their primary individual therapist and additional cotherapists in the group. (We routinely conduct our groups with cotherapy teams of two or more therapists.)

Nancy's mother had had such serious difficulties with female identification that she had been unable to like even her own daughter. As a result, Nancy felt unwanted both as a person and as a girl; she was plagued by a deep sense of shame about her longings for closeness. In an attempt to compensate for her terrible sense of inadequacy, she developed a "tough guy" front. Her demeanor and mannerisms were not so much masculine as they were demonstrably antifeminine. Her voice was usually sharp or rough, her gestures broad and often awkward, her wit tinged with sarcasm, her laugh too loud. Not only had her attempts at softness and sensitivity been ridiculed by her mother, but they were also crudely put down by her older brothers. Her father, the only person who seemed to have had some understanding of the little girl's difficulty, was too frightened and unsteady himself to defend her against the continued harassment of the other family members.

In her work Nancy was competent and professional, often even innovative. But her personal life was lonely; her relationships with both men and women were only marginal and usually disappointing. She lived alone, literally and figuratively. Although she had eventually

discovered that sexual contacts with women were more satisfying than those with men, she had given up on those, too. No relationship was ever lasting or really satisfying and meaningful to her. When Nancy's loneliness became unbearable, she sought therapy.

I was a cotherapist in Nancy's group, but since she had experienced her father as the best "mother" she had known, we therapists had concluded that it would be easier for her to become involved with a male individual therapist. Often disappointed in him and in her group, as she was with people in general, she slowly took more chances over the course of a few years and very hesitantly let her guard down. Her softness and sensitivity eventually began to show for brief moments in sessions before she would get frightened and close up again. Then, a few minutes or a few sessions later, she would feel safe enough to venture out once more. She began to lose weight and to dress in a more feminine manner, at first claiming that she was doing this just to get the therapists "off my back." But slowly she began to derive more and more pleasure from being a woman.

I became her individual therapist then. We believed that she was ready to face yet another layer of her deep fears by testing the waters of a trusting involvement with someone who could more readily evoke her painful experiences with her mother. These were often stormy times. Her previously hidden and suppressed rage was now out in the open. She hated the woman who had mothered her so poorly; consequently, she hated all other women, including me and herself. For weeks at a time, I could do nothing right. If in sessions I spoke little, I was tight and ungiving like her mother. If I intervened more frequently, I talked too much and wanted the session to go my way. "Just like my mother," she would bitterly complain, "you're not making enough room for me."

Her longings to be seen, held, nurtured, and mothered were also very powerful, however, and she sometimes feared being overwhelmed by them. It was then that I decided to have her use my couch in individual sessions, hoping that lying on this extension of me—my couch—would provide her with the sense of being "held" and help her feel safer and less threatened by her primitive fears. It did not work. Session after session, she was very tense and often silent. It was not possible for me to reach into that silence in a way she could tolerate.

One day as Nancy lay on the couch, her breathing shallow in a semiconscious attempt to choke back both her fear and her wishes for closeness and contact, I had a fantasy of physically offering her my hand. I did not then approve of ever making such a gesture in individual sessions, since I believed that the potential for confusing the patient was too great. As I observed her and her clearly evident pain, I wondered about myself and my unusual fantasy. Was I trying too

hard? Was I overidentifying again? Was I confused as I had been with Jean? My intentions were obviously good, but good intentions are never a guarantee that an intervention is correct or necessary. I could find no particular anxiety within me—just compassion for Nancy, who was fighting so heroically to escape the inevitable pain brought about by her troubled background. I finally decided to take a chance and offered her my hand.

Nancy refused it, of course. And she criticized me for yet another inept attempt to help her. But I persisted in my offer, without pushing. Slowly her body began to respond. It showed in small muscular twitches in her hands, arms, and neck, and in a perceptible change in her facial expression. Her hand reached toward mine several times, each time pulling back before we touched. Her arm then began to shake. Feeling a rush of shame, as if she were doing something terribly wrong, she turned her face and then her whole body away from me, gasping in horror.

I wanted to reach for the frightened child I saw before me. It was so clear that the woman's body was only the casing that held a needy and terrified little girl. I wished to take her in my arms as I had done with Jean so many years earlier and let the warmth and steadiness of my body reassure hers. But I did not do it, having learned my lesson well. Instead I used my voice to touch her, to remind her of the reality of our situation, to coax her to turn back and not to turn away again. Once more I offered her my hand. Slowly, painfully, shivering and whimpering, she turned back. At my suggestion, she looked at me and slowly took my hand. Her bodily resistance then gave way, and she trembled, heaved, and sobbed deeply, holding on tightly to my hand. On her own, she added her other hand, cradling mine in both of hers.

A few minutes before the end of the session, I gently withdrew my hand from Nancy's and encouraged her to reflect on what had happened in her and to her in this unusually powerful hour. It was almost impossible for her to think then; her feelings were still so strong. So I asked her to sit up and focus on me. With her feet on the floor and her eyes observing the real me, her therapist in the present time frame, she could eventually speak sensitively about the painful longings of the child inside her. She had always tried hard to hide these yearnings for a good mother because they seemed shameful to her.

By the following year, Nancy felt safe enough in her group to expose and experience her hurt openly sometimes. She spoke with difficulty in one session about my apparent insensitivity to her and my not seeming to understand the depth of her pain. My cotherapist helped her talk directly to me about loving me and wanting more from me—an understandably difficult task for this patient especially. His sensitivity and calm, firm, male voice were very reassuring to her and

gave her enough support to proceed. As she spoke tearfully and haltingly, her right shoulder tightened visibly. He helped her tell me about the painful tension, and persistently encouraged her to ask me to "Rub it, please." Conquering her shame again and again, and tempted to withdraw with every breath, she pressed forward, never giving in to her enormous fear.

As always, I asked for permission to touch her even though she had requested it. And she again cringed as she granted it. She understood that the physical intervention had nothing to do with either rubbing or massaging a tight muscle. It would instead be a further step toward facing the irrational fears that dominated her body. I stood behind her, one hand on her painful shoulder, the other on her forehead. The back of her head rested against my abdomen. Reminded to breathe deeply through an open mouth, she began to shake and cry, visibly fighting her tendency to hide her face in shame. At my suggestion, she held on to my arm with both hands as she continued to sob and whimper alternately. This lasted for several minutes. A few group members spoke about their reactions to what Nancy was going through; some were envious, others frightened.

"Well, I'm hurt! You never touch me that way," Laura whined in my direction. Her face quickly took on the pouty look of a hurt 4-year-old, and her toes turned inward toward each other without her realizing it, as a little girl's feet might do in their patent leather Mary Janes. "It's obvious that you don't like me as much as Nancy. You just put up with me because I pay you." She folded her arms, raised her chin slightly, and averted her gaze, really sounding like a little girl.

Nancy's freedom to regress temporarily without being ridiculed and without suffering any actual damage enabled the otherwise controlled Laura to do the same. It was a safe setting, indeed. The visible, beneficial effects of the work with Nancy had made it possible for others, too, to repress less. Residues of very old hurt were bubbling up.

Laura had been infantilized and overindulged by both parents. They experienced her as a "blessing" bestowed on them late in life. Although now a young adult, she was crippled by her infantile expectations that the world would always provide for her. This was not the first time she had appeared to be like a 4-year-old, but these character habits had never before been so obvious or so openly observable. Laura was often on the verge of leaving therapy when pushed to take more and more responsibility for herself. At our insistence, she was now paying for half her therapy on her own rather than depending on her parents—a major achievement for Laura, but one about which she still needed to complain frequently.

Laura was right about my never touching her the way I had Nancy. It would clearly have been the wrong message, at least at this point of her therapy, and would have confused her. As a baby and toddler, she had been physically held, cuddled, and attended to too much by her anxious mother, who was trying to allay her own anxiety. Even now the mother occasionally addressed Laura in baby talk. Instead of touching Laura or allowing her to withdraw after her tantrum, I insisted that she straighten her feet and adjust her face in spite of the storm of feelings that had just passed through her, and that she talk thoughtfully about what she had experienced. It took a great deal of effort on her part, but finally she spoke sadly about the little girl who had never received the firm pressure she needed to grow up to be a competent adult. The contrast with Nancy was now obvious even to Laura: Nancy had learned to behave like a competent adult while still a child, since in her family there was no room for the little girl. Later on, after I had returned to my seat and several other patients had spoken about themselves, Nancy reflected easily on her current calm and pain-free state, contrasting it with her tight, contorted body and powerful feelings of just a few minutes earlier. In so doing, she began to integrate another therapeutic experience—another small step in the corrective emotional work she was engaged in.

“Even though we have no conscious memory of our early experiences, our body remembers. We adapt to them or perish,” says Bar-Levav (1988, p. 323). Wilhelm Reich (1942) recognized many years ago that the “muscular armor” is formed in response to subjectively fear-filled experiences during the period of character formation. Considerable work has also been done in the past 25 years by Alexander Lowen (1975), Charles Kelley (1974, 1988, 1993) and many others (e.g., Durkin, Glatzer, Munzer, O’Hearne, & Spotnitz, 1972) to expand our understanding of these concepts and to enhance our ability to work with the body directly. Strange as it may still sound to some, it is clear now that muscles like those in Nancy’s shoulder are indeed the seat of “memories.” Somehow that area of the body became Nancy’s locus for storing fear and other forms of emotional pain. We do not yet know the exact mechanisms of how or why one region rather than another is “chosen” for this purpose, but our recognition of the existence of physiological memory traces allows us to address the musculature directly. An intervention that temporarily loosens the level of tension in a burdened shoulder, for example, converts the physical pressure into affects and makes room for experiencing feelings as such and for vocally expressing long-buried fear, rage, or hurt. When this occurs in a group session, the presence of others who are not critical undercuts the patient’s lifelong sense of shame associated with the open expres-

sion of feelings. The "certainty" that strong feelings can be safely experienced only in private and in hiding eventually gives way. Consequently, it was reasonable to expect that the general level of anxiety in Nancy's body would subside as the shoulder, like her vocal cords and other muscle groups, no longer bore the extra pressure.

Patients sometimes begin to believe that the therapist's touch (as well as other well-timed therapeutic interventions) has magical powers. This sense ought to be quickly and repeatedly defused. Otherwise the way is open to a positive transference "cure," which is transitory and unreal and can never heal emotional illness. The power of physical touch is great, since the body (and "soul") long for the exquisite sensitivity of a perfect "mother" in whose literal or figurative arms one feels safe. Patients must have such experiences with their therapists in order to elicit formerly frozen affects that block healthy functioning of body parts (including the ability of the cortex to reason under continual pressure), but the observing ego must always put each such experience in perspective without a long delay (Bar-Levav, 1988, p. 225). Eventually patients learn to mother themselves, and then they neither cling to others nor shrink away from intimate contact.

DARREN

Patients with an "as-if" defensive structure are often experienced by psychotherapists as being among the most difficult to treat. Specific forms of physical touch can be useful to some of these patients, but the circumstances in which such interventions are utilized must be very clearly delineated. Terrified at the core, such patients protect themselves against perceived emotional dangers by adapting to what they believe is pleasing to others. Emotionally they resemble chameleons, with many shades of color available to them to camouflage themselves in order to seek a sense of safety. This adaptive process takes place automatically on an unconscious level whenever danger is perceived; consequently, such individuals are unaware of its presence. Such patients do not mean to fool their therapists or others, since they themselves are blind to their "as-if" changes. Although they manage to keep their massive anxiety in check, such patients have an unclear sense of who they really are.

Darren, a middle-aged psychotherapist, is such a person. Now, in the middle phase of his own therapy, enough cracks in his defensive walls have been produced that he can no longer deny his nearly overwhelming tendency to try to please others, particularly women. Born into a large family with other siblings before and after him, he

understandably developed this way of being in the hope that he would be better seen and perhaps even praised. He became a rigidly efficient man who, though well liked, condemned himself to walk a narrow path that always demanded near-perfection. Any slip on his part, any deviation, led to anxiety, self-deprecation, and self-reproach. Darren's apparent "giving" to others was a facade behind which he hid his desperate wish to "be given," as well as his harsh treatment of himself. His need to "give" overdetermined his choice of profession and the quality of his relationships, but it did not save him from living with debilitating anxiety. This finally pushed him to seek therapy.

Darren's ready smile and compulsive helpfulness were barriers to his experiencing his rage or panic in the group. At the suggestion of his therapists, he agreed not to help any of his fellow group members in any way for 3 months. At first, he used to chuckle as he caught himself again and again reaching for a box of tissues, eagerly offering it to someone who was crying. He eventually began to grip the arms of his chair and to grit his teeth to force himself not to make helpful gestures and interpretations. Finally he could tolerate it no longer. Deeply buried anger and impatience bubbled up in sessions as he complained openly and powerfully about the "stupid" suggestion of his therapists. Eventually he even found some characteristics of his fellow group members to be annoying, and he said so openly. His anger frightened him. Without his compulsive "niceness" to help hide his rage, his body now tended to tighten and to rigidify. The fear of rejection resulting from his open expressions of anger then combined with his fear of losing control and of becoming violent, and all his feelings again went "underground." Temporary numbness and a flattened affect sometimes followed such breakthroughs—a not uncommon sequence in patients reaching this point.

Physical touching can be most helpful at such times. With patients like Darren, the sense of being exposed and therefore grossly unsafe is so great that the tendency to re-repress the emerging affects becomes nearly overwhelming. The sight of the therapist and the sound of his or her voice are often no longer enough to "hold" such a patient in the here and now, since the powerful "new" affects appear subjectively as a threat to the integrity of the less than fully competent ego boundaries. A firm and prolonged physical touch on the arms, back, shoulders, forehead, and/or neck can often literally "remind" the patient's body that the current situation is, in reality, safe. The terror-filled body is thus reassured that even the strongest feelings that temporarily cloud the brain and confuse the observing ego are not in fact dangerous.

This, indeed, was what happened to Darren over and over again.

One of the male therapists would firmly press his hands on Darren's shoulders or support his forehead with one hand and the back of his head with the other, while insisting that he keep his mouth and eyes open and breathe deeply. Darren would again and again thus regain enough of his sense of equilibrium that he could continue to experience and to openly express his previously hidden terrible fear. This was often associated with deep sobbing. The little boy who always felt constrained to be sweet and helpful, and who had to choke back all traces of his hurt and powerful rage, was now free and able to feel it all as such. Such experiences slowly release the pressure that has been locked in the body for a lifetime. The deep crying is always followed by a sense of profound relief.

The touch of a male therapist's hand at such times is usually more effective than that of a female, particularly with a male patient. The unconscious wish at such moments of daring to reexperience old and long-buried subjective horrors is to melt into the softness of a woman, exactly as a frightened baby would burrow into its mother's bosom. But the immediate need of a patient like Darren (whether male or female) is to reestablish the sense of boundaries and separateness, ideally almost in the midst of such a "regressive" progression. Thus, a physically firm masculine touch is usually the medium of choice.

MARJORIE

One of the major goals of psychotherapy ought to be the development of the ability to self-mother. This is an essential capacity for healthy adult living (Bar-Levav, 1988, p. 329). Without it, people must always look to others for nurturance. Proper attention to one's body and to its real needs is one important function of self-mothering. Another is properly satisfying one's own real emotional needs, which can and must be distinguished from indulging one's infantile wishes. Those who have been inadequately mothered as infants and as small children hardly ever develop this ability for loving self-care, and proper therapy must therefore include work in this neglected and underdeveloped area of the personality.

The case of Marjorie is a good example of this. The poor mothering this 24-year-old had received was evident from her appearance. Seriously overweight, she walked with an awkward gait and always appeared unkempt. No matter how hard she tried—and she made great efforts—she was unable to pull herself together completely. If her clothes were clean and pressed, she had runs in her hose. If her makeup was attractive and appropriate, her hair was a mess. If her skirt was the

right length, her shoes were scuffed or showed outright wear and tear. She usually looked like a young child in need of help in dressing herself. She was often embarrassed about her appearance and deeply ashamed of her inability to do everything right. Bright and competent, Marjorie did well in her graduate studies, but she spent an enormous amount of time in silent ruminative deliberations involving self-blame.

In individual sessions, Marjorie's body eventually felt "safe" enough to relax some of its chronic tension. Then she would sadly cry for herself or talk thoughtfully, freed for a few minutes from her almost continual self-recriminations. But in the group this was more difficult. There she was more frightened by the multiple stimuli and usually felt a need to be on guard. Although able to be sensitive and helpful to other group members, talking about herself led quickly to ruminative struggles to be "perfect." This was followed by a deep sense of shame when she felt she had failed again.

Marjorie was hurt, embarrassed, and certain that I was making fun of her the first time I suggested she sit on my lap in a group session. At my urging she talked about these feelings rather than withdrawing. Encouraged by her peers to try out what seemed to be a very strange suggestion, she anxiously and very slowly joined me, trying hard to support some of her own weight for fear that it would injure me. (I have found that my lap can in fact tolerate quite a bit of weight for a few minutes, and that usually only a few minutes are needed for a Marjorie to take one or two new steps away from the physiological prison of her body.)

At first Marjorie's body was jumpy and tense, and she was driven to ruminate about returning to her seat. It was enough now, she said, and I really should remember to work with some of the other patients who also needed my help. Firmly placing both my hands on her shoulders and back, I invited her to look at one of the other group members and describe her experience. Her quivering body began to settle down as she spoke about how surprised she was at being comfortable and feeling somewhat comforted. This did not last for long. Soon she was driven again by her rising anxiety to ruminate about liking all this too much, and to try to convince me that she ought to go back to her seat. The continued physical reassurance, combined with my observations that the little girl inside her grown body was probably unaccustomed to being held in a safe lap, helped her slow down. She began to talk sadly and thoughtfully, with specific examples, about the child who was always afraid to ask for much and who was always on guard against Mother's unpredictable outbursts and Father's demands for perfection. I asked if that child knew any songs. Bouncing her slightly on my knee, I joined her in singing "Row, Row, Row Your

Boat"; she then continued singing on her own, giggling like a little girl who was no longer self-conscious.

Marjorie did not even want to intellectualize about what this all meant, and I would have discouraged her from doing so. She simply and innocently enjoyed her own laughter, "mothering" herself once the little girl inside her had absorbed my steadiness. When space is made for the legitimate needs of the frightened child, more room exists for the adult. This, indeed, was how Marjorie walked back to her seat. She was less awkward, although only temporarily. Physical touch is not a character-altering magic, and the body overcomes its familiar ways only very gradually.

Following such episodes, patients generally experience real freedom from their normally high level of anxiety—at least for a few minutes, sometimes a little longer. During such periods, not only is the body generally more relaxed, but the characteristic facial expression usually also changes. As the tension level of all muscles is temporarily lessened, vision and hearing often become more acute, and gait and other movements may become smoother. Hundreds of similar experiences are needed in a full course of successful psychotherapy, during which the physiology changes in basic ways and the patient's body slowly sheds the suit of armor it has "worn" for years. Eventually, a much more relaxed state of being becomes the rule rather than the exception. This is a necessary part of overcoming chronic anxiety and depression.

GUIDELINES FOR THE USE OF PHYSICAL TOUCH

Physical contact with patients is often a necessary tool in intensive therapy that aims at healing emotional illness and not merely relieving symptoms. But such a powerful tool should be used judiciously, only under very specific conditions that protect the patient from abuse and also guard the therapist. Physical touch can confuse therapists whose ego boundaries are not well delineated, which is why clear ground rules are necessary. The potential for abuse in utilizing these powerful techniques is great, even with the best of intentions.

The following guidelines ought to be carefully observed at all times:

1. *Beginning therapists should never touch their patients under any circumstances.* At best, they will confuse them slightly; at worst, they will open the door to distortions that can put them in real danger, as I did with Jean. Only experienced therapists should use physical techniques,

and they should do so only after they have mastered other "holding" techniques and have a clear understanding of physiological memory.

2. *A real adult relationship between patient and therapist must clearly exist.* This serves as a solid foundation for clarification of any transference distortions, especially those that might be stimulated by physical touch. Clear arrangements regarding time and money clarify the purpose of the relationship. Not only hugs but even routine handshakes are best avoided in intensive psychotherapy, to emphasize the basic difference in nature between this relationship and a social one. Bar-Levav (1988) comments:

In a sense, two parallel relationships must develop and remain in existence between therapist and patient—a real one and a therapeutic one. The basis of the real relationship is complete honesty and mutual respect, combined with a two-sided commitment to remain involved even in the presence of powerful expressions of hurt, anger, or irrational fear by the patient. (Therapists are expected to be essentially free of these, at least in relation to their patients.) But in the therapeutic relationship room is made for the expression of any thoughts and all of the patient's feelings, without limiting their intensity and with no need to hold back or hide anything. What is unpleasant, painful, or embarrassing to the patient finds room here, and so does any criticism, disappointment, and anger at the therapist. (p. 222)

The therapeutic relationship is often extremely stormy, but as long as it occurs within a real-relationship that holds the patient lovingly, firmly, and consistently, all the storms eventually subside. (p. 236)

3. *Physical touch of any kind is contraindicated at the beginning of therapy,* in order to help establish the real relationship on a firm footing. At the beginning of therapy, patients' involvement is almost always based largely on positive transference. At the very least, physical touch at that time is likely to overload the holding capacity of the real relationship. At worst, it may damage the patient by causing him or her to leave therapy or to develop a psychotic transference.

4. *The therapist must be ready, willing, and able to make a long-term commitment to the patient and the therapy process.* Any and all feelings stimulated by physical touch must be worked through; this may well require working through the most basic developmental defects in the character structure. Touching physiological memories and attempting to alter habitual pathways of physiological response constitute a difficult and lengthy process that should never be undertaken lightly. Since the therapist's major tool is his or her self, the therapist ought to be present throughout the entire process.

5. *A clear contract that separates actions and feelings must already be in effect in the relationship between the patient and the therapist, and among all the patients in a group.* No action, especially physical touching, is ever permitted by either patient or therapist without requesting and obtaining explicit verbal permission in every case anew. Since feelings often masquerade as thoughts, it is essential to double- and triple-check the rational basis of any wish to act in any form (Bar-Levav, 1993a). It must be remembered that physical touching can merely be a way to discharge feelings, and thus can impede the therapeutic work.

6. *Physical touching is safest for patient and therapist alike if done almost exclusively in a group setting, and hardly ever in individual sessions.* This serves to protect patients from possible abuse by emotionally immature therapists, and to protect therapists from distortions by patients that could lead to lawsuits. Patients need to have both group and individual sessions that take place on a regular basis. The processing and integration of experiences involving physical touch are most usefully done in the presence of peers, who serve as very effective reminders of current reality.

7. *Ideally, a cotherapist should be present whenever physical touch is applied.* The reasoning here is the same as that of a male gynecologist who routinely has a female nurse present when performing a pelvic examination. The additional importance of such a practice is self-evident in the age of so-called "recovered" early memories of abuse. Furthermore, the cotherapist may see indications or contraindications to which a colleague is insensitive. Together they can decide which of them is more suited to the patient's needs at the moment, in terms of gender and possible transference reactions (Torraco, 1995, p. 24).

8. *Before physical touching is used, its value should be weighed in comparison with all other possibilities.* Touch is only one of many possible interventions an experienced therapist has at his or her disposal at any one moment. The ongoing work of intensive psychotherapy requires an ability to be emotionally open, involved, and available, based on reasonably intact and flexible ego boundaries. Such demanding requirements develop only with emotional maturity and time, and they are unlike the demands of other learned professions. "The work itself exposes us and makes us vulnerable to experiencing any and all feelings with the greatest intensity" (Bar-Levav, 1993b, p. 14). Consequently, therapists must check and recheck themselves to guard against possible lapses in judgment caused by strong feelings. Since all people harbor yearnings to be touched and held, even an experienced therapist can momentarily overidentify with a patient and touch him or her at the wrong time and for the wrong reason.

9. *Touching should only be used to move a patient through and beyond*

a layer of fear that "freezes" his or her ability to benefit from other interventions. Fear can paralyze the physiology, the feelings, and/or the thinking, and can thus cause the patient either not to move forward or to regress. Physical touch is one of several possible avenues of intervention at such times. 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.

10. *Sexually suggestive or stimulating touch must always be avoided; even an arm or shoulder can never be fondled.* Therapists not only must avoid the genitals, but must take extra care even when touching the chest or abdomen. Experienced therapists are likely to be neutralized themselves to zones of potential confusion, but patients can easily become confused without knowing it when they are emotionally very open and therefore more vulnerable. Erotic transferences or psychotic-like, unworkable early preverbal transferences can develop and harden if exquisite care is not taken at crucial moments.

11. *Touch must always be firm, have a clear and easy-to-define purpose, and be relatively brief.* The patient's tissues will respond to a tentative, unsure touch; they will "know" that this touch cannot be trusted. A therapist's touch can never be a caress, and any sort of casual touch is at best useless.

Heeding these factors, we can safely touch our patients from time to time, thus expanding the variety of techniques available to us in this difficult, challenging, and exciting work. But whether or not we actually use physical touch, we hold lives in our hands no less than a surgeon facing a draped patient on the table does. We need intrusive techniques to reach insidious pieces of pathology, but they must always be used prudently and sensitively. Our patients count on us to remain vigilant that what we do is in their best interests and not our own.

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