The Role of Touch

Introduction

Touch has a greater significance in the therapeutic process than most other actions in that its use remains controversial and often approached with caution. My intention is to evaluate the role of touch in the context of the clients process through a case example. In this I acknowledge much may be done without touch however I intend to point out how powerful and restorative the intervention with touch can be.

As part of the use of touch I will draw attention to the need to consider mind and body as one and how this provides for addressing somatised experiences in the context of the Gestalt cycle of contact, and associated interruptions.

The Role of Touch

The role of any action, activity, task, construct, etc, in the therapy needs to be justified on the basis of its therapeutic value in the process for the client and these are justified in the context of the moment. The role and action of the therapist must continually be considered in the light of the ethical and professional being of the therapist. In this the underlying approach to the therapeutic process needs to be clear and consistent for the client and the therapist. Through this the therapist can remain clear as to the role of the interventions to be made. This is particularly important when it comes to the use of touch.

Why particularly with the use of touch?

Well, physical contact has proven and continues to be a controversial aspect in therapy. Its use by some is considered absolutely contrary to the therapeutic process and is to be avoided at all costs; even to not shaking hands with the client.

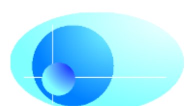
Even so, touch is such a direct and definitive way of communicating body to body Kepner (2001, p77),

and

Mearns (1994, p87) gives an example to show touch being used to help the client focus and to communicate human warmth.

Shaw (1996, p109) points out that the traditional psychoanalytic therapy decried any form of touch. He goes on to reference authors that argue for and against the use of touch and this shows the depth and breadth of opinion and argument that continues with this topic.

When we first enter into this world our physical and emotional needs are met, and requested, through our body. Stern (1998) shows how the newborn infant is developing a sense of self, and this forming



from birth. This development is dependant on the contact of the infant with its environment, through sight, smell, sound, and, mostly, by touch. The awareness of the body based upon tactile sensations is the first developmental experience of the body self (Krueger 1989 p5).

Touch and pre-verbal communication

Touch is our first experience, is pre-verbal, is a felt experience, through which the infant first learns. As I ponder on this I am aware that one of these very first experiences of touch is pain through being slapped to induce the first cry/breath of the baby. I wonder about this and its impact.

In reviewing the factors attributing to successful therapy Rubin and Niemeier (1992) argue that pre-verbal, emotional factors are effective agents in psychotherapy.

Well, at the non-verbal level of therapy the role of touch is able to provide a focus that taps into our pre-verbal level of communication.

In all aspects of our living there is anecdotal evidence for the effectiveness and value of the comforting hug, the gentle holding, kiss away the tears, stroke the hurt; of touch being of value, and valued, in moments needing, calming, or relaxing, or focussing.

When a small child falls and hurts itself the motherly hug and soothing words provide the healing. When the adult suffers similar it is the bottle of painkillers that is reached for. Where and when did the change take place? At what point did the healing get replaced with medicine?

Mind and Body

This is the dualist, mechanistic view that has evolved over the last three centuries and permeates the world of Western medicine. This view splits the mind and body and has split further in concentrating on smaller and smaller fragments of the body thus losing sight of the person, the human being.

The reference as Western is misleading in one sense in that this is no longer a geographical description or locator. Stemming from what was once the Western/European science - Cartesian and Newtonian - such science, and medicine, is global. A distinction is required to provide for different models such as Indian and Chinese, which are empirical and holistic, as indeed was Western medicine prior to Descartes. This distinction provides to highlight cultural differences in how both touch and, more generally, experience of the body is considered in therapeutic encounters.

Mumford et al (1991) , states It is frequently asserted that patients from developing countries 'somatise' their emotional distress, whereas patients in the western world 'psychologise' their emotions

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And Hoole et al (1988) It has been found that patients from developing countries, who lack psychological awareness, 'Somatise' their mental and emotional problems in terms of physical complaints.

To somatise is to interpret as being of the body. Somatic: Affecting or characteristic of the body as opposed to the mind or spirit (Princeton University 2001)

My view is that whilst the body - physical hurt - is kept separate from the mind - emotional hurt - full healing will remain difficult, if not impossible. RenÃ¨ Dubos cited by Capra (1983, p328) points out that Whatever its precipitating cause and its manifestations, almost every disease involves both the body and the mind, and these two aspects are so interrelated that they cannot be separated one from the other

I believe strongly in the power of mind and body together and too much attention to one at the expense of the other results in an imbalance. This imbalance puts the ignored aspect into a repressed state that seeks expression through other ways such as a nagging feeling at the back of the mind or by the tensing of particular muscles. In the Gestalt sense the organism imparts resistance. The organism is expressing itself. Resistance is an expression of self (Kepner 2001,p65)

Resistance

Resistance is viewed in different ways, and as such the meaning and value of resistance is treated differently. Kepner (2001, p61-68) contrasts various understandings of resistances, of Psychoanalysis, of Reichian, and of Gestalt. In the two former approaches the resistance needs to be overcome, or broken down as it is viewed as an interruption or barrier to the self. In Gestalt the resistance whilst very close to the former approaches differs in being a part of the self. As such any breaking down or breaking through is to the self. Gestalt works with the resistance to bring this into awareness.

Gestalt Psychotherapy

Gestalt psychotherapy is a humanistic, holistic model of therapy. From Perls et al (1951:1984, p257) We (Gestaltists) see that meaningful wholes exist throughout nature, in physical and conscious behaviour both, in the body and the mind.

and

The Gestalt approach is based on the absolute inseparable unity of bodily experience, language, thought and behaviour (whether or not in awareness). Clarkson (2000, p20), and Zinker (1978, p162) The goal of Gestalt therapy is awareness, and awareness is that an individual is attending to his experience

A holistic approach takes into account the total self, mind and body as one organism.

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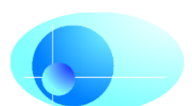

Gestalt psychotherapy is therefore well placed to attend the client in the mental process and the body process, dealing with this as two aspects of a single process; two facets of the same organism.

The Gestalt Cycle

The stages through which the organism moves, organises and experiences figure and ground has been termed the Cycle of Gestalt Formation and

Destruction by Clarkson, P. (1989, p32) and provides a useful diagrammatic representation, from which I produce my model, figure 1.

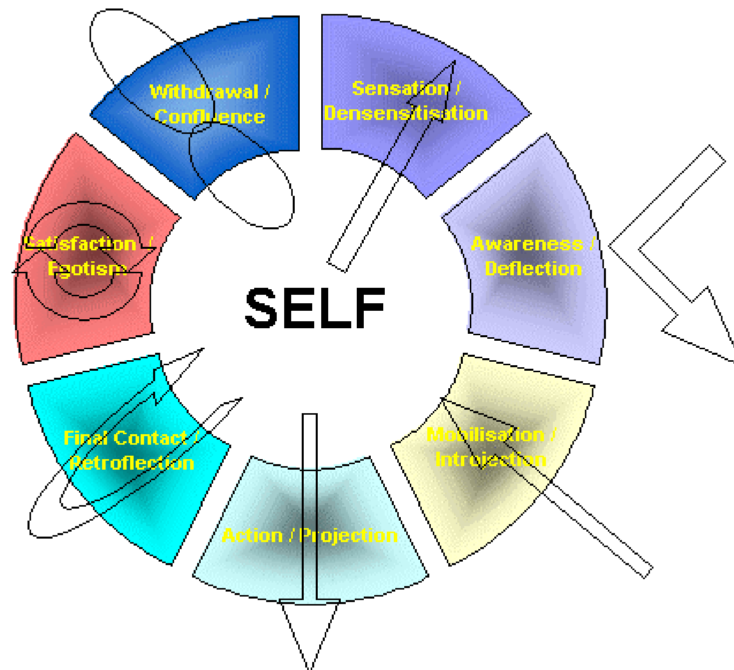

Figure 1 Cycle of Gestalt Formation and Destruction, with disturbance representations

Diagrammatic representation is usually shown as a circle but I do like the diagram, see figure 2, shown by Mackewn, J (1997, p19), 'inspired by Zinker' on the basis of showing a more fluid motion.

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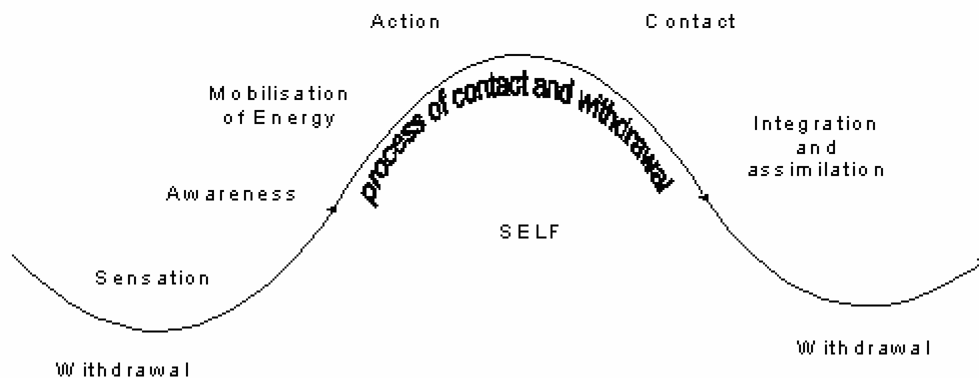


Figure 2 Mackewn, J (1997, p19) Interactive cycle of contact - withdrawal of organism and environment (inspired by Zinker, 1978)

The organism requires integration and assimilation to grow, and this is achieved through this process of contact and withdrawal.

Figure 1, above, indicates associated interruption to contact. Visually these are linked to the stages of the cycle. In practice the interruptions to contact may occur at any point in the cycle.

I will make use of my own therapy experience to show how introjects and retroflections were somatised and in this therapeutic process how the use of touch was the appropriate and useful intervention of the therapist.

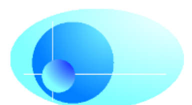
In terms of body process, somatisation is a retroflective act. The organism is turning into itself, rather than the environment where its actions belong. The process by which movement is inhibited or distorted. Kepner (2001, p147)

Strongly linked to retroflection is introjection, being to swallow down whole what does not belong in your organism. Perls et al, (1951:1984, p199)

Attending to the clients experience and seeing the client as one mind and body requires attention to both the mental feeling and physical being on the client. In dealing with the body I believe the use of touch cannot be ruled out in the therapeutic process. With associated training in areas such as physiotherapy, chiropractic and osteopathy there lies the opportunities for more integrated work with psychotherapy clients, becoming more truly holistic.

Ethical considerations

The constraints on this use of touch are bound by both ethical and practice considerations. From the ethical point of view recognition of the different sexes of therapist and client requires the therapeutic alliance to be strong enough and clear enough to allow for the use of touch.



Kepner (2001, p84) highlights the need for a strong bond and close trust to exist between therapist and client.

In addition the therapist needs to be clear that the process justifies the use of touch for the client. Ongoing use of touch needs to be considered in the light of codes of ethics. The SPTI code 3.4.3 recognises this:

Sexual harassment in the form of deliberate or repeated comments, gestures, or physical contacts of a sexual nature that are, or could be, considered offensive by the client, are unethical. (Evans 2001 p109)

The key wording is: deliberate or repeated contacts that could be considered offensive.

In this context repeated handholding may be deemed offensive. Equally, repeated handholding may be an effective intervention to ground the client.

From the ethical standpoint the difficulty would always be around the context of the intervention and the therapeutic environment holding at the time.

Kepner (2001, p82) raises the point that it maybe too easy for the therapist to be responding with his or her own needs. Any lack of awareness on the part of the therapist in this will lead to missing the clients needs. Indeed Kepner argues for all therapists who wish to engage in body-orientated work to have undergone similar work as a client.

Case study

So, now to exemplify how the use of touch may be used in therapy.

At this point in my therapy I was tackling a difficult issue and the session was a culmination of weeks of preparation. This issue was to look at the fear I experienced of the dark, and of darkened stairs.

All did not go well. My resistance remained high and a distinct, familiar pain occurred in my back. This became the focus of the therapy and in working through this I became clearly aware of how this physical pain was representing a childhood situation - a situation then linking to the difficult issue I had wanted to tackle (all roads leading to Rome!)

Somatised

The pain was somatising my childhood experience. This would occur at night.

So now the focus was on this somatised pain and my therapist gently touched (having sought permission) the area in pain. The accompanying dialogue about how I am now and how this is not as before enabled the experience of the touch to move from one of pain and discomfort to pleasure and warmth.

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Incredibly not only did the pain cease, and not return, also the actions brought out clearly what was happening with regard to the issue (I anticipated) I was wishing to deal with regarding the dark, and the stairs.

I came to the therapy session to deal with what it was about the dark that disturbed me; I was deflected from dealing with this because of the pain in my back. In attending to this pain I come to know this represents the childhood experience.

The therapy session might well have reached the same conclusion without the use of touch; however, the additional importance of touch in this situation was much more than the catalyst to awareness to what was going on for me. The added importance of this touch was the experience that the can be comforting. I was able to dissociate the pain and the touch and associate touch and comfort.

Without the physical touch the awareness of my feelings could have been satisfied through dialogue however without the physical touch the experience to associate to comfort, or pleasure - to non-pain - would not have been achieved.

Somatising my emotional pain in the now grew out of the childhood experience and the physical response to tighten the muscles for protection.

In relation to disturbances to the Gestalt Cycle of Formation and Destruction I kept safe by desensitising:

Desensitisation

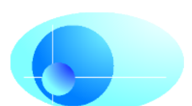
To survive and stay safe I needed to protect myself. Pain is a subjective experience. The level of pain that requires the body to react is altered through desensitising and this allowed me to experience the suffering without feeling. This was necessary also as the suffering was accompanied by the message that to cry would lead to further pain.

Retroflection

Being unable to act towards the environment it was necessary to retroflect these actions:

Being unable to fight back, being unable to understand what was happening I turned my anger and distress in the only available direction, inwards, to my self, in a retroflective action. In so doing I was able to prevent bodily expressions - the vocalisations in the throat, the expelling of breath in sobbing, the angry flash of the eyes or the sad face, the movements of pushing away, grasping, or striking out, of reaching out or escaping Kepner (2001, p147)

In doing this I lost the act of outward aggression I was not able to assimilate my self with my environment. Assimilation in this context is the breaking down of introjects and holding those patterns of behaviour agreeable to my self an the rejection of those not in keeping with my way of being. The



rejecting was inhibited, indeed crushed, by the stifling of the natural tendency of aggression - a healthy function which prevents introjection Perls et al, (1951:1984, p201)

Introjection

The introjects was to not cry, to keep still, to not answer back. To achieve this it was necessary to control the body. Breathing was held to prevent the cries, muscles tensed against attack, and other muscles held rigid to deflect further antagonism. Kepner (2001, p178) describes this as overbounding - the body boundary is hardened and made impervious and the overbound person creates a shell whenever contact with his or her boundary is threatened.

Where did the energy of such actions go? Where does the energy created to scream go when inhibited from being expressed? The vocal muscles are readied, yet the throat constricts and suppresses the rising breath; utilising the thoracic cage and muscles to hold the tension the lungs -the powerful bellows - are blocked.

The energy is held in the body in a tense state. In this case study, almost certainly, bringing about an asthmatic state. Additionally the body continually holds the tension as a fixed gestalt. The posture is rigid and lacking in flexibility. Muscle groups will be hardened and the individual may manifest anxiety or defences with physical movements or adjustments.

The therapist is able to make these observations and in the context of what is being experienced at the time may intervene with highlighting the posture or muscle tightness.

Conclusion

Gestalt therapy is a holistic model viewing the client as one, being self and mind. In working with the client the therapist is able to communicate both verbally and physically (and actually at a non verbal level also). Whilst there are wide ranging views on physical contact between therapist and client in terms of a holistic approach its use is available. This use, indeed the use of any action, is subject to the need of the client. The therapist is responsible for ensuring his or her own needs are not interrupting the clients process and this is the key to touch as an ethical action.

The case study highlights how a therapy session may move its focus, and in fact demonstrates the phenomenological nature of Gestalt therapy. The use of touch had clear implications for resolving a fixed association of touch and discomfort. The use of touch in this example demonstrates its ability to focus the work.

As also stated in this case study much of the work may have been achieved without resorting to physical contact and this highlights the need for the therapist to be clear the intervention is valid.

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My own view is that there is justification for touch in the therapeutic environment and further that to this is necessary in recognising the holistic model of Gestalt.

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