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THE DYNAMICS OF INTERPERSONAL AND
PSYCHOTHERAPEUTIC TOUCH

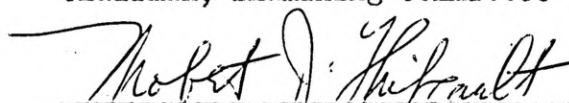
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ABSTRACT

A review of literature was conducted in the area of psychotherapeutic touching to investigate the history, dynamics, value, applications and limitations of touch as a therapeutic tool.

The research available in this area was somewhat sparse, although some of the literature included fairly descriptive attitudinal information concerning the therapeutic utilization of touch.

The counselor and educator must be aware of new innovations, recently developed theories and contemporary viewpoints which may lend added effectiveness to the performance of their professional function.

The need for touch is most apparent in pre-adolescence as infants will not develop physically in a healthy manner without tactile manipulation. Slightly older children deprived of normal tactile experiences may develop learning and communication disturbances.

Society has attached a stigma to physical contact such that much touching has come to be tabooed. This taboo extends into psychotherapy making counselors who touch extensively somewhat suspect.

Touch is useful in the therapeutic setting in the reduction of anxiety, defraying of defensiveness, establishment of maturational environment, expression of feelings.

A definite lack of research exists in the area of the therapeutic effectiveness of touch, requiring further investigation.

More extensive research should be conducted to provide counselors with more accurate predictors of client-interpretations of touch, to compare client's pretherapy touching behavior to client's posttherapy touching behavior, and to provide counselors with enough data to derive their own philosophy of touch.

Chapter I

INTRODUCTION

Touching has probably always existed as a mode of nonverbal communication, but has usually been reserved for use within romantic or early parent-child relationships. The current trend toward psychotherapeutic touching is manifested by the increased frequency and degree of physical contact in encounter and sensitivity groups. (20) Tactile communication, stimulation, and expression are echoed in many publications of professional and general interest.

Physical contact is nearly a continuous experience for the barber, chiropractor, and nurse, as well as for members of many other non-psychotherapeutic professions.

Everyone has had the experience of having his scalp rubbed and massaged by his barber or hairdresser. This experience at being touched is done in the name of the health of the hair and scalp, it is quite impersonal, and so the customer can relax and enjoy the feel of another's hands touching a part of his body. By the same token, patients in hospitals can relax and enjoy a back rub that is given by a nurse without guilt or embarrassment, because the back rub is given in the name of health, to relax muscles. For nurse or patient to admit that there might be sheer delight in the giving or receipt of the back rub might provoke embarrassment, and so the pleasurable aspects of the back rub are seldom discussed, either by nurses among themselves or between nurse

and patient. Chiropractors, whose theory of the causes of health and disease is not accepted by medical scientists, doubtless aid many of their patients, not only because of the latter's faith in the power of chiropractic ideology, but also because there is much body contact involved in chiropractic healing. The chiropractor massages, manipulates, and otherwise touches his patients' back, and this doubtless has relaxing benefits for the patient. (23:144)

Touching seems to be culturally sanctioned for limited professional use but much interpersonal contact is still discouraged. Even physical closeness within the family is diminishing with the utilization of larger houses wherein each person has an area of physical privacy.

Certain situations determine touching to be socially acceptable such as when two people shake hands or when an older person places his hand or arm on the shoulder of one who is younger. A greater degree of physical contact outside the realm of male-female relationships does not usually occur publically except at times when a display of emotion is acceptable as in athletic competition. A homerun or touchdown may induce hugging and embracing between same-sex friends apart from the intrinsic physical contact defined by the rules of the contest. (22) One professional football team seems to be bending tradition somewhat more than usual, however.

Players on the Denver Bronco defensive unit held hands in the huddle during the 1973 season. In spite of this rather unique, isolated public display of touch among same-sex friends, the current mores concerning touch are derivatives of archaic practices.

In the study of the treatment of primitive emotional illness, it is difficult to distinguish clearly between physical contact as magic and as an intrinsically curative procedure. Historic literature in mythology, religion and magic all place considerable value upon touching and the "laying on of hands." Early European medical writings review Galen's treatment of hysteria in women. His practice of genital massage and application of warmth to the patient's body is described as "purely mechanical," lacking erotic undertones. Even before the pre-Freudian use of touch in hypnosis by Mesmer, Greatrakes the Stroaker utilized a stroking massage to force noxious humors, thought to cause mental and physical illness, from the body. (30:365)

The spirit of freedom in twentieth century psychotherapy seems to be much more confined and inhibited than the freedom experienced and exercised by historic therapists.

Today, a psychotherapist, social worker, or school counselor may find himself in a dilemma concerning his use of touch. Even if he feels that touching can be therapeutic, he may be restricted or inhibited by a culture which might place sexual, homosexual, or corporal punishment connotations upon his use of touch. Therefore, the conflict a counselor may face concerning whether to touch or not to touch appears to be a social constraint rather than a natural or moral problem. The therapist must not allow the mores of society to dictate which techniques he may use in a helping relationship, in view of the fact that a potentially therapeutic or maturational technique may be culturally taboo. "Every shred of material is useable regardless of its cultural 'tag'."

(29:200) Within the framework of a counseling philosophy developed to promote the healthy maturation of each client, touching may be included as a useful communication to help ease tension, confusion, and anxiety.

Statement of the Problem

The problem of this study is to investigate the attitudes manifested by writers in current and past literature toward the use of physical contact in psychotherapy.

Need and Purpose of the Study

Professionals involved in psychotherapy and counselor education must remain abreast with a changing society and allow, indeed seek, innovations that will enable them to function more effectively, efficiently, and productively. An individual who feels a need to experience a growthful contact is fortunate when he can seek the assistance of a counselor who is specially trained and qualified, and genuinely concerned. Whenever the needs of a person are not met, he will attempt to meet the demands of the need in other ways. Often these attempts result in emotional or behavioral problems. While most therapy is not intended to totally satisfy the needs of any client, it is a means by which the client may gain insight concerning those needs. When one becomes aware of inner feelings and pursues what he sees as best for himself, he may be freed from confusion and anxiety, enabling him to think clearly and act accordingly. Often, resultant from this process is improved social relationships, enjoyment of self and friends and increased spontaneity and honesty in behavior. Touching has the potential to convey genuine concern, bridge verbal communication

gaps, and to reduce barriers of age and defensiveness.

Because of the potential value of touching, it is critical that this area be explored for the purpose of improving the effectiveness of both short-term and extended psychotherapy.

The recent focus of attention on touching in publications and verbal discussion may have altered some counselors' attitudes concerning its practical utility. Opinions may differ additionally because of the counselors' exposure to encounter or sensitivity groups. A university counselor education department could benefit greatly from a compilation of contemporary attitudes toward touching, in that the training program could be reevaluated if it were found that a potential valuable mode of communication is partially or totally being ignored.

In spite of a new awareness of touch and its therapeutic potential, there exists a lack of systematic objective research concerning the utility of physical contact in counseling. Research cannot indicate the manner in which each individual therapist should employ or not employ touch. This study provides counselors with information on touch derived from writings in psychotherapy, psychoanalysis,

psychiatry, counseling, psychology, sociology, education, and nursing. A subjective analysis of the material presented in this study will aid counselors in the determination of their own philosophy of touch, hopefully enabling them to touch effectively, if and when it is therapeutic.

Limitations

This investigation was limited to a review of literature concerning the attitudes of current and past writers on the various psychotherapeutic aspects of physical contact between counselor and client. The reviewed material was limited to those sources available through the facilities and services of the Montana State University Library.

Most of the reviewed literature was dominated by the attitudes of theorists and therapists. This appears to result in a somewhat onesided overview of the effectiveness of psychotherapeutic touch.

Definition of Terms

Touch, touching, tactile communication, and physical contact all are terms which for the purpose of this study were defined as any bodily association between the counselor and client during a therapy session.

Summary

Touch has been utilized by mankind down through the ages in a number of different ways. Almost immediately after the appearance of woman on earth, man discovered the pleasurable erotic stimulation of a caress, a kiss, or fondling of each others bodies. He also discovered the cathartic value of touch when comforting, soothing, or persuading another human being. As time passed, man became more sophisticated in his therapeutic use of touch until today, the professional publications and journals are filled with numerous articles on the use of touch in the therapeutic setting.

Therefore, it is the purpose of this study to present a synthesis of the use and dynamics of, schools of thought concerning, and therapeutic value of touch in the field of psychotherapy.

Chapter II

DYNAMICS OF TOUCH

Introduction

Physical contact in a perfunctory manner seems to be of great importance in the social rituals of every-day life. Most men shake hands when meeting each other for the first time. The hostess usually dances with guests of honor at a formal function. While most people would agree that this kind of touching is somewhat unnecessary and done for appearance, there are other types of physical contact which are more serious and much more necessary. Touch is essential for the physical and mental growth of an infant who has no other mode of communication. (2) Verbal communication is soon learned by the infant but touch remains important throughout his life as a means of developing knowledge and awareness of new objects and people.

Curtailed communication at any age has a tendency to produce serious disturbances in an individual. (2) Communication includes verbal as well as nonverbal actions, both of which may be used to rehabilitate someone hospitalized for inadequacy in functioning physically or medically. Medical

team personnel are constantly in physical contact with patients, possibly because touch is one of the best ways to establish mental contact. (8) Nurses who touch frequently find their patients require less medication. (28) In addition to the rapport between the health personnel and patient, one must consider the "healing" powers of a doctor or nurse as a "significant" person. The patient develops a mental and emotional desire to recover when he discovers that he is a desirable enough person to be touched. (13)

A touch may communicate desirability or hostility, differentiated by the manner in which it is given and received. The correct or accurate interpretation of a touch depends upon many factors, including the previous experience of both toucher and touchee and the influence that other nonverbal indicators, such as facial expression, have upon the receiver. Touch is misinterpreted a great deal, partially because the same physical gesture can mean love to one person and hate to another, or sensuality to one person and aggression to another. Physical contact can be a significant asset to communication, but it can also be a serious detriment in the relationship of two people.

The Need for Touch in Personality
Development

Man's greatest need is to be loved and love cannot arise in a human being without touch and sensuous arousal. (2)

The most accurate description of the normal relationship between a baby and its mother is a love relationship. The mother has a variety of ways to communicate caring to the baby: nursing, caressing, bathing, massaging. All of these means involve touch, although at an early age the infant can interpret various other nonverbal messages. Touch is the earliest kind of message the baby learns, first to receive and later to send. (3)

The infant has the closest communication with and initially learns the most from its mother. His first exposure to acceptance is learning to trust the mother to provide nourishment and physical security. There is presently much discussion concerning the attributes of nursing a child as contrasted with bottle-feeding him. The mother's natural milk, said to be scientifically more nutritious than a synthetic product, is extremely beneficial to the child, but even more important to the child than nourishment is the

factor of bodily contact. The baby's contact with the maternal skin and his manipulation of the breast are more important than the nourishment itself. The feeding intimacy may be more important than the feeding. (5)

The first intimate relationship any person experiences is the nursing process. Initially, the baby is only interested in this experience for the immediate nourishment and security it receives.

Later in the baby's development (about three months) he expresses unbounded pleasure in the mother's touches. The response must come from the baby, however; no one else can evoke the mother's commitment to him. After the fingertips stage, the whole hand is used for maximal contact with the infant's body. The mother's hands are relaxed and comfortable and express how she perceives herself and her relationship with the baby. She transmits to him her security in herself through touch, and his responsiveness to her firm, comforting touch feeds back into her own well-being. The increasingly larger body surface involved in contact indicates a deepening relationship in which the mother is becoming much committed. (2:105)

The infant's world is built on and shaped by tactile experiences. He is first touched by other persons and soon has developed confidence and trust in the world around him. The baby begins to communicate with himself by feeling and exploring his own body, thereby developing a familiarity and

awareness of his own body image. This image is positively reinforced or negated by pleasurable or uncomfortable tactile experiences with human beings in addition to the mother. Body contact with people and things is necessary for the normal physical, mental, and emotional development of the child. (2,3)

When the child has physically developed to a certain level, breast feeding is ceased. All too often the physical "oneness" declines much too abruptly, and shortly thereafter the previously experienced intimacy, including emotional and physical contact, has ceased. The separation is much more than a psychic phenomena and involves the "breaking apart of what was formerly one." (5:97) Anxiety and loss of security emanating from a traumatic weaning may later be manifested in emotional disturbances. The loss and deprivation of these early tactile experiences can damage the infant's future ability to learn in the areas of symbol recognition, speech, cognition, and especially in its capacity for mature tactile communication. (2)

Tactile communication is never entirely superceded, even after the child can fluently communicate verbally. Throughout

his life, touch will remain an important medium of experience. Even though the greatest need for physical contact is in pre-adolescence, touching will provide the basis for self esteem as one matures. (8) Self esteem and body esteem go hand-in-hand and one must not ignore the importance of a positive body image, the absence of which tends to relate to the development of an adolescent homosexual. (4) Every teenager needs a confidant, but even intimate verbal contact may leave one in a limbo of isolation from other bodies as well as one's own. Guiltless contact with another person has the power and strength to reassure that one is a unique individual while not existing in total aloneness. (13) Thus, the interpersonal cooperation necessary for social identity and conformity is not possible without tactile stimulation.

Sports and dancing are probably the most socially advanced outlets for the inescapable need for skin contact. People participating in these activities seem to be consciously aware of their body in relation to other bodies. The social recognition derived from these activities may be nearly as important as the contact. Other methods are available to achieve social acknowledgement, however, so there seems to

a measure of satisfaction in viewing oneself in bodily esteem. (13)

Need for Touch in Physical
Convalescence

Most people experience a need, or at least a wish, to engage in physical contact. The cause of many disturbances has been described in part as the consistent lack of physical contact. A study reviewed by Barrett (3) presented the evidence that babies born by Caesarean section and infants born prematurely, not having experienced uterine contractions at birth, showed a significantly higher incidence of nasopharyngeal and respiratory difficulties. Obviously this type of problem cannot be resolved with even an extensive frequency and degree of contact, the absence of which initially contributed to the problem.

Touch may be somewhat effective in the rebuilding of body tissues through the use of the massage. More importantly, however, is the special role touch plays when the body suffers pain and trauma. From childhood, physical contact is associated with the relief of pain as the mother comforts the child and "kisses the hurt and makes it better." While

handicapping injuries typically lead to depression and helplessness, touch can reassure the mutilated patient and convince him that he is still touchable. Conversely, direct physical contact may stimulate the patient's emotional regression to an earlier phase. He may react to the hospital situation with the anxiety and fear of a frightened youngster, the nurses's touch being reminiscent of the comfort of mother, and he retreats back into the security of childhood. (9)

The nurse, often seen by patients in a mothering role, may be able to establish nonverbal contact with this patient whose verbal communication capabilities are impeded. Also, in the regressive state, a patient may be more capable of accurately interpreting nonverbal communication than verbal. (2) If the nurse can first establish nonverbal contact thru touch, the possibility of getting in contact verbally and mentally is much greater than if touch was not utilized and the length of convalescence conceivably much shorter. (8) In view of the previously stated examples, touch can greatly hinder or help healing, depending on the interpretation by the patient.

(2)

Some consensus of opinion seems to exist among the writers

concerning the positive effects of touching. This consensus remains unsupported by research as there is a glaring lack of systematic objective investigation about the use and effects of touch. Studies by Barrett (3) and De Augustinis (7) provide interesting and useful information about touch, but both are inconclusive as to touch's therapeutic utility. Barrett (3) used the observational method to collect data to determine the types, extent, and frequency of touch used by a hospital staff. Some interesting and thought-provoking results are listed below:

1. The patients most frequently touched were females aged 26 to 33.
2. The patients most frequently touched were listed in good condition.
3. The patients least frequently touched were listed in serious condition.

The De Augustinis (7) study, investigating the various meanings to touch gestures in patient-ward personnel dyadic relationships, reported the following conclusions:

1. Touch involves risk. Even with thought and foresight, the initiator's message was misinterpreted as much

as fifty per cent of the time.

2. Being touched was more anxiety producing than touching.

3. People who use touch are more likely to have a background of pleasure and satisfaction associated with touch, as opposed to touch associated with anxiety and punishment.

4. Some people touch only to express anger and aggression; others convey only tender feelings.

5. Specific touch gestures do not have universal meaning.

Touch appears to be a potentially valuable means of communication in a convalescent setting. However, so many variables influence the interpretation of a touch that it is difficult to categorically declare its utility as helpful or hurtful to the physical healing process.

Types and Interpretation of Touch

A touch must attempt to convey a message in order to qualify as a form of communication in a therapeutic sense. Johnson (21) views touch as a way to emphasize verbal communication, while other sources (2,3,5) see physical contact as

the basis for communication with words being symbolic of the touch. All the writers agreed, however, that the most important part of touch to consider was the interpretation by the recipient. The important thing is not what one has tried to communicate but what the receiver thinks one has tried to convey. Specific instructions accompany a communication and determine how it will be received and interpreted. These messages about messages are termed metacommunication. These instructions concerning interpretation lie in the nonword context of a message, such as a smile or body tension. In the case of touch, the metacommunication may include other nonverbal indicators or may lie in the touch itself as in the firmness of a handshake or the hesitancy with which a person touches. The interpretation of the contact depends upon the metacommunication about that contact. Many additional factors influence the receipt and translation of a touch. (33)

The meanings of verbal and nonverbal expressions are most greatly influenced by past experiences. Tactile encounters of the past color verbal communication but more importantly dictate in part how a new haptic encounter will be received. For example, a person upon whom physical advances have been

initiated by a homosexual may be reluctant to receive the concerned touch of a same-sex friend. A female may be resistant to the touch of a male therapist because of her past experience that "men are all alike." (25,26) (This expression may have some empirical basis as brought out by Jourard (26) in a study which indicated that men may establish physical intimacy without psychological closeness to a female; whereas, according to the research, females tend to act in a more integrated manner. However, females were not found to have as great a capacity for self-disclosure without intimacy as were males.) Someone whose only exposure to touch has been in a punishment and aggressive manner will tend to view all physical contact within that framework. Conversely, a client whose entire developmental exposure to physical contact has had sexual overtones may react inappropriately to a tender touch from a counselor.

Any communication is viewed as a figure, symbolic of past experience. The feelings and values held in relation to this experience are reactivated and enter the client's expectations when he is touched. The communication may change greatly when it is interpreted by the client. These

considerations emphasize the fact that the communicator needs an ability to project himself into the mind of the recipient and perceive and influence his readiness for touch. (7) While a touch often need not, and maybe can not be translated into verbal language, it is important for the therapist to give careful thought and consideration to the possible interpretations of his touch. This is especially true in therapy with psychiatric patients, for a touch may be misread as much as fifty per cent of the time. (7)

Despite possible misunderstandings, nonverbal communication can greatly enhance verbal messages. Communication is at its best when both verbal and nonverbal means are used. A conflict between verbal and nonverbal messages may place the recipient in a quandry concerning which mode to judge as valid. Speer (37) reports that nonverbal indicators are more accurate than subjective reports with regard to feelings and emotions. Therefore, it would follow that since nonverbal indicators are more accurate, they should be responded to, but of course, with discretion. It would not be appropriate to respond to a very anxious new client about his tense body, perspiring face and clenched fists. This indicator can be valuable to

the counselor in terms of recognizing the stress the client is experiencing. Johnson (21) suggests it is possible that an individual responds to verbal messages verbally and non-verbal indicators nonverbally. An example of this follows:

Client : I sure enjoyed today's session. Wish we didn't have to stop (as he rises from his chair and exits in one motion).

Counselor: Yeah, I know. I hate to stop now too (as he leans back in his chair, places his feet on the desk and clasps his hands behind his head).

In addition to the interpretation of verbal and nonverbal factors, the counselor must examine his use of touch as a role or goal-directed activity. A role-directed touch would fit into the framework of a counselor as a nice person. Because one's instructors touched, he may touch also. He may be under the false impression that all successful counselors touch, so he must touch. The role-directed touch rather defeats or confuses the purpose of touch as a goal-directed activity. One must decide what purposes he wishes to accomplish by touching. Playing the touching role consciously or unconsciously prohibits the initiator from examining the goal and value of each individual touch. While it may not be important for a touch to ever be actually translated into

words, it is necessary to consider how the touch will be received. (21)

Touch, as the most significant form of nonverbal communication, can have many meanings and interpretations. There are many different ways in which a touch may be received, ranging from happiness to hostility. Touch can be sensuous without being sexual, communicating a great amount of concern and caring. Through touch, one may express inner feelings and reactions, conveying his emotions to another. The most accurate and colorful description of the relationship between people in physical contact was defined by Marita De Thomaso as a "close openness." (8:115) Touch can convey a variety of hostile and aggressive messages, also. A handshake or touch on the shoulder can indicate hostility just as mild striking or pushing actions can convey affection. Touch can convey nearly any emotion a person can feel. Similar gestures may mean entirely opposite things and the interpretation is largely dependent upon previous tactile experience and the kinesic metacommunication which accompanies the haptic contact.

Summary

The necessity for physical contact between human beings has been recognized, resulting in an incorporation of touch in human development, social rituals, and mores of every-day life. A baby cries soon after parturition, communicating his need for warmth, security, and comfort. This manifestation sets in motion a process of touch that is essential for the development of the child. The infant's world is built and shaped by tactile experiences. He is first touched by other persons and through these experiences develops confidence and trust in the world around him.

Curtailed communication, both verbal and/or tactile, has a tendency to produce serious disturbances in an individual. The loss or deprivation of early tactile experiences can damage the infant's future ability to learn in the areas of symbol recognition, speech, cognition, and especially in the child's capacity for mature tactile communication necessary for a good self esteem and good mental health.

Touch also reassures the convalescing patient that he is still touchable and worthy of shared emotional intimacy. Physical contact has a tendency to thwart depression and feeling of helplessness. Thus, when the body suffers pain

or trauma, physical contact can provide a balm to the distressed individual.

The way a person perceives a touch experience determines the therapeutic or harmful effects it will have for that individual. A person takes into consideration both verbal and nonverbal aspects when experiencing a haptic encounter. Someone whose only exposure to touch has been of a punishment and aggressive nature will tend to view all physical contact in that framework. Conversely, a client whose entire developmental exposure to physical contact has been tainted with sexual overtones may react inappropriately to a tender touch from a counselor.

Thus, through touch, one may express inner feelings and reactions, conveying his emotions to another. However, the interpretation of a touch is largely dependent upon previous tactile experience and the kinesic metacommunication which accompanies the physical contact.

Chapter III

PROPAGATION OF TABOOS CONCERNING TOUCH

Introduction

The history of the social taboo against touching dates back to before the life of Christ. In every society since then, something has been taboo which by definition implies a prohibition maintained on the basis of tradition rather than rationality. (31) If the current taboo on psychotherapeutic touching is as encompassing as most of the writers declared it to be, perhaps it is because many contemporary therapists help to maintain it. Their use of touch may be determined more by societal mores than by professional ethics, thus promulgating the taboo. However, the primary reason not to touch in therapy seems to result from a cautiousness concerning the welfare of client.

The reason for not touching in every-day life seems to be the desire for social acceptance which may be evoked should one engage in physical contact. The taboo remains in the home as parents discourage children from touching even themselves for fear that the child will grow up to be over-sexed or perverted in some way. Actually, in the common

family it is much more basic than this because touching is simply "bad." The taboo will remain as long as counselors, parents, and members of society continue to pass judgment on physical contact before having examined it in its entirety.

Society and Taboo

The taboo against touching in therapy seems to be indicative of the every-day touch taboo in the behavior and relationships of the average person. While the taboo problem is not necessarily unique to the American society, it does have common developmental roots with the remainder of Western culture. The taboo has not always been **in existence**, but was derived through a historical sequence of processes emphasizing the value of the mind and deemphasizing the value of the body.

Archaic man was close to nature both in his beliefs and life-style. There were few distinctions between himself and the world he lived in. This unity caused and lent itself to the development of few barriers between man and the natural world. This flow continued at a constant level, endlessly exchanging energy between the human and his

environment. This early personality was unconcerned as to whether he was a subject or object within the realm of the universe as he knew it. With the advent of the teachings of the great philosophers such as Socrates, Plato and later Aristotle, a distinction began to be made between the function of the mind and the corresponding, but sometimes opposing desires of the body. The Biblical law transcribed by Moses finally harnessed the separation of the mind and body that had previously been only speculation by the post-Platonic philosophers. (5)

Mosaic law and the Apostles firmly saddled Western civilization with dualism and separation of mind and body, giving man a certain agency beyond his organism. This gave him a divinity in the image of his gods but with a concentration on the mind and soul portion of divinity and ignoring the physical aspects. Guilt and repression sprang up from the influence of the "evil" desires of the body and these instinctual impulses thereby came to be tabooed. (5)

Since touch was inherently linked with these "evil" desires, puritanical tradition tended to make the touching of bodies shameful. (23) This attitude has so firmly

attached itself to current cultural mores that in the American society, touch is generally equated with heterosexual or homosexual intent, either on a conscious or less-conscious level. (26)

The Western man seems to be presently experiencing an estrangement from his body in the area of touch as well as in other physical awareness pursuits. The fact that Occidental man is unaware of his physical self concept may be contrasted with the philosophy of the Eastern man who looks within his own body and spirit for grace, or what we might call meaning, peace, and happiness. Western man searches outside of his own body for "higher" and "purer" forms of ennoblement, the result of which makes it a more anxiety-producing experience for him to touch. (5) Because of the taboo and unclear societal restraints, touching between adults often takes the form of disguised and deflected gestures, resulting in little body contact of much sincerity. (35) The variation in adult's comfort with the initiation or receipt of touch relates largely to the mores of society during their maturation and to the cultural dictates of their current age group. (21) For example, an Italian male would consider it

a common practice to compliment an attractive woman by pinching her on the posterior, while this would not be a socially acceptable practice in other cultures.

It seems to be more acceptable for females to touch and be touched than it is for males to engage in this kind of activity. While sex and touch that is symbolic of the intimate physical relationship are taboo, even more inviolate is body contact between same-sex friends, especially males. American stereotyped morality virtually leaps to the conclusion or, at least, inquiry of homosexuality should any significant contact occur between two males. (25,28) The taboo becomes more complete with the inclusion of this additional restraint as opposite-sex and same-sex touching is equally prohibited.

Human Development and Taboo

Throughout one's life, the feel and appearance of the body are bases for the development and maintenance of one's self concept. The experiences of touching and being touched are definite factors of how one sees himself as a physical person. Some writers declare that body esteem and emotional self esteem are inseparable. The adult individual loses his

social right to physical closeness as many people forget that contact and warmth are not synonymous with sex. The baby or small child still possesses the cultural privilege to touch and be fondled, but at a certain point even children are stopped from exploring themselves. The childhood taboos of "don't stare" and "don't eaves-drop" are reinforced by negative verbal means; whereas, a child caught touching his own body in the "wrong places" might get his hand slapped. Soon he learns not to touch. (5,8,33,35)

One of a child's early basic experiences is to learn the inviolability of things, animals, places, and persons. This begins when the child starts to explore his world. It involves the curtailment and prohibition of tactile experiences, forbidding the child to touch whatever is defined by adults as inviolable (precious belongings, glass objects, one's own genitals). The instinctive approach to inviting objects is blocked and prohibited, often with punishment, until these objects are perceived as non-touch unless they are sanctioned through the permission of ritual (buying, earning, marriage). Gradually the child transforms the parental prohibition into self administered inhibitions by

learning to perceive things and persons as signs or symbols for avoidance. Through this process the former touch response is relinquished. The child must now identify everything by sight, getting out of contact with touch recognition. (14)

The transformation of instinctive touch responses into learned observance of inviolability may involve emotional disturbances due to conflicts with parents and forced over-learning. Thus, the child becomes inhibited and less capable of making tactile contacts, especially in interpersonal relationships because of his perceived failure in his first interpersonal experience. (14) The personal taboo on touch is now well on its way ingraining itself into the functioning of this individual, culminating in neurotic behavior in post-adolescence.

Psychoanalytic theory describes the taboo on touch to be one of the most fundamental commands of obsessional neurosis. Freud very clearly follows the development of this type of neurosis from its earliest point of evolution.

Right at the beginning, in very early childhood, the patient shows a strong desire to touch, the aim of which is of a far more specialized kind that one would have been inclined to expect. This desire is promptly met by an external prohibition

against carrying out that particular kind of touching.¹ The prohibition is accepted, since it finds support from powerful internal forces,² and proves stronger than the instinct which is seeking to express itself in the touching. In consequence, however, of the child's primitive psychical constitution, the prohibition does not succeed in abolishing the instinct. Its only result is to repress the instinct (the desire to touch) and banish it into the unconscious. Both the prohibition and the instinct persist: the instinct because it has only been repressed and not abolished, and the prohibition because, if it ceased, the instinct would force its way through into consciousness and into actual operation. A situation is created which remains undealt with—a psychical fixation—and everything else follows from the continuing conflict between the prohibition and the instinct.

The principal characteristic of the psychological constellation which becomes fixed in this way is what might be described as the subject's ambivalent attitude towards a single object, or rather towards one act in connection with that object. He is constantly wishing to perform this act (the touching), and looks on it as his supreme enjoyment, but he must not perform it and detests it as well. The conflict between these two currents cannot be promptly settled because—there is no other way of putting it—they are localized in the subject's mind in such a manner that they cannot come up against each other. The prohibition is noisily conscious, while the persistent desire to touch is unconscious and the subject knows nothing of it. If it were not for this psychological factor, an ambivalence like this could neither last so long nor lead to such consequences. (15:29,30)

¹Both the desire and the prohibition relate to the child's touching his own genitals.

²That is, from the child's loving relation to the authors of the prohibition.

It might appear somewhat unusual to some that the avoidance of touch should play such an important part in the development of a system as complicated as a total personality. Again, Freud helps to explain this phenomenon. Touching and physical contact are the immediate aims of the energy directed toward the loved but tabooed object. The id desires contact and eros desires to make the ego and the loved object one. The obsessional neurosis begins by persecuting erotic touching. After regression has taken place because of this persecution, the superego attacks aggressive touching also. Soon the individual is not experiencing any physical contact at all.

(16)

The prohibition against touching, the nucleus of neurosis, involves much more than simple physical contact. Anything that directs the persons thoughts to the forbidden object is as taboo as the object itself. Touch supposedly directs a person's thoughts toward sex. So sex, touch, and thinking about touch all become taboo. Anyone who violates the taboo by coming into contact with something that is taboo, such as touch or sex, becomes taboo himself. Then no other person may come into contact with him without becoming taboo

also. As one might imagine, this causes interpersonal relationships to suffer greatly. The person experiences a need to make contact emotionally and physically, but if he does, the objects of this contact become taboo. (15)

Psychoanalysis has shown that the taboo is predominant among conscience-dominated obsessive-compulsive personalities who isolate their thoughts from their feelings, their minds from their bodies, themselves from others, emphasizing self-control, rationality and aloofness. This type of person would be ideal to excel in the objective technical world of a scientific and engineering civilization. The interpersonal relationships experienced by a person greatly influenced by and involved in the touch taboo tend to become much like the society he lives in — technical, intellectual, unemotional, impersonal, and neutral. (13) Nothing could help this person as much as physical contact agreed to by him and the other person involved. However, he usually isolates himself, removing the possibility of contact, and causing further conflict. He lives in a world of ambivalence and self-preservation, not loving and feeling unloved, all the while trying to isolate these thoughts from his other

thoughts. The effect of the taboo is complete; he can not touch or be touched. (16)

Therapy and Taboo

Early references to psychiatry and especially hysteria make note of an impressive healing effect apparently brought about by massaging the head and neck of the patient. Numerous references also indicate the mystical power of touching in the relief of distraught patients suffering from somatic symptoms. (13) Even before Freud, psychiatry was essentially the application of various physical things to the body in an attempt to influence the mind. While defining the structure and function of the psyche, Freud himself kept the body and its systems as a frame of reference. (5) In spite or possibly because of these early psychophysical Gestalts concerning a total personality, the mainstream of psychotherapy grew away from bodily inclusion of symptom treatment. The time period in which psychiatry and psychoanalytic theory were born may have had a great influence on the divorce from the body.

Victorian sexual prudery was at its apex late in the nineteenth century. The extent of the prudery was demonstrated

in an example by Elizabeth Mintz (30) in which a women's magazine of the 1880's condemned the baby carriage because it encouraged women to wander away from home "and for what purpose?" The desire of early analysts to establish themselves as scientists during this period may well have been a rationale for the establishment of the therapeutic touch taboo. For mere survival in a world of hostile public opinion, these analysts had to be very judicious with physical contact as is exemplified in the case of a London neurological scientist who was forced to cancel his appointments because of inquiry into the sexual life of his patients. (30) The early analysts also wanted to divorce their science from religion or magic, both of which were inherently linked to touch and the body.

Freud's early theory and practice were biological and body inclusive as he frequently stroked the head or neck of a patient for stimulative effect. Freud and his followers were regarded as sexual perverts and a tangible threat to the Vienna community. Many people interpreted Freud's theories and practices as an encouragement for the patient to rid himself of all self-restraint. Freud went thru a period of

experimentation with hypnosis and free association, but when he rejected these endeavors, the touching for which he was so criticized was thrown out with the theories. From this point on, it was important to steer clear of any practice or gesture that might be misconstrued as sexual by an uninformed hostile public. (30)

The psychoanalytic movement institutionalized the touch taboo in psychotherapy by providing a theoretical rationale for understanding unconscious meanings of body contact. (13) Freud himself fostered dualism while attempting to preserve a monistic position. This began with his discovery that a repressed idea could lead to a bodily symptom. Psychoanalysis then became to him a systematic cleansing of the human storehouse of complexes. The body was nothing more than a container of complexes and often was an interference to the analysis of those complexes. If the body issued pain, the patient was referred elsewhere or the pain was the subject of the analysis. (5) It was this early in the development of the theory that psychoanalysis became somewhat impersonal as the distance between patient and analyst was clearly defined. (31)

The distance between analyst and patient is supported in actual psychoanalytic theory by giving rationale for non-touching. The first sustenance for the taboo is the "rule of abstinence" which means that neither the analyst nor the analysis may become a source of gratification to the patient. The analyst who touches places himself in a position to gratify the patient, thereby perpetuating the neurosis. The second no-touch principle is the "transference factor" meaning that transference should develop in a situation minimally influenced by the real personality of the therapist. Touch may contaminate the transference and block the development of its negative aspects. (30) Thus, Freud seems to have added significant rationale to the touch taboo but analysts and other therapists have certainly contributed to the maintenance of the taboo.

Furthermore, psychotherapists seem to have a fear of touching a client's body and are very quick to refer should physical discomfort appear. Therapists apparently fear the possibilities resulting from touching and somehow avoid contact, no matter how minor. A classic example of this phenomenon is described by McCormick (29) when he states

that he will not even initiate shaking hands with a patient. Although one may critique McCormick's avoidance of touch in several ways, it does appear that many people involved in helping professions are at best tentative with the use of their body as it relates to contact with other bodies.

Therapists possibly dislike all bodies on an unconscious level. The body is finite and will someday deteriorate and die, but the mind or soul lives on after death, even if only in the memories of those still alive. The therapist's countertransference of the body is in part the counter-identification with the patient's body and the rejection of it as mortal. By contacting the patient in a manner other than through psychic communication, the therapist is contaminating his body and that of his patient. (5)

It must be pointed out that viewpoints such as the one just reviewed have not gone unnoticed. There seems to be a current attempt in therapy and especially in psychoanalysis to bridge the gap between the body and mind and to return the body to the psycho. (5)

The relationship between the therapist and client may often be described as intimate. If physical contact is

included in this bond, it must be divorced from erotic stimulation of any kind. It is interesting to note that psychoanalysts often find the supine posture on the couch the position necessary for "curing" the patient. The fact that this just happens to be a principal sexual position leads to a curious paradox. It seems as though the couch is used or needed to reinforce the strength of the taboo against touching. (5)

Summary

In summary, the taboo against touching in therapy seems to be indicative of the every-day touch taboo in the behavior and relationships of the average person. Through a historical sequence of processes emphasizing the value of the mind and deemphasizing the value of the body, the taboo on touch came into existence. Thus, guilt and repression sprang up from the influence of the "evil" desires of the body and these instinctual impulses thereby came to be tabooed.

As a consequence, man presently is experiencing an estrangement from his body in the area of touch as well as in other physical awareness pursuits, even though the feel and appearance of the body are bases for the development and

maintenance of one's self concept. The adult individual has lost his social right to physical closeness because most people do not realize that contact and warmth are not synonymous with sex. Thus, a well ingrained personal taboo on touch often culminates in neurotic behavior.

The neurotic person then usually isolates himself in order to remove the possibility of physical contact and further conflict. He lives in a world of ambivalence and self-preservation, not loving and feeling unloved.

In the past, the therapists who recognized the value of touch and endeavored to utilize it in their therapeutic sessions were regarded as sexual perverts and a tangible threat to the community. As a result, the value of touch in therapy became a mute question and therapists steered clear of any practice or gesture that might have been misconstrued as sexual by an uninformed hostile public.

Chapter IV

THERAPEUTIC CONSIDERATIONS REGARDING THE USE OF TOUCH

Introduction

The value of touch in psychotherapy has been the topic of a great deal of discussion ever since Freud first massaged the head and neck of his patients. The viewpoints expressed over the years have included both professional and public considerations, often centering upon the personality and reputation of the therapist in relation to touching. The archaic discussions involved several different schools of thought about therapeutic touch. One school strongly agreed with the positive aspects of touch, another school strongly reinforced the negative things about touch, and the final school assumed a neutral position. Current attitudes have changed little from those of earlier generations. This chapter reviews the three viewpoints in the present practice of psychotherapy. The school of thought that strongly advocates touch will be presented, followed by the converse school which strongly prohibits the use of touch. The final position is a middle-of-the-road philosophy which considers touch to be a possible means of communication, but also examines its limitations concerning psychotherapeutic touch.

Positive Aspects of Therapeutic
Touch

The therapist's attempt to help an anxiety-ridden client live in maximum comfort and efficiency often involves verbal as well as nonverbal means but often eliminates one potential means of achieving that goal. Contact seems to act as a powerful catalyst in communication and often strengthens the verbal interaction. The greatest error that commonly occurs in therapy is the withdrawal of the counselor away from the client, rather than going forward to allow emotional contacting.

(5) Empathy with the client is strengthened and vitalized when the client experiences physical contact with someone who society confirms as a "significant" person, giving the client symbolic cultural approval and the personal attention of the therapist. (13) The investigator remembers the importance of being touched at times in life when communication thru any of the other senses would not have approached the meaning that the touch conveyed. However, the message reached all parts of the personality through the medium of physical experience. Some therapeutic systems hold the belief that the total personality may be reached only through physical contacting.

Alexander Lowen's Bioenergetic theory places importance on touch as a technique. For example, pressure with the thumbs upon the cheek bones will enable the therapist to see the terror lying behind the schizoid mask of the client. Neo-Reichian therapists value physical massage as a useful tool in the therapy session. However, the most involved body contact therapy is Orthodox Reichian therapy in which muscle rigidity, corresponding to psychological tension and emotional blockage, is diminished by rubbing and stroking. (4)

According to Reich, Freud approached the analysis of mental contents of the repressed unconscious from above rather than through direct release from below. (4:103) The body, Reich states, is hampered by seven rings of character-muscular armoring extending from the head to the pelvis, each ring corresponding with emotional tension. Reich therapy systematically attacks each ring of emotio-physical tension by various body contacting methods, opening the client's ego defense system from underneath.

The direct manipulations of the client's muscular network has powerful effects upon the individual's psyche. Although Reichian therapy has undergone some changes over the

years, many Reichian therapists still believe that if they can induce a low grade orgasm in therapy that this achievement indicates that the patient will be able to experience consummatory orgasms with lovers. It appears that the capacity to achieve orgasm is the only criterion upon which a healthy personality is determined. The Reichian therapist usually proceeds in the following manner:

The Orthodox Reichian therapist usually requests that his patients disrobe entirely for each therapy session. Patients are also usually required to lie in a horizontal position on a bed or couch most of the session. These two conditions alone predispose the therapist to relate to the patient always with his body in the foreground of the former's attention. Most Reichian therapists begin by asking the patient to do some deep breathing exercises while also giving full attention to subjective body phenomena of the most primitive kind—proprioceptive sensations of various sorts, muscular tensions, and the degree of spontaneity and depth of the breathing cycle itself. This will normally become a triggering device for either the patient to volunteer talking about those aspects of his experience since the preceding session which are clearly associated with organismic dimensions, or else facilitate the therapist's active inquiry regarding such experiences. A third and very common alternative is for the therapist to actively begin to manipulate the patient's body with two hands, placing them in such a way as to either further the process of organismic relaxation set going by the deep breathing or else to give relief and release to those parts of the body which seem resistive to the whole relaxation process. What little talking is engaged in is highly selective, there being a

certain obligation on the part of both patient and therapist to confine themselves to bodily-related phenomena. (4:105)

The commitment and determination with which Reichian therapists confine themselves to the body is the same type of dedication many humanistic counselors give to their clients.

More and more counselors are looking at therapy, not as a service, but as a relationship or dialogue between two people. Many times the client is afraid of spontaneity and is afraid to reveal himself. In like manner, the therapist is afraid to let himself respond in honesty and transparency to the client. Both need to become unselfconscious and reveal.

Touch can play an important role in the patient becoming aware of the subjective being of the therapist and demonstrate the counselor's commitment to the relationship. If he did not care, he would not touch. (12, 24) The relationship can now progress toward the honesty and transparency ideal as both disclose to the other. Touch may allow closer emotional contact and stimulate more self disclosure than each would allow himself verbally. (27) The developing therapeutic relationship then becomes personal to client and counselor.

Therapists with the most personal therapy often touch

and make selective use of physical contact. A recent survey showing that the majority of clinical psychologists do touch lends support to the opinion that counselors should approach clients on a person-to-person level, making his total Gestalt available to be experienced by the client. (13)

Permitting the patient to touch the therapist has additional significant meanings. For the very disturbed it is reassuring and ego-strengthening to learn that the therapist trusts them, does not fear their rage, will permit or even encourage their assertive exploration of reality, first represented, of course, by bodies. For those whose separateness is less of an issue the taboo against physical relatedness is lessened and assertive behavior encouraged. For all patients this kind of contact is a step beyond the dependent reassurance toward challenging the infantile position which defines the therapist as omnipotent and the client as helpless, inadequate, or unlovable, i.e., untouchable. Touching makes for mutuality and is part of the process of testing whether one dares to become or will be permitted to become an equal. (13:231)

A therapist must be secure within himself to initially risk meeting the client on a parallel basis. After the initial trauma, however, the counselor will find that touch on an equal reciprocal level will assist the client in examining the dynamics of his needs. "The therapeutic task is one of helping the patient recognize his need to be touched, to understand its origin and current intensity, and to verbalize this

understanding." (39:461)

Clients who engage in the process of trying to understand their needs are often those clients who have been touched. A study involving physical contact as it relates to the search for self-understanding has shown that touch is a contributor to the establishment of a relationship and to self-exploration. Clients who were touched engaged in more self-exploration than not-touched clients and counselors reported feelings of closer rapport with clients whom they had touched. One of the possible ramifications of this in terms of learning theory is that the behavior of caring may elicit the feeling of caring. While this general consideration has been, is, and will be the topic of much discussion among fellow psychotherapists, the open-minded examination of such a possibility may stimulate personal growth, regardless of theoretical orientation. (34) The effect that touch had upon self-exploration maybe some indication of the effect touch might have on other aspects of interpersonal psychotherapy.

A Silverman study concerning the relationship between self-esteem and tactile communication indicated that self-esteem increased with an increase in intimacy. People with

high self-esteem indicated more clarity in communicating emotion than did the lower self-esteem subjects. As self-esteem increased, clarity increased. More significantly, however, high esteem people found communicating through touch easier than did lower esteem people. (36) It is possible that people who feel more comfortable with themselves can take more risks in communication and the meaning is conveyed more clearly because of an openness factor. Sidney Jourard supported this belief in a series of studies on self-disclosure. The clients in his investigations engaged in more disclosure when the self-disclosure of the counselors was accompanied by touch. (27) The study also indicated that if a therapist discloses and touches, the client may not consider the touch as much a threat or invasion of privacy because the therapist has accompanied it with a risky self-disclosure. Because of the touch-self-disclosure duo, the client may trust and invite the counselor into his world. Even if the client does not develop trust, there is a possibility that he might self-disclose to the therapist, expressing his non-trust or fear in the relationship. The consistent feedback from the counselor would determine for the client whether or not he

could develop a trust within the relationship. (27)

Touching is one of the methods of altering feedback to a client. Positive feedback reinforces the steady existing state of the organism, but negative feedback induces reorganization. If the client receives the same type of feedback in therapy as he does the rest of the time, this results in a non-growth situation for him. However, when feedback is altered, such as when an unexpected touch occurs, there is room for growth because the client is forced to react differently than he has been. This results not in gratification for the client, but in a process by which the therapist assists in changing the structure of the client so that he becomes open to new relationships. (11,33)

This process involves a succession of steps. The well-timed contact interprets to the client his emotional distance from the therapist, his resistance to feelings and wishes, his expectation of rejection, too often confirmed by purely verbal interpretations. The therapist's touching can be used as a contradiction of the client's expectations and thus demonstrates the client's own resistance to human relationships. His emotional response may surprise him into a recognition of deep longings. He can then be helped to recognize that his oppressive conscience and the roles that he has played to get along with it has limited his freedom to give to and obtain from others. Thus, taking the therapist inside is an antidote to the destructive residuals of early

relationships and opens the closed system of the person to new interpersonal experiences. (13:230)

Although in the past, many psychoanalysts have consciously attempted to remain "outside" the patient, there has been a recent renaissance of personalized analysis.

Despite the constraints of psychoanalytic theory, there has been an increasing emphasis on therapy itself as a growthful emotional experience. Orthodox psychoanalytic theorists categorically state that the therapy itself or the relationship between therapist and patient not be a source of gratification to either therapist or patient. However, there is pleasure taken by ego in its own expansion and maturation, pleasure in diminution of superego, guilt, and immediate, though partial satisfaction of dependency needs. Contact can not be cut off on the rationale that it might gratify the client. If physical contact with the client does not make him more dependent and if the relationship can continue in a therapeutic state, then touching may not be wrong after all. (29,30,31)

One of the primary reasons for the touch taboo according to psychoanalytic theory is also one of the main justifications for touching. Positive physical contact may very well

facilitate transference by allowing the patient to reexperience his negative childhood memories in a more positive manner. Since the therapist will be the target of the transference despite his personal involvement, he may as well become involved and assist the client in working through early negative tactile experiences. Touch may function as an active ingredient in resolving resistance. It is also valuable in developing insight and furthering the breakthrough of repressed feelings. The recently published utilizations of touch in psychoanalysis may be the first of many indications of taboo relaxation within a therapy system that has been basically no-touch. (30,31,39)

While Freudian therapy has been basically no-touch, activities related to group counseling and encounter and sensitivity groups have been characteristically touch oriented in publicity, if not in actuality. If the members of a group touch spontaneously, it will increase growth and awareness if they are led to look at the causes and results of touching. Sometimes, a touch is the only spontaneous thing a person does. The importance of contact in a group does not lie in the touching of a lot of bodies, but in the incorporation of

physical contact as another thing to be experienced, expanding the range of awareness. (19) The power of a group is very potent in a therapeutic sense and the use of touch with the group can create an even mightier system. The immediacy of touch as applied to a group situation can carry the special force to break through layers upon layers of intellectual armor. In this type of situation, aggressive contact might be as valuable as the tender touch. (35)

Hostile touch, if it is to be used at all in a therapeutic sense, should be reserved only for the group therapy situation. There are a great many ways in which non-aggressive touch may be employed in all modes of therapy but especially in one-to-one counseling. While tactile experiences may be valuable to all variations of therapy, there are some optimal times to touch. The more difficult it is for a person to control himself, the more likely he is to respond to an appropriate touch as a release of action. Touch helps him break down some of the walls of inhibition-caused lack of control. (39)

There are times when an individual most needs altered feedback, different from what he usually receives. The patient who holds himself rigid in anxiety and despair, the

person who is at the peak of a period of feeling unlovable, or the game player who should be rewarded for not living his script are all prime candidates for a judiciously executed touch. (33) For the client who is struggling with internalized parents in the form of an oppressive conscience, the therapist may become more appetizing to the client than the internal parents by allowing touch. Haptic contact might be especially valuable in the therapy of a child who is too young or an adult who is too disturbed to communicate adequately on a verbal level. The empathy and other "healing" messages would be conveyed nonverbally out of necessity. (6,13)

Healing is not, however, the result of touch, but the response to a touch is an indication that a catharsis is at least in progress. A client whose only exposure to touch was within a punishment or genital framework might respond especially well to contact with a same-sex counselor. The contact would be indicative of his self-esteem and body-esteem. When he can enjoy a touch, he is enjoying a sense of his body as his own. His ability to touch would be a physical sign of psychological achievement. Contact with a male with actual or feared homosexual tendencies must be

approached with extreme care. However, under the right circumstances a same-sex counselor could share in this person's feelings of warmth without sexual overtones.

Some general guidelines as to the appropriateness of touch in certain situations are outlined by Mintz. (31)

Touch may be most appropriate as:

1. A means for symbolic mothering at times when patients cannot communicate verbally.
2. A conveyor of the therapeutic acceptance when the patient is overwhelmed by excessive low esteem.
3. A method by which to strengthen or restore the patient's contact with reality when threatened by anxiety.
4. A natural part of a warm, ongoing relationship.
5. A gratification of the patient's infantile needs.
6. A gratification of the patient's manipulative needs.
7. A means of eliciting feelings toward aggression.
8. An expression of the therapist's feelings.

The therapists and writers that strongly advocate the use of touch in therapy define it to be useful in numerous applications and it is said by them to be valuable in nearly any situation.

Negative Aspects of Therapeutic
Touch

The counseling philosophy that strongly prohibits the use of touch seems to be perpetuated by a group of writers and therapists who are very concerned about the welfare of their clients and choose to express a portion of this concern in protecting the client by not touching or allowing physical contact because of a possible detrimental effect upon the therapy. The literature included in the scope of this investigation seemed to substantiate the no-touch viewpoint on the basis of therapeutic ineffectiveness rather than on adverse public opinion and social constraint.

The no-touch philosophy holds that therapy becomes less effective when the relationship between client and counselor becomes intimate, especially when this closeness involves or results in touching between members of the opposite sex. While no definition of intimacy is given, the source continues on to indicate that physical contact is "absolutely taboo" because it may mobilize sexual feelings within the client and the counselor. (7:278) Even a perfunctory kiss by the therapist in any type of situation is definitely forbidden because kissing is genital-symbolic contact. (29:200)

Tender touching may arouse sexual cravings and the unfulfilled "promise" of this type of intimacy with the therapist may provoke anger, depression, and outbursts of rage. (39) To patients who possess a great neurotic defensiveness and wish to avoid even thoughts of sex, touch may be interpreted as an intrusive and unwarranted suggestion of sexual desire. The client with feared homosexual tendencies might prefer to avoid contact with a same-sex therapist and a confirmed homosexual may attach completely antitherapeutic connotations to a touch. (7,33) All physical contact with the client should be avoided because of possible sexual interpretations by the client which may defer or destroy the therapeutic process. Touch may have a variety of sex-related interpretations by certain clients, but it may have a completely different and unpredictably spectrum of definitions to other clients.

Touch may stimulate the anxiety of a neurotic client resulting in his becoming more anxious. Many victims of severe neurosis drop out of treatment because they fear the ambivalent feelings stimulated by a therapist's touch and closeness may lead to the loss of self control. Many of the hazards of touching can not be accurately and consistently

predicted. Many times the patient is not even consciously aware of the interpretation of a touch, but reacts to the touch in unpredictable manners because of the unexpected release of repressed emotions. (39)

Furthermore, the therapist must not touch because he can not assume how the patient will interpret contact, even based upon the popular meaning of the gesture. A haptic encounter may be misinterpreted as hostile or aggressive communication by clients who are out of contact with reality. Messages received by someone experiencing a schizophrenic break or psychotic episode would be especially vulnerable to this type of misinterpretation and the resulting behavior of that person might involve violent and uncontrollable outbursts of emotion. (12)

To some patients, even a minimum of contact may be frightening and threatening and must be avoided because it may be an invasion of privacy. Perhaps this is the reason McCormick (29) will not even invade the client's secure personal area by initiating a hand shake.

A simple touch such as a hand on the shoulder may have a severe effect upon the client. Touch has the power to arouse

infantile cravings which appears to precipitate severe regression. It may be that the contact conveys a permission for the patient to engage in infantile behavior, the counselor's touch being reminiscent of the way the client was touched as a child. The client then acts out id impulses rather than verbalizing them and moves into a regression. (39)

Touching an adult may cause other infantile reactions such as artificial stimulation for Oedipal fantasies which might actually be carried out with the therapist or with the mother because the client is now capable of sexual intercourse.

Haptic contact may also hinder pure transference as the personality of the counselor conflicts and/or interferes with the character of the actual parents. (31) In Freud's terminology, the use of touch would be id-affirmative, reinforcing the impulses of the id, as opposed to ego-affirmative which is involved with testing the reality of the impulses the organism receives. (4)

Orthodox Reichian Therapy is decidedly id-affirmative according to promoters of the no-touch school. This system of therapy approaches the feeling dimension of a person's psyche from "below" through direct body contacting, rather

than from "above" through a person's phenomenological field. The results of the phenomenological field approach should be less impulsive and longer-lasting since the person "lives" through the phenomenological field in all activities involving the world and people around him. However, the greatest deficiency of Reichian therapy is its preoccupation with the orgasm formula. This formula states that the more orgasms a person is able to experience, the less he is hampered by character-muscular armoring and that this criterion is the one and only method by which to judge any person's freedom from psychopathology. The Reichian orgasm idea seems to dismiss growth-motivated needs like love, self esteem and self actualization and centers around a reductive-mechanistic model of healthy human functioning. Reichian therapy ultimately involves the autonomic or involuntary nervous system and almost completely ignores the central nervous system and many uniquely human capabilities. (4)

The faculty of a healthy organism includes many instances of two different but integrated systems within which the personality functions. An example of this dual system or double semi-system concept is communication involving verbal

and nonverbal modalities. While an effective counselor makes use of verbal and nonverbal exchanges and indicators, it is recommended that touch, one particular mode of nonverbal communication, be excluded from use within therapy. Because of the possibility of misinterpretation, touch may be a damaging and destructive technique when used in a psychotherapeutic application.

Conditional Aspects of Therapeutic Touch

The "neutral" philosophy concerning the use of touch in psychotherapy does not define touch as either good or bad, therapeutic or antitherapeutic. This standpoint regards touch according to its contribution to the catharsis of the client. The use of contact requires an understanding of the client's psychodynamics and an awareness of the probable effects of touch at that moment. Also considered should be the client's readiness for touch and the effect contact will have upon the helping relationship. If both client and counselor can not feel comfortable with touch, it should not be used. The criteria to be considered concerning the use of touch are the same as for any other type of communication or therapeutic

intervention. Resistance to touch should be dealt with just as would resistance to any other form of communication. The average counselor is probably not as schooled in touching techniques as he is in verbal techniques, but with thought and practice he will be able to determine his personal philosophy of touching. However, just as with verbal interaction, touch needs constant awareness in the mind of the therapist. (7)

A rationale against touch expressed that the anxiety resulting from any kind of physical contact may lead to inappropriate and destructive acting out and that the therapist may become involved and reciprocate with inappropriate intimate behavior. The therapist who would be swept away by embracing a regressed patient probably could not stand the sustained intimacy of therapy in any case. Unpredicted expression of repressed feelings certainly may appear to be seductive if not actually destructive. However, for growth purposes, it is necessary for those feelings to be expressed. The repeated occurrence of outbursts should indicate to the counselor that these episodes need to be worked out in verbal interchanges. (31,33)

The decision to use any verbal or nonverbal activity in

therapy should depend upon the maturational ingredient the action will add to the relationship. Touch may be growthful, but a therapist must know something about a patient's dynamics to understand the meaning of a gesture. Touch use must involve foresight and knowledge. A physical gesture may convey better than words the messages of acceptance, knowledge, and concern for the emotional turmoil the client is experiencing. (7,39)

The therapist must also be aware of both his own and the client's emotional situation as well as the state of the client's transference. A touch during an unstable emotional period might be as ineffective as tender physical contact during a period of strongly negative transference. (11)

Each time a counselor touches, he should consider what the touch is providing for the client. The contact may provide the client with a reward, safety, a breakdown of defensiveness or resistance, an increase in anxiety or a decrease in stress. (34)

Touch must be initiated in a spirit of giving and offering a service as opposed to an attitude of taking from the client or viewing him as a source of satisfaction. A "giving" touch may be a means of partially meeting an immediate need of a client, but no part of therapy should provide such

a gratification for the client's growth requirements that he need not look elsewhere to seek fulfillment. When the full complement of understanding communication provided in therapy does not fully meet the client's needs, he is forced to look outside the treatment for gratification. The very goal of psychotherapy is to assist the client in developing an awareness of his needs so he will search for need satisfaction in a healthy manner outside of therapy. Therapy can help the client learn how and where to look. (29,34)

Touching as a natural form of communication may have positive or negative effects. Since it is inherently neither benevolent nor malevolent, it is possible that the emphasis in this regard should not be placed on whether or not to touch, but on how touch may be used to most effectively meet the needs of the client. (19) Not to touch a patient when it would be beneficial is as objectionable as touching when it would be antitherapeutic. The controlled, discriminating use of contact can be therapeutic and useful just as uncontrolled and indiscriminating touch can be noncathartic if not actually harmful. (32,39) These evidences may tend to cause one to be very judicious and thrifty in his use of touch. However,

wariness of possible consequences of behavior may be as crippling as the prohibition of the forbidden behavior. An overly guarded counselor may interdict the contact before it reaches the growth level for fear that the effects of the touch will continue on through the growth point to the damage point. For example, it is necessary for the client to experience a certain degree of anxiety in order for client-centered therapy to be growthful to him. A counselor may need to be somewhat forceful to "push" the client to a level of anxiety at which he will begin to examine himself. However, too much force could result in damage to the client and possibly cause a termination of the therapy. Avoidance of touch would not be so much of a problem if it did not also prevent counselors and clients from enjoying closeness and warm communication. (35)

The abstention from touch may diminish the possibility of growth experiences just as overuse may decrease the potency of touch. One may challenge the use of any touch on the basis that nongrowth is better than damage. Physical contact can help both the client and counselor to become aware of the feelings and emotional state of the other. As Virginia Satir says in Jane Howard's Please Touch, "Touching is one of the

ways we can learn about each other's worlds." (20:149) Even if the response to a tender touch is hostile, the client has learned that the counselor cares enough about the relationship and the client to touch him.

In spite of the importance of considering all aspects in the development of the relationship and the client, many practicing therapists continue to touch when they feel the desire. John O'Hearne (33:447) took a survey of practicing therapists across the country and when asked the question, "When do you touch patients?" most of the practitioners replied, "When I feel like it. When I feel (or think) it will be helpful to the patient."

To feel like touching is not sufficient reason to do so because of unpredictable responses. The reaction to an objective action such as a verbal statement is somewhat predictable, but touch countertransference is not nearly so foreseeable. (39) Since the touch initiator has different ways of thinking and of utilizing symbol recognition and response, the receiver must "take the role of the other" in order to accurately decode and interpret the touch. If the learned symbol patterns of each are too divergent from the experience of

the other, neither can "take the role of the other" adequately, possibly causing an extremely erroneous interpretation of a touch. (14:215) In situations such as this, it is very important that the therapist act with caution to avoid such uncontrollable disturbances in functioning as regression, psychotic episodes or depression. (39)

Some patients may not be able to sufficiently "take the role of the other" to establish a new interpersonal relationship or alter a present one. Some psychiatric patients are very threatened by touch and closeness because these modes of communication force a relationship, overwhelming the individual at a point when their ability to form relationships is already taxed. Should the disability to form relationships become less of a problem, touch might be used with this patient in an increasingly effective manner as he becomes more integrated. (12)

Furthermore, it has been pointed out that touch stimulates all aspects of the personality, not just the skin. Concerning the spontaneous reactions of a personality Gestalt, touch could elicit a wide range of feelings in the emotional spectrum of the client and counselor. The therapist must expect to

experience erotic reactions just as he feels other things. No emotion or reaction is to be feared per se. When the therapist can accept client behavior that has a sexual aspect as an expression of need for physical contact, then the counselor can accept the client more fully and attempt to meet some of his needs while setting the limits. While these limits preclude sexual activity, some intimate contact and sharing regarding the contact may bring about a partial but growthful gratification of the client's needs. (7,29,39)

Self disclosure and sharing are necessary in a client-centered therapeutic setting. According to Jourard, touch and self disclosure go hand-in-hand. (34) There is a risk involved, however. Studies have determined that self disclosure increases with an increase in touch. The converse is true also, and a counselor must be careful not to be drawn into a game with the client of increasing touch just because of increasing self disclosure. The client who can assertively "ask" for touch is probably strong enough to be able to find it in non-symbolic relationships outside of therapy. He or she may be, in fact, trying to seduce or cajole the therapist. The patient who genuinely needs physical contact is unlikely

to be able to express the need clearly. While not every client needs touch, it is one way the counselor can express that he cares and accepts the client. (34)

While touch may be an effective communicant, it must not be used by the therapist as a "cure-all" or as an "easy-way-out" kind of shortcut. The same ramifications must be considered in the use of touch as in the use of all other forms of communication. Touch should not be pushed onto a client for he will accept it when he has developed to that level. The therapist's way may not be the patient's way. It is most beneficial to let the client decide what is best for him at any particular time as opposed to the counselor determining what would be most maturational to the client. (33)

However, when the counselor does initiate an action such as touching, he must consider that a touch usually communicates an invitation for **reciprocity**. (39) A therapist touches a patient with respect to how he feels about himself in the relationship. Some therapists inevitably experience difficulty in touching because of their own discomfort with being touched. Therefore, the problem of touching often lies more with the therapist than with the patient. It is because the therapist

has a need to touch that the taboo comes into play. The guilt and fear about touch present in a therapy session are more often brought in by the counselor than by the client. This adds countertransference barriers to the relationship on a conscious as well as unconscious level. (5,12,21)

Some therapists, themselves, may experience erotic feelings and become upset out of their own unresolved shame and guilt. If they need to defend themselves against such awareness, they are likely to be rejecting and confirm their patients' own convictions that words are good and touch is always erotic or destructive and bad. Both therapist and client need to learn tolerance for their own excitement and realize that fantasies need not lead to action. (13:231)

Touch must be reserved for use in meeting clients' needs and not for the diminution of the therapist's security or loneliness needs. The therapist who recognizes himself as lonely must closely control his own need for physical closeness and not let it interfere with meeting the patient's needs. The counselor must especially safeguard against a lack of alertness in listening due to the interference of his own unresolved needs. (17)

The difficulties encountered in the working-through period in a therapy group frequently tend to increase a therapist's feeling of inadequacy, deepen his sense of failure and guilt, and often impel him to employ more active substitutes which may actually defeat the arduous and time-consuming job of working

through transference and resistance. The blow to his self-esteem for his inability to reach his patient is augmented in groups because there are witnesses to his felt "ineffectiveness." Overconcerned, he may try to make up for it by touching his patient and be gratified by the patient's strong response. (19:467-468)

Therapeutic touch is not usually necessary. The important thing is that both client and counselor feel free to engage in physical contact when it is needed. Freedom in therapy is to be what one really is. The freedom to act as one wishes is liberating, whether or not one actually acts. What the client seeks in therapy is freedom rather than actual touch. A constriction against meeting this need reinforces frustration by adding to the blocked energy, thereby intensifying the need. (5:104)

Freedom from constriction leaves all communication media accessible for use and permits the open expression of symbolic processes (verbal communication) to function, elevating the need for nonsymbolic processes (tactile communication). If the patient is free to engage in symbolized or fantasied touching, this return to the psychoanalytic primary process meets the patient's momentary and infantile needs. (5:104)

Areas of Applied Therapeutic
Touch

Physical contact may be considered in various dimensions concerning its application to psychotherapy. Touch may be instrumental in providing reinforcement of verbal encouragement, reducing fear, transmitting feelings of interest and concern, and demonstrating the counselor's commitment to the client in a recovery and growth effort. In short, touch makes a relationship more personal. A close or even intimate relationship is characteristically very personal and communication occurs on a deeply emotional level. If the media for the communication in this type of encounter is exclusively verbal, the relationship is missing a great dimension, according to Geis. (18)

In a study examining the stress levels of persons involved in verbal encounters only, as compared to persons in verbal and tactile encounters, Geis concluded that tactile communication coupled with a verbal exchange could reduce anxiety in the presence of stress. Mutual contact in a stressful situation can be said to reduce anxiety. It is possible that the sheer presence of others increases stress, but when the encounter is carried out to the extent of physical contact, stress is reduced.

The dynamics of many emotional and mental deficiencies involve a significant level of stress. One goal of psychotherapy may be to assist the client in the reduction of his internal stress. The following section briefly reviews the use and ramifications of touch in application to the treatment of loneliness, neurosis, and schizophrenia.

Loneliness. The presence of loneliness in the middle and upper strata of Western culture seems to be a current problem. Physical loneliness is a specific problem since culture is governed by so many obsessional taboos with regard to people touching one another or having their physical privacy threatened in other ways. (17)

Loneliness denotes a sensation of feeling alone, but at the same time having an awareness that one needs a connection with fellowman. Loneliness is not only a factual acknowledgement of being by oneself, but also indicates an urgent desire to re-enter human contact. Despite this desire, the lonely one can not reach out to touch another and others can not or dare not touch him. The widening gap evokes anxiety that is overwhelming to the lonely one and at times paralyzing. (8:114)

Because of the tremendous anxiety, a client may be experiencing, touch and physical contact should not be forced on a lonely one before he is ready to accept it. The client's own return to reality helps him to join life with others with a

greater dedication and a deeper desire to come to a healthy resolution of problems. Forcing the client to make contact before he is ready may drive him deeper into his loneliness and depression. Additionally, if the client is still involved in an unresolved fusion with a destructive parent, contact may at first be rebuffed as a threat of self annihilation. Even though an initial attempt at contact with this type of patient is rejected, it must be remembered that such persons may be so far out of contact with reality that they have an enormous need for emotional, mental, and especially physical contact.

(8)

One reaction a lonely or depressed person may have to being touched gently at critical periods is a feeling of body relaxation and support and a reassurance that one is not alone. A tender touch may assure a client that his old feelings of unworthiness are not justified and give him courage to step out of the cyclic pattern of a life-script. Many victims of loneliness become aware through treatment that their feelings of rejection were precipitated in early childhood. (13) In a study conducted by Greenwald (7) involving call girls, the young women reported that at an early age, they discovered they

could satisfy their feelings of loneliness and unworthiness and needs for affection and interest by giving sexual gratification. This physical contact was one way of obtaining the closeness and tenderness they did not receive from their parents.

Therefore, in the treatment of a lonely person, it is important to establish physical contact because the absence of this may well elicit childhood feelings of deprivation and rejection. The inclusion of touch is one way in which early parental rejection may be constructively worked through in therapy with contact assisting the client to relive and replace old impulses stimulated by physically detached parents. (30)

Neurosis. The neurotic personality is characterized by a weak sense of identification with one's body. The neurotic is unsure of himself as a total person because his body does not seem to be part of him. This lack of body esteem and the resulting lack of self confidence often causes the neurotic to avoid physical contact when he really would have liked to experience it.

The gap between what one ultimately wants to refuse and what one actually refuses is the neurotic gap. The mere existence of one within this chasm involves a tremendous waste

of personal energy and life-time. When one says "no" when he feels "no", the action is not neurotic. But when one is afraid to stand close to another even though he wants to, he is creating a separation between what he is and what he could be. The greater the gap, the fewer the possibilities of growth through contact.

Contact with a neurotic client may often stimulate a positive reaction in terms of growth because the touch he feels reinforces the fact that he is touchable and may possess some degree of worth. While a touching experience usually has affirmative results, it may, however, reinforce the neurotic's dependency on touch, perpetuating the neurosis. (32) Conversely, not touching may gratify the need of a neurotic to avoid touching. The neurotic wants and needs to touch and be touched, but can not because of self perpetuating aspects of neurosis. (30) Physical contact is generally useful in the treatment of neurosis because of its reassurance value and its effectiveness in breaking down barriers of defensiveness. (4, 30)

Schizophrenia. Physical contact may be effective in the treatment of the schizophrenic illness, but it must only be

used with well-compensated schizophrenics who possess a considerable ego strength. (7) In the treatment of mild schizophrenia, the therapist must consider the patient's abnormal relationship with his mother and help him to reexperience the relationship in a more normal way. Some therapists think that the best method of reexperience is through physical contact accompanied by corresponding feeling for the patient and reassuring words. (2) However, the patient may seek physical contact to form a relationship and reduce his isolation and loneliness. (7) In either case, if a point is not reached where the patient desires to touch the therapist, the treatment is not progressing satisfactorily. (5:99)

Schizophrenia is by definition a return to the primary process. (5) Some patient's psychological development is so retarded and their suspiciousness of words so profound that only nonverbal intervention can meet these patients where they are. Those who are so inadequate in verbal communication can often be reached by experiences on the sensory level. The patient's decreased ability to talk effectively causes him to seek touch as a substitute form of communication. Touch supersedes the need to verbalize and offers reinforcement more

congruent with the deficient states of the patient's mind and emotions. No matter how schizophrenia treatment is thought of, what the patient seeks is human relatedness and the use of touch in psychotherapy is the process of reestablishing such a relatedness. (2,40)

Summary

The value of touch in psychotherapy has been the topic of a great deal of discussion ever since Freud first massaged the head and neck of his patients. Various schools of thought concerning therapeutic touch have spanned the chasm from extreme usefulness to severe devastation. Those who would advocate the use of touch in their therapeutic sessions point out that touch strengthens verbal communication, demonstrates the counselor's commitment to the relationship and his care for the patient, facilitates self disclosure, provides reinforcing feedback to the patient, facilitates transference, helps break through layers of intellectual armor, and provides evidence that a growth-process is occurring in the client.

Conversely, professionals who refrain from the use of touch in their counseling sessions base their reluctance on the opinions of therapists who state that therapy becomes less

effective when an intimate client/counselor relationship is formed. All touch is housed in a sexual framework and is thus taboo. A haptic encounter may be misinterpreted as hostile or aggressive by clients who are out of contact with reality. Touch may be frightening and threatening because it is an invasion of privacy. Furthermore, touch may arouse infantile cravings which may precipitate severe regression.

It is the "neutral" philosophy that perhaps is the more rational school of thought concerning touch because its main emphasis on whether to use or not use touch is how it contributes to the catharsis of the client and how his psychodynamics and awareness at the moment would let him respond to the touch. Touch use must involve foresight and knowledge. A "giving" touch may be a means of partially meeting an immediate need of a client, but no part of therapy should provide such a gratification for the client's growth requirements that he need not look elsewhere to seek fulfillment. The very goal of psychotherapy is to assist the client in developing an awareness of his needs so he will search for need satisfaction in a healthy manner outside therapy. Therapy can help the client learn how and where to look.

Chapter V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary of Research

Therapy is a stressful experience to many clients. While the absence of all stress would preclude growth, it is often helpful and sometimes necessary to reduce the level of tension in a therapeutic encounter in order for the client to become comfortable enough to remain in therapy. If the client cannot stay in therapy long enough to establish a relationship with the counselor, he cannot benefit from the encounter. While touching may be useful in the treatment of many emotional deficiencies, it is possible that the greatest contribution physical contact has to add to the practice of psychotherapy is in the area of reduction of anxiety.

A few of the major factors that serve as anxiety reducers incorporating touch are synthesized in this summary. A decrease in a person's defensiveness may also decrease the anxiety level of the client in that more energy may be channelled into growth activities while less is required to maintain the formerly armored equilibrium of the organism. The sheer relief of releasing a portion of one's pent-up emotions will result

in a decrease of anxiety. While a touch may convey the therapist's concern for the client, the client's anxiety level will be reduced, resulting from his relief in being seen by at least one person as a worthy individual. Thus, the end product of an anxiety-free individual is the liberating effect which opens the individual's awareness to the world in which he lives and helps him to function in a more productive and efficient manner.

Conclusions

The conclusions of this review must be individually examined by counselors, educators, and other professionals involved in promoting the mental health of their clients.

1. Objective systematic research concerning touch in psychotherapy is somewhat sparse. Most of the information describing touch as a therapeutic tool has been derived from attitudinal studies and research conducted outside the therapeutic setting.

2. Any means of nonverbal communication that may have a positive maturational effect upon the relationship and the client may be used in therapy.

3. Touch may be an effective and useful mode of

communication between counselor and client.

4. The therapist attempting to effectively use touch must take into consideration the following:

- a. The client's interpretation of the touch.
- b. The therapist's motivation in initiating the touch.
- c. The personal background of both counselor and client.
- d. The social maturity of both counselor and client.
- e. The therapist's view of touch as a therapeutic tool.
- f. Present cultural trends.

5. Each therapist should be culturally free to accept a philosophy of touching that will be consistent with his own personality.

Recommendations

As a result of this study, the following recommendations are made:

1. More research in the area of therapeutic touch should be conducted comparing individual and group therapy

using touch with therapy where touch is not used.

2. More research is needed to reveal client's impressions of the effectiveness of touch in therapy.

3. Research should be conducted to determine more accurate means of predicting the effects and interpretations of touch.

4. Research is needed to determine in which treatment of emotional disorders is touch most effective.

5. Research should be conducted comparing client's pretherapy touching behavior to client's posttherapy touching behavior.

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