The Human Touch

An Exploration of the Role and Meaning of Physical Touch in Psychoanalysis

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This article addressed the meaning and significance of minor physical contact (e.g., a hug or handshake) within the psychoanalytic dyad. Although undoubtedly a controversial topic, the plain fact that it is occurring makes touch an important and necessary subject of discourse. Furthermore, as psychoanalysts come to define the role of the more human analyst within the 2-person field and come to regard so-called extra-analytic techniques as necessary and even highly therapeutic, there is no logical basis from which to exclude the judicious use of actual physical contact as one of the tools of the more "human" analyst. The author presented clinical material in which touch seemed ill-advised as well as that in which it proved efficacious. She thus endeavored to clarify and bring into conscious awareness those factors by which decisions are made to touch or not to touch as well as how, when, and with what types of patients psychoanalysts decide to have physical contact.

The role and meaning of physical contact between analyst and patient remains a thorny and perplexing issue within psychoanalysis. The very topic of touch becomes quickly connected with the gross disruptions

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engendered by aggressive acts or sexual intimacy within the relationship. As McLaughlin (1995) pointed out, "the spectre of this ultimate excess has made almost impossible a dispassionate assessment of the technical implications of lesser forms of physical contact" (p.434). Yet it is at our own peril that practitioners continue to ignore the significance of simple human touch within the psychoanalytic dyad. The importance of touch must be acknowledged if for no other reason than the plain fact that it is occurring. Instances of physical contact—a handshake, a hug, touching fingers, or holding hands—are mentioned sporadically in many psychoanalytic accounts. In the literature, they are most frequently only mentioned in passing, a throw-away line. In a few instances, such as the well-known accounts of Ferenczi (DuPont, 1932/1988), and Little's (1985) description of her treatment by Winnicott, as well as more recent reports by Casement (1982), McLaughlin (1995), and Maroda, (1999), they are discussed and integrated as an important piece of the analytic work. Discussions with colleagues have provided further confirmation that although rarely talked about, physical touch takes place, particularly in work with very regressed patients. These "confessions" by beleaguered colleagues as to the occurrence of minor physical contact often carry with them enormous guilt and impassioned reminders that they have in no way crossed the sexual boundaries that the great majority of analysts find abhorrent.

Because this phenomenon is in fact occurring within psychoanalytic treatment, it is imperative that it be brought into the open as a legitimate subject of discourse. Psychoanalysts are certainly aware of the inherent power of those aspects of themselves that remain secret, disavowed, unconscious. Gabbard (1996) has stated that it is precisely those features of clinician’s thoughts, feelings, and actions in the therapeutic setting they would like to keep secret that should in fact be brought out into the open. If this policy is followed, Gabbard adds, “then the early stirrings of countertransference love, the minor boundary crossings, and the wish to keep certain aspects of the therapy sequestered in a secret compartment can all be openly discussed before they crescendo into a disastrous situation” (p. 317).

The topic of touch within psychoanalysis intrudes into consciousness on at least two additional fronts. As analysts have come to define the psychoanalytic field as a relational two-person enterprise, the role of the analyst has been redefined as a more human one. For example, the clinician’s responses to the patient have come to be viewed as important pieces of data that must be explored and understood as vital parts of the treatment process. The so-called extra-analytic techniques such as self-
disclosure, enactment, and holding, are now perceived as necessary and, often, highly therapeutic when used responsibly and analyzed carefully. When one considers the role of other extra-analytic techniques, including many kinds of nonverbal communication, it becomes clear that there is no logical basis from which to exclude actual physical contact, when it is used with judicious self-restraint as one of the tools of the more "human" analyst.

Further relevant to the consideration of touch is the fact that as the role of the analyst has become more human, psychoanalysis itself has become more humane. Practitioners have widened the scope of pathology amenable to analytic treatment and opened the doorway to work with those patients whose pathologies occur in the early developmental period of childhood, before language, and before significant structural differentiation has taken place. This has, in many instances, necessitated a revision or at least a reassessment of the traditional tools of psychoanalysis (i.e., free association and symbolic exploration of the transference). For these patients who have recently found acceptance in the psychoanalytic framework, as well as for the majority of patients who occasionally communicate in a developmentally early mode, it becomes necessary to widen the scope of the psychoanalytic store. Therapists must frequently provide the reparative holding, the empathic attunement, the affirmation of continuous existence, much of which must be communicated nonverbally, before the symbolic conflict-based work can proceed. It is within this area of psychoanalytic treatment, where verbal means of communication are insufficient, that I explore the role and meaning of physical touch.

On the premise, then, that physical contact is occurring and that with certain groups of patients and at certain points in many treatments, it may be efficacious and even necessary, I endeavor in this article to elucidate those commonly held technical considerations from which analysts make their clinical judgments about touch. As Maroda (1999) stated, the decision of "who to touch, how to touch them, and when to touch them" is an exceedingly difficult one involving

understanding of the patient's intrapsychic meaning, placing this in an appropriate historical context, understanding how the current request for touch represents a reenactment in the transference–countertransference interplay[,] . . . intellectual and emotional depth on the analyst's part; a profound knowledge of the patient; and an ability to be aware of the affective countertransference. (p. 143)

As I address this complex and undoubtedly controversial topic, I attempt, through the presentation and discussion of case material, to share
my own experiences with touch—for example, how, when, and with what types of patients I have made the decision to have physical contact; when I have decided that contact would be inappropriate or ineffective; how I have dealt with unexpected patient-initiated contact; the effects of physical contact on the treatment process and, where possible, its ultimate transformation and integration into symbolic form; and finally my own countertransference reactions to the phenomenon of touch in the treatment setting. This is in the hope and belief that sharing these common and once privately held experiences and subjecting them to the searing light of psychoanalysis will illuminate yet another vital facet of the complexity of human interchange.

Nonverbal Experience

The relentless privileging of language, or, as Freud (1939/1964) stated, “a turning from the mother to the father” (p. 14), has in the past conveniently shielded clinicians from the vast wealth of confusing and even “messy” nonverbal data that is used consciously and, more often, unconsciously, in work with patients. In recent years, however, therapists have come increasingly to understand the significance of nonverbal experience in human development. The explosion of research on the human infant has illuminated the astonishingly rich and complex nature of the continuing social dialogue that takes place between the infant and the mothering one, a dialogue that, at least on the part of the infant, is primarily nonverbal.

As this has been integrated into work in the consulting room, practitioners have increasingly come to recognize the significance of that period of life before language has developed and notable structural differentiation has taken place. Moreover, they understand that the period when individuals experience life totally, globally, outside the bounds that language places on them is important not only to the understanding of deficits, developmental arrests, and pathology, it is also a vital and abundant source of creativity, artistry, religion, intuition, and love. It is a component of experience that must be nurtured, understood, and as much as possible, made conscious. It is a rich vein of information for which psychoanalysts ultimately hope to provide their patients at least the availability of language to describe.

It is the mother or mothering one whose capacity to provide empathic attunement, regulation of affect, and a safe space or holding environment that allows the child’s early developmental needs to unfold. It is similarly the ability of therapists to provide this kind of safe space, to
resonate to the patient’s affective states, and to respond affectively and even cross-modally from their own inner store of feeling memories as they strive to comprehend the patient’s experience. This is with the recognition that although the capacity of the therapist to provide a preverbal kind of “holding” environment may not be linked to gender, the strong and nearly universal historical connection of women to mothering may influence, both consciously and unconsciously, the patient’s expectation of nurturing.

In their identification and description of the maternal erotic transference, Wrye and Welles (1994) have contributed greatly to the understanding of the nature of the mother–child bond to the extent that it is recreated in the consulting room. It is mother and baby in close physical contact. It is, for both, a phenomenon that is largely nonverbal, physically encoded. The authors described it in the following way:

The infant, having once been literally encapsulated in mother’s womb in amniotic fluid, experiences closeness postnatally through contact with skin and bodily fluids, through her caretaking in relation to milk, drool, urine, feces, mucus, spit, tears, and perspiration. A mother’s contact with and ministrations to her baby in dealings with these fluids may optimally create a slippery, sticky sensual adhesion in the relationship; it is, so to speak, the medium for bonding. This sensuality, experienced by both parties, is key in their relationship. (Wrye & Welles, 1994, p. 35)

It is the creation of this type of bond that allows the patient to have the kind of transformational experience he or she is seeking and that ultimately allows him or her to come alive.

Although Wrye and Welles (1994) did not advocate physical contact with patients, their description of the very sensual and physical nature of the maternal erotic transference raises, it seems to me, the topic of touch as patients and therapists together endeavor to maneuver through the very “sticky” issues presented by the early mother–child bond. I am talking now about a period in which life is experienced globally, through all of the senses. Richards (1997) stated that “touch, that most universal and ineluctable of senses has been shown to provide information of a subtle and powerful kind about the external world” (p. 2). Turvey (1996) believed that like the eye and ear, our muscles provide information about what is around us without being directed to do so by conscious scanning or seeking. It is an avenue for information about the world, not every aspect of which reaches our consciousness, even when it affects later behavior. Physical touch, then, may provide a unique kind of learning and indeed a route to the unconscious that is difficult to achieve through verbal means.
Although psychoanalysis has traditionally focused on the realm of the symbolic as the repository of unconscious material, I have encountered in my own clinical experience those patients who, although lacking the capacity for significant symbolic work, are still amenable to treatment. How does one work with those patients for whom consequential aspects of their experience remain at nonverbal levels? How does one address early prerepresentational issues such as safety, regulation, engagement, and acceptance versus rejection, much of which is communicated nonverbally? How does one ensure that those early experiences do not remain unconscious, disavowed, a part of the split-off "not me" self? As one works with this period of life dominated by the senses, can one make judicious use of the sense of touch, not simply as a way of gratifying patients’ wishes (which it may, of course, do), but as a way of actually changing the very nature of the ways in which they encode the world?

It is questions such as these that I hope to address as I present clinical material in which the issue of physical contact became very relevant. In fact, my own experiences with physical contact with patients have been quite rare. In earlier years, before I "knew better," I am certain that I shook hands with patients or hugged them. I can only speculate as to the meaning of that contact to the patients, as we never addressed it. There have, of course, been instances in which physical contact of any kind would have clearly been inappropriate. I begin my presentation of clinical material with two brief vignettes that illustrate this. I conclude with the discussion of a lengthy treatment in which physical contact did take place. I also explore the meanings I believe those experiences had both to the patients and to me.

Brief Vignettes

The two brief vignettes I discuss herein do not represent comparable case material, and time does not permit me to present detailed descriptions of the treatments. They are, however, similar in that both illustrate situations in which physical contact would, I believe, have been ill-advised and quite problematic.

Case 1

The first case involved a man in his mid-40s whom I will call Nick. He decided to enter treatment because he had had an affair that had nearly destroyed his marriage. He was very interested in preserving the marriage
but was not sure he could prevent himself from having another affair. He said that he thought of almost all women sexually and that it had only been a lack of opportunity that had prevented him from having an affair sooner. We discussed the affair at length and began to formulate issues in terms of needs for control and related fears of intimacy.

After some months Nick came into a session and immediately moved his chair very close to mine. He stated that he was sexually attracted to me and wanted to go to bed with me and he was sure that eventually we would. He continued in this vein for 4 or 5 sessions, his chair close to mine, describing fantasies about his seduction of me though not in graphic detail. He was sure that I would be accepting of all of this, professional and "cool." I could have asked him to move his chair but I felt that this measure of control was very important to him. I was very certain from my work with him that he in no way posed a physical threat to me. Parenthetically, I believe that his relatively small stature was a significant factor in my decision to allow him to proceed. I was also very certain that under no circumstances would I tolerate physical touch from him. Though we never spoke about this he seemed to understand this limit as well and made no move to touch me.

Throughout this period I believe that I managed to appear outwardly calm, though it was certainly unsettling at times. I would say nothing but would occasionally think to myself: "You touch me, Buster, and you're going to land in the middle of next week." Nevertheless I tried not to respond in a manner that could be construed as seductive, sexual, or fearful. I attempted to maintain a positive friendly curiosity about the meaning of this behavior. By neither recoiling nor participating I was able to allow Nick to reenact in a very limited manner his sexualized way of relating to women. Thus he could still stay connected to me in a way that would allow him to explore and understand the meaning of this behavior. He subsequently became less fearful that he would have another affair. He also began describing more open communication with his wife and son.

After about 2 years of treatment, Nick elected to terminate, perhaps prematurely, but as he said, he "wasn't in pain any more." At his last session he discussed the period when he had "come on" to me. He said that this had previously been an active fantasy he had with many women but that he didn't feel the need to do this any more. He had also thrown out his entire collection of 90 hours of pornographic tapes and all but a few of his magazines. He said, "Now I own it [his sexual drive]. It doesn't own me." He also stated that he was at a different level with his wife, taking more initiative and responsibility in the relationship. Once allowed to
express his driven sexuality in the presence of another who would neither reject it nor be seduced by it, he was able to explore and maintain healthier avenues of connection and communication.

Case 2

The second case was a woman in her mid-50s whom I will call Cynthia. She was referred to me after attempting to asphyxiate herself in her car with the garage door closed. The garage was very large and, as she put it, she “ran out of gas” before she was able to accomplish this. She had contacted a number of therapists, but no one wanted to “touch” the case because it involved a long-term affair with a male psychiatrist who had been her therapist off and on since she was 21 years old. She was still in the relationship with the therapist, although she “knew” at some level that she should not be. Although she was no longer in treatment with him, they still met for 50-min liaisons in his office between his sessions with other patients.

From my initial contact with her, Cynthia presented an often overwhelming array of stimuli to the senses. She spoke in a rapid-fire driven manner, filling the space with her words, almost without pausing to breathe. As she told her story in intricate detail, with lengthy and seemingly tangential digressions, my mind was taxed in merely trying to comprehend, much less recall, all that she was saying. I was at first scarcely able to interject questions or clarifications, let alone interpretations. Visually she was a tall striking woman, still bearing the look, carriage, and manner of dress of a high-fashion model, a profession in which she still occasionally worked. Though she sometimes dressed casually in jeans and a sweater, she also at times wore elaborate designer outfits which were again visually very complex. She often chose unusual color combinations in which shoes, handbag, coat, jewelry, scarf, and dress were carefully coordinated to match and harmonize. In my opinion her choices reflected a creative genius for color and design.

Immediately after beginning treatment Cynthia began to barrage me with her demands, seldom couched as such but rather as reflections of her needs, her helplessness. She spoke to me ingratiatingly, flattering my kindness, my competence, my attention to detail, even my manner of dress. Soon she was telling me that she loved me. We struggled to maintain a reasonable therapeutic frame. Sessions were held regularly and on time. I insisted on regular and timely payment. This was in itself often difficult since her wealthy husband from whom she was separated did not give her money regularly. She managed to keep up her payments however,
occasionally borrowing from her elderly mother to do so. Yet I did not believe that she was able to keep to a strict analytic frame at this point and still remain in treatment. She was terrified, in a state of almost continuing panic. She was fearful of losing her therapist–lover and aware at some level that the relationship was terribly exploitive of her. In the beginning of treatment I spoke to her briefly by phone almost daily in addition to sessions three times a week. It was difficult for her to leave the sessions on time. Always there was the continual barrage of words.

In addition to her detailed and highly erotic reports of encounters with her previous therapist she also described numerous other relationships with workmen, massage therapists, physicians, attorneys, her husband and even her daughter, nearly all of which she experienced as exploitive of her. Yet she had very little awareness of the kinds of demands she placed on people with her helplessness, her driven manner of speech, and her constant demands for reassurance. Her “assaults” on those around her were, I believe, a reflection of the way in which she experienced the world—as continually taxing and overwhelming her ability to cope. This was manifest quite literally in a debilitating physical illness known as multiple chemical sensitivity. She had multiple allergies as well as documented physical reactions to many foods, cleaning products, natural gas, insecticides, paint, and so forth. The psychological component of the illness served to provide a protective barrier from her experience of exploitation from others. It also provided an acceptable way for her to control, even tyrannize, others as she required them to respond to the needs of her illness. At the time I saw her, the symptoms of her illness were less severe than they had been in the past. They also improved considerably during the course of treatment.

Responding to a chaotic and out-of-control inner world, Cynthia seemed to be continually testing and challenging the limits and safety of the relationships around her. Would she be exploited yet again? Could she in fact create yet another situation in which professional boundaries could be eroded, thereby exercising some control over her external circumstances? I believe that these were the issues that had to be addressed in order for treatment to stabilize to a point where we could work productively. Her testing of the limits came early and in very concrete ways. In a session early in treatment she was sitting across from me on the couch when, to my obvious horror, she slid off the couch and literally sat at my feet. This ingratiating and yet self-deprecating pose was apparently one she had adopted with her previous therapist, a gesture he had found
charming and endearing. I quickly and probably rather abruptly explained that she did not need to sit on the floor and asked her to resume her seat.

Given the boundary violations the patient had suffered in her previous treatment and undoubtedly in her early life, it seemed inevitable that the issue of physical contact would come up. A few weeks after the treatment began and before a short break for the holidays, Cynthia made a move to hug me as she was leaving. I moved slightly to the side and gently offered her my hand to shake, which she did. We did not discuss this in great detail, but she indicated that she understood that I could not allow her to hug me in view of the nature of the relationship she had had with her previous therapist.

The decision not to have any more physical contact with this patient than a handshake on one or two occasions was not one I made consciously before accepting her in treatment. In retrospect however, it seems very clear that close or prolonged physical contact with her would have been very inappropriate given her history and the point at which she was entering treatment. She was dealing with a huge and chaotic mass of data that needed, above all, to be sorted out and put into some kind of order. Any kind of physical contact could easily have been confused with and added to the overwhelming burden she was already carrying as a result of the sexual relationship with her therapist. Undoubtedly, the mere handshake had profound meaning to her as did my refusal to hug her; but in the face of an overwhelming mass of data, it was necessary to prioritize and begin with what was most important. It was essential that she experience me as a relatively safe person who would not cross significant professional boundaries and who could thus provide a safe space in which she could begin to sort out her own feelings. I believe that she was able to do this, and we worked together for about 2 years. During that time she was able to gain some sense of autonomy and some recognition that she could be in a relationship that did not require her to please the other person at the expense of her own welfare. I was, of course, always dealing with my own rage at this man’s continuing exploitation of her. Although I did give her information about appropriate channels, should she wish to take legal action against him, I could not force her to do this, nor could I do it for her, though I was sorely tempted. I have had occasional sessions with her since that time. She told me that she has finally extricated herself from that relationship, though unfortunately she has decided that it would be too onerous and fruitless a task to take legal action against her former therapist.
Sarah—A Case Study

Sarah, a single women in her mid-30s, initiated treatment because of problems she was having at work. She had great difficulty communicating with her supervisors and was in danger of being fired. She was also ending a relationship with a man who had begun seeing another woman before their relationship had ended. She was relatively isolated except for her contact with men and women who frequently used and occasionally sold drugs. She herself was a regular marijuana user and was also addicted to cigarettes and food. She also had and continues to have physical problems related to her health habits.

The initial phases of treatment consisted of my attempt to provide a stable contact point for her as she struggled to manage her life. I was able to do little more than provide a secure and dependable holding environment consisting of regular twice-weekly sessions, payments on time, attention to vacations, missed appointments, cancellations, and so forth. She seemed able to tolerate this and was aware of her need to keep coming though she couldn’t articulate why.

During this period Sarah would frequently begin the sessions by attempting to “read” my moods and facial expressions and would comment endlessly on my feeling states. It was as if her task in life was to assess others’ moods and adapt to them as best she could. Her other focus consisted of descriptions of the people and situations in her life which were often exploitive of her. Any effort on my part to explore her own inner reactions to these situations or her responsibility in them initially proved fruitless. Her responses were occasionally defensive, but more frequently, puzzled and uncomprehending.

Literally years went by before I had any sense of her early history and background. I still have remarkably little knowledge of her perceptions of her early childhood. I know that her older sister spent several years in a mental hospital. I know that she had older brothers and that her parents divorced when she was in her early teen years. Her mother remarried secretly a few years later and this was clearly a pivotal event in Sarah’s life.

Gradually an image of her father emerged. He was an extremely bright and talented man who was in school during much of her life, eventually earning a PhD. He was clearly the dominant figure in the family. He was occasionally physically abusive, but more frequently he controlled verbally, through sarcasm and razor-sharp intelligence. He was, in many ways, feared and hated. The patient recalls verbal arguments
between the parents, heard while huddled in her bedroom with the other children. The sister who was hospitalized refused to allow the father to even visit her. She said she would “explain it to Sarah sometime.”

To this day I have very little sense of what Sarah’s mother is like. Our joint efforts to explore this area are met with a kind of fogging of the room and certainly of my own mind. If some reference is made to the mother and I attempt to clarify this, both of us become distracted. I cannot remember what was said or what line of thought we were pursuing. This is also true if we are discussing her sister’s hospitalization and the patient’s reaction to it. Memories of events of childhood are brought out only with great difficulty. They seem to exist but cannot be readily accessed or held onto. They are also accompanied by a look in Sarah’s eyes which I have come to identify as terror.

Gradually, over many years of treatment, we have become able to communicate verbally. This has come about as I have been able to abstract patterns of meaning from the fragments of largely nonverbal data Sarah has brought in. Sometimes I was able to construct meaning from the messages on the sweatshirts she was wearing. Sometimes I could reconstruct something from her facial expressions, presence or absence of sunglasses, or the chair in which she chose to sit. We would have conversations about the books in my bookshelves or about tiny details of my office, particularly if anything was moved. She asked me many questions about my life which I would occasionally answer briefly. It is only recently however that she has been able to explore the meaning behind her questions. Earlier attempts to do this were experienced by her as mystifying, rejecting, and shame-producing. I have come to understand this curiosity both about me and the details of my office as manifestations of her desire to become close to me and to my body. I believe it to be the early manifestations of a maternal erotic transference.

As a result of this early work, Sarah’s communications have moved to a different developmental plane. In retrospect I believe that the work that we were doing consisted of my provision of a kind of “scaffolding” for language (Wrye & Welles, 1994), just as an attuned mother might do. A mother, for example, might say to a 9 month old who is somewhat distressed and searching eagerly, “Oh, you’re looking for your bottle,” just as if the child were already able to speak. Our work together has literally provided this developmental phase which was missing in Sarah’s early life.

The patient has now come to recognize that she does have inner states. These are not necessarily categorical emotions such as fear, anger,
and so on, but some kind of inner experience that she is beginning to articulate verbally. The states are often quite fluid and fleeting, literally changing moment by moment. They are also very uncomfortable and distressing. She will ask, "Can I leave now?" and we both understand that she is feeling something uncomfortable.

As Sarah has come to realize that she does have inner experiences, she has also recognized that she is not able to "feel" in the ordinary sense of the word. She has never shed a tear in my office and reported that she didn't cry even when her father died. She began to be very persistent in the idea that I was not helping her enough, that I could do something to help her "feel" things. About this time and after several years of treatment, we decided to try having her on the couch, with me beside her in her peripheral vision. With hindsight I believe this was a distancing type of maternal erotic countertransference as I attempted to pull away from her increasing demands.

While she was on the couch she began to talk more and more about her belief that I needed to help her "feel" things and that I could do so by touching her. If only I could touch her she would be able to feel. I began to think that after all this time in treatment in which she had not even been able to actually cry, this might be accomplished through physical touch. Again looking back, I believe this was in part a grandiose aspect of the maternal erotic countertransference described by Wrye and Welles (1994). Somehow I believed I could magically cure Sarah through actual contact with my body. In any case, during a session on the couch she held out her hand to me and I took it.

For the next few sessions I sat in my chair beside the couch and held her hand for some part of the time. Both of us became increasingly uncomfortable. Part of my own discomfort, of course, had to do with my guilt about breaking the "no-touching" rule of psychoanalytic treatment. But the discomfort I experienced was far greater than this. I am still uncertain as to the origin of some of the feelings, but I believe they partook of fears of merger, fragmentation, engulfment, and annihilation for both of us. We mutually made the decision to stop holding hands and have not done so again.

The decision to stop at that time was ostensibly made by both of us. But in the aftermath it was as if the gates of hell were unleashed, so intense was her fury at no longer being able to do so. "Will you hold my hand?" became her battle cry, endlessly and seemingly sadistically uttered in virtually every session. Although she was often able to work productively through part of a session, as the end drew near she would ask, plead,
cajole, threaten, and then apologize and berate herself for doing so. She would ask that if she were going to kill herself, would I hold her hand. This was not an idle threat given that early in treatment she had been actively suicidal. While I did not think that she would kill herself, I did have to take this comment very seriously.

As she began this intense kind of interpersonal pressure, the last 5 min of the session would seem interminable. It was as if time had stopped. She would accept none of my explanations as to why I could no longer do this. Nor could she do any exploratory work as to the meaning of these requests. This continued for many months and, at one point, she stopped treatment, feeling that she could not bring herself to stop making these requests, though at times she wanted to try.

Through consultation on the case and my own self-exploration I was finally able to understand and make use of my countertransference and thereby enable us to work through this impasse. As the grandiose omnipotent mother, I had believed I could heal Sarah through touch. Still holding onto grandiose fantasies, I now believed I could make her understand why I could not and that, through understanding, I could still meet all of her needs. Only as I was able to let go of this belief and state firmly and emphatically that I could not meet all of her needs, but I could meet some of them, were we able to move forward.

Gradually the intensity of Sarah’s demands began to lessen. She became increasingly able to understand her feeling states in the session. She was able to describe several different “selves” who came to the sessions. One was a powerful child who totally took over. This child could not be reasoned with or controlled by other more rational adult selves. She also became able to view situations and people from a perspective that allowed her to describe and understand what was happening.

There are, of course, still many difficult moments. In a session prior to my vacation, Sarah came in with a jumper cable wrapped around her neck. She was however able to identify that the powerful child was in the room and then talk about how angry the child was that I was leaving. When I told her of another upcoming vacation, she asked me to help her remember because she is aware of how angry she becomes.

In very recent weeks we have seen a new side of the child aspect of her personality. Where formerly the powerful child would appear as disruptive, angry, manipulative, even bullying, we now have access to the child Sarah, which is frightened, hurt, and vulnerable. Sarah often refers to this aspect of herself in the third person, stating that “she” is here, but “she cannot talk.” The patient has also said that it is this element of her
personality that holds all of her feelings. With the capability she now has to represent her inner experience, it seems very likely that she will ultimately be able to access and integrate the feelings that have so long eluded her.

In retrospect it is perhaps inevitable that, given the intensity of this woman’s longings for emotional and physical contact with me as the representation of her mother, some type of mutual enactment would occur. The fact that it occurred in the form of physical contact obviously posed certain special problems. It greatly intensified the transference, sometimes to unbearable levels. It further clarified for me the significance that physical contact, even as innocuous as holding hands, has for a patient. In virtually every instance of physical contact, whether it be a handshake, a pat on the shoulder, a quick hug, the meanings will be elaborated in some form or other and should ultimately be explored. The destructiveness of uncontrolled sexual contact with a patient is almost beyond imagining. As Richards (1997) stated:

If the touch has already taken place, the analysis of the impulse, the feelings engendered by the touch itself and the patient’s ideas about how the analyst will feel have to be taken into consideration, talked about and related to other feelings, memories, fantasies and events in the patient’s life. They have to be analyzed! (p. 23)

**Discussion**

The issue of touch is an extremely complex topic, one that raises many significant issues within psychoanalysis. In my discussion I address two of those issues I believe to be key. The first concerns the question raised by Richards (1997) as to whether it is possible to distinguish erotic from nonerotic touch. Richards believed that if psychoanalysts cannot come up with a standard of what constitutes erotic touch, then touch must be eschewed altogether. Gabbard (1996) stated that even what purports to be a nonsexual touching is almost inevitably sexual when it takes place in the context of the transference. Even when touch is comforting or soothing, comparable with that of a mother to an infant, it may, as Wrye and Welles (1994) pointed out, have an erotic component.

From my own perspective it seems likely that although all touching has an erotic component, this in itself does not preclude its usefulness. After all, are psychoanalysts not attempting in work both with themselves and their patients to master and channel unacceptable sexual impulses? Furthermore, it seems that a group of professionals who make it their
business to study human sexuality, can come up with sensible guidelines to assist in the judicious and carefully conceived use of touch with patients.

In the vignettes I presented, for example, it was clear to me in retrospect that the requests for physical contact presented by the first two patients, Nick and Cynthia, both involved a highly charged erotic component that could not be managed in the treatment situation. Nick made his intentions toward me very clear. Although there were undoubtedly many levels to his wish and fantasy, an adult erotic component was predominant. Any type of physical contact would clearly have been inappropriate.

Cynthia’s wish to hug me undoubtedly partook of many levels as well, from infantile to adult. Yet her experience with her previous therapist was in the forefront. The first order of business in her treatment was that of maintaining boundaries and providing a safe space wherein effective work could proceed. Any kind of intense physical contact would, in my opinion, have irreparably damaged even the possibility of a viable treatment relationship.

The decision not to have physical contact seems to me very clear in both of these situations. An adult erotic component was very much in the forefront. Physical contact would have unnecessarily complicated the treatment and would have thwarted its goals. Both patients were struggling with issues of impulse control as was Cynthia’s previous therapist. Neither patient was, at that point, able to work symbolically with the material.

The case of Sarah seems to me a different matter. The issue of touch occurred after a lengthy treatment in which much important groundwork of a nonphysical nature had already taken place. This is not to say that physical contact could only occur after a lengthy treatment, but in this instance a strong base of trust and safety had already been established. It was also, I should emphasize, always at the initiation of the patient. In addition, issues of impulse control which were very significant for this patient had been dealt with at length. We had worked extensively with nonverbal material including data gleaned from facial expression, body language, manner of dress, and a host of less readily identifiable bits of information, but we seemed to be at an impasse. Physical touch (i.e., holding the patient’s hand at her request) provided a viable avenue of communication and expression. This is not to say that there was not an erotic component. The sexual aspect of the physical contact undoubtedly contributed to the “unbearable” feelings that ensued for both of us. Yet as difficult as it was to deal with afterward, it is my belief that the minor physical contact with Sarah “worked.” Where verbal methods had failed,
it provided a channel of communication, a type of contact or engagement between us, comparable in many ways with the physical touch that, of necessity, must take place between mother and infant. This contact, along with the subsequent verbal processing of it, allowed her to achieve the necessary internalization of objects which resulted in enduring structural change.

This brings me to the second point of my discussion, which is that physical contact in and of itself may in certain instances provide a unique channel of communication between therapist and patient. It may provide a singular avenue to the unconscious for those patients whose symbolic expression is blocked or inaccessible. Although it would certainly be used optimally and most effectively with the kind of verbal processing that is the hallmark of psychoanalysis, one cannot overlook the possibility that the touch itself is in some situations the curative agent. It may hark back to that time in all our lives when the mother’s loving, soothing touch quite literally changed and accelerated our development.

I have thus come to consider the usefulness of physical touch in the treatment process because I believe it works. I have found it to move treatment along, break through impasses, and allow patients to endure the incredible agony that often accompanies the realization of early insights. It taps into a period of one’s life wherein physical contact was primary, a life-sustaining link to the mothering one. It is particularly salient for patients such as Sarah, whose access to verbal and symbolic material was limited by significant developmental arrests. It is also my belief that this level of communication is important for everyone, a conduit to that level of experience that escapes the bind of language and without which individuals cannot be fully human.

It is my opinion furthermore that physical touch is occurring far more frequently than is ever reported. If this is indeed so, then it would be extremely helpful and informative to acknowledge and share what we are doing with all types of nonverbal data and means of communication, including physical touch. If we come to acknowledge what it is we are actually doing with our patients, we can then begin to integrate these interventions in a conscious way into our theory, training, and, most importantly, our processes in the consulting room. This would mean, of course, that we would have to undertake the difficult responsibility of working out guidelines that would ensure the appropriate restraint in the use of such a powerful and yet potentially destructive tool as physical touch. This task is surely not beyond the capability of our discipline. Moreover, it is my belief that our efforts in this vein will enrich all of us
as we strive to advance psychoanalysis in a direction that is both more humane and more fully human.

References


