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body
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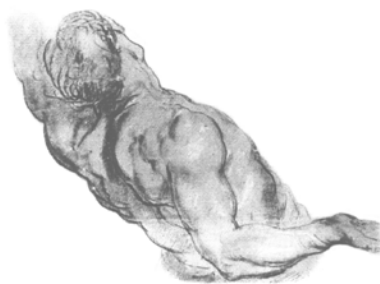


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USABP Mission Statement

The USABP believes that integration of the body and the mind is essential to effective psychotherapy, and to that end its mission is to develop and advance the art, science, and practice of body psychotherapy in a professional, ethical, and caring manner in order to promote the health and welfare of humanity.

The USA Body Psychotherapy Journal Editorial, Volume 6, Number 2, 2007

I feel so fortunate to be part of body psychotherapy at this point in time. Courtesy of neuroscience and the attachment literature, we are suddenly relevant to the more “mainstream” areas of psychology and psychoanalysis. Freud’s 1923 assertion that “the ego is first and foremost a bodily ego” is finally being taken seriously and explored. When Freud and Reich split in 1930, Reich seems to have taken the body with him leading many modalities to consider the mind the antithesis of the body, characterizing intellect a mere defense. In the ensuing decades psychoanalysis and body psychotherapy developed in parallel lines, which by definition never cross. With some exceptions (Authentic Movement, for example, grew out of and has stayed closely allied with Jungian analysis.), each seemed to ignore the other, stuck in the conflict of an earlier era.

In the last few years, perhaps particularly in the years since the founding of the USABP just outside of Boston, body psychotherapists have begun to study and incorporate developments in object relations, self psychology, etc. into their thinking and practice. People originally trained in dance, movement, body work of all sorts pursue graduate degrees in psychology and social work and attending analytic institutes. Practitioners trained in both areas sometimes amalgamate them seamlessly and sometimes run two totally separate clinical practices.

Trauma treatment has also built bridges between the two land masses. People such as Bessel van der Kolk, Peter Levine and Pat Ogden have pointed to the ways in which both developmental and shock trauma are held in the body in their considerable writings and trainings. Psychoanalytic institutes have begun to offer training specifically in the field of trauma treatment, which inevitably includes consideration and to greater and lesser extents, treatment, of the body.

What, then, of the relationships between different schools and modalities within body psychotherapy? In his thoughtful article, “Common Factors in Body Oriented Psychotherapy”, Fernando Ortiz grapples with questions such as why, historically, there is such polarized diversity in body psychotherapy and then with what are the common factors, most of which are shared by every form of psychotherapy. How significant are these factors to the outcome of the process? His report of a pilot project surveying seasoned body psychotherapists of 8 different countries provides some interesting suggestions.

In a similar vein, A. Pribaz and Mauro Pini, in “Recovering the ‘Reasons of the Body’ in Psychotherapy,” discuss the historical, philosophical and theoretical bases of the distrustful attitude of many verbally oriented therapists to the inclusion of techniques focusing on or including the body in their work. They suggest several ways in which integration might be fruitfully and easily accomplished.

In a companion piece, “Toward Mind-Body Integration: the Organismic Psychotherapy of Malcolm Brown,” the same authors, Mauro Pini and A. Pribaz suggest the model developed by Malcolm Brown and derived from theories originally proposed by Kurt Goldstein as exemplifying the marriage of humanistic psychotherapy with psycho-corporeal techniques inspired by Reichian and Gestalt traditions.

Again in an inclusive spirit, Judith Blackstone describes and illustrates a method of somatic attunement that she has developed for 35 years, first for her personal use and then with her clients. The series of exercises, which she has called Realization Process, has recently been included in two research protocols at New York University Medical School investigating reduction of PTSD symptoms in adult women survivors of sexual abuse. In “A Somatic Approach to Recovering from Sexual Abuse,” she proposes that these exercises can seamlessly supplement either verbal psychotherapy or other body psychotherapy methodologies.

In “Subtle Touch, Calatonia and Other Somatic Interventions with Children and Adolescents,” Anita J. Ribeiro and her colleagues, Maria Irene Crespo Goncalves, Maria Amelia Pereira, and Ana Maria G. Rios, introduce us to the psychophysical reorganization and integration theory and methodology originated by Petho Sandor. Utilizing Jung’s concept of the psyche and its relationship to the body, he devised a gentle body psychotherapy designed to foster self-regulation (which he understood to be “the ability of an individual’s organism, in its physical, emotional and cognitive aspects, to spontaneously adjust to find its optimum state of activation in response to a given moment or challenge”).

They then describe utilization of Calatonia and Subtle touch in diverse settings in Sao Paulo - residential, outpatient and educational - with children from preschool age through adolescence.

Lisbeth Marcher and her colleagues Erik Jarlmaes, Kirstine Munster and Ria van Dijke, analyze and illustrate the neurophysiology and bio-psychological effects of touch, and describe various examples of touch in psychotherapy, in their article, “The Somatics of Touch”. They give illustrations of both therapeutic and educational settings in which they have found a “measurable psychological effect caused by bodily interventions.” We await the report of that research.

And, anchoring this issue of the USABP, we have Ofer Zur’s important and lucid discussion of “Touch in Therapy and The Standard of Care in Psychotherapy and Counseling: Bringing Clarity to Elusive Relationships”. He defines the standard of care in psychotherapy, reviews clinical research on touch in psychotherapy, identifies different types and articulates how non-sexual, clinically appropriate touch falls within the standard of care of psychotherapy and counseling.

I am pleased that this issue represents work by authors in and from a multitude of cultures: Mexico, Brazil, the US (both coasts), Denmark, Netherlands, and Italy. More multiculturalism, internationalism, whatever we want to call it, can only be of benefit to us all.

Jacqueline A. Carleton Ph.D.
New York City
September 2007

Common Factors in Body Oriented Psychotherapy

Fernando Ortiz Lachica, M.Psych.

Abstract

This paper addresses the causes of diversity in body psychotherapy, the relationship between body psychotherapy and the common factors operating in every form of psychotherapy as proposed by Lambert, and the perceived common beliefs, concepts and techniques in different modalities of body psychotherapy as explained by 13 therapists of 8 different countries in an informal survey.

Keywords

Body Psychotherapy – Common Factors – Diversity

Diversity

When I first learned about body oriented psychotherapy back in 1973, it was practically synonymous with Bioenergetics. However, in their practice, many therapists were already experimenting with a great variety of techniques from all kinds of sources outside the Reichian tradition. That was the case with my first trainer, Dr. Héctor Kuri whom I met in 1979. He had been in training with Lowen and Pierrakos when they were still working together, but he was also experienced in Yoga, and incorporated Sufi dancing, Kum Nie and many techniques that he had learned from Bagwonn Sree Rajneesh into his practice and training. Nevertheless, his students thought they were learning Bioenergetics.

As I came to know more about the field, and particularly after attending the First Congress of Body Oriented Psychotherapy, organized by the International Scientific Committee, in Oaxtepec, Mexico, I was amazed by the number and variety of approaches being offered. For a few years, I had an ever growing list of therapies and psychotherapies in my computer that I eventually included in a book (Ortiz, 1999). It soon became clear that it was not a homogeneous list. Some of the entries were distinct psychotherapies comprising a coherent theory of personality, change and/or growth and a method for working with individuals or even groups, while others were specific techniques, blown up out of proportion. Most practitioners did not make any distinction between therapy and psychotherapy, or between method and technique, and the whole field had fuzzy boundaries with various forms of physiotherapies, massage, and shamanistic practices such as sacred dance, rhythmic sounds, breathing regulation, meditation and even drugs,¹ healing and many kinds of alternative or complementary medicine, particularly those concerned with energy, to name but the most outstanding disciplines. Although the Congress was held in 1987, it still had a flavor of the 60's and early 70's. If one could describe the general atmosphere in the Oaxtepec conference with a single phrase, it would be "anything goes".

The motto of the Fourth International Congress of Body Psychotherapy, which took place in Boston in 1996, invited us to build bridges and celebrate diversity. Good phrase because, indeed, one of the characteristics of the field is diversity and one of the tasks is precisely building bridges between the different schools of body psychotherapy, and between body psychotherapy itself and other "mainstream" approaches. At that time, the European Association for Body Psychotherapy had been in existence (it was founded in 1988) and meetings were held leading to the foundation of the United States Association for Body Psychotherapy. Through the efforts of both associations and individuals in Europe the U. S., and beyond, body psychotherapy has found, or is finding a place among mainstream approaches. As for celebrating diversity, everyone can testify that the number of modalities keeps growing (Young, 2005a, Young, 2005c), and this is not necessarily cause for celebration. Anyone can start a school, invent a name for his or her "new" method or technique and make a synthesis of theories to try to explain the work. Some of these new approaches may really be a breakthrough in the theory and practice of body psychotherapy while many others simply offer new names for concepts and procedures that have been around for a long time. Nevertheless, the allure of specific modalities of body psychotherapy is such that generic training programs are significantly fewer than "brand name" programs in the U. S. A. (MacMillan, A., personal communication)². People seem to prefer to identify themselves with a particular school than to say, simply that they are body psychotherapists. The followers of different approaches are not always on good terms with each other, and many of them do not tolerate any form of heterodoxy in their ranks, as Young (2005d: 11) so aptly outlined:

The various modalities within body psychotherapy have, to date, been hardly recognizing, let alone communicating with, one another. When practitioners trained in one particular method develop their work in that

¹ Joseph Campbell (1985/1962) stated that every culture developed its own Yoga, meaning particular forms and combination of those practices.

² In Mexico, as far as I know, most training programs are generic, either because founders of schools are not willing to open a franchise of an international school and thus subject themselves to rulings and royalties, or because some of them teach a combination of concepts, methods and techniques that come from different schools and have not yet decided to claim that they have created a new modality with a brand name.

method they are accused of “diluting” the therapy, of being “impure” or betraying the work of the founder. There is the “arrogance” of the converted, those who do not question the wonderful therapy they have discovered and then trained in.

This trend towards diversity may be explained by three sets of interrelated causes:

First, Reich trained therapists in five different countries: Germany, Denmark, Sweden, Norway and the U. S. between 1930 and the late 1940's. During those years, his way of doing psychotherapy changed, and undoubtedly his approach varied with the different patients. As he did not write a manual of technique when he practiced character analytic vegetotherapy and psychiatric organomy, or founded a stable training program, his students and patients were left with the particular experience of their own therapy and apprenticeship which was necessarily partial. Thus, it was from a partial view of Reich's work that some of his pupils started new modalities (X. Serrano, 2001, personal communication).

Secondly, for many years, even experts found it hard to keep up to date with the new developments in the field. Many practitioners never published material explaining their work, or else it was not easily accessible. The work of authors publishing in languages other than English, or in small publishing houses was read by relatively few people. That may have been the reason why some founders of “new schools” acted on *bona fide* ignorance, unaware of the fact that someone else was doing, or had done similar things. Even in the English speaking world, many founders of new methods were isolated. Ilana Rubinfeld (1997), for example, was an orchestra conductor when a spasm took her to a teacher of the Alexander Technique. Eventually she made a synthesis of that method, Feldenkrais' and Gestalt Therapy. For a long time, she worked alone: “For the twenty-five years before (1988), I felt like an isolated voice in the bodymind wilderness. Few people understood what I was doing and I had no colleagues to share with.”

When the founders of “new approaches” did publish books or journals about their work, many tended to restrict their references to their own work, ignoring or debasing other modalities. Fortunately, the number of publications that do not refer to a single modality and go beyond the jargon of a particular school is growing. In the last few years, attempts are being made to make the material accessible, such as the CD ROM, compiled by the European Association of Body Psychotherapy, Jacqueline A. Carleton, editor of USABPJ, who writes a column in the USABP Newsletter reviewing new books and CD,s sent to to her, or the long awaited Handbook of Body Psychotherapy (already published in German as Handbuch der Körperpsychotherapie: 2005: Hogrefe).

Of course, reading a book about a specific modality of body psychotherapy does not necessarily give an idea of what psychotherapists actually do, and, although the workshops given at conferences may offer a taste of the procedures used by a particular school, the smorgasbord of workshops and demonstrations offered in congresses is usually different from the menu of everyday practice. So, even with the best of intentions, it is hard to keep up with the literature as it is impossible to go to all the training programs or even workshops in every modality.

And third, the other set of reasons has to do with the personal needs of the founders and their disciples. First of all, starting a “new school”, or belonging to it, has its own, inherent reward, such as prestige, satisfaction of narcissistic needs or identity. Besides, many founders of “new schools” and their followers make a living by marketing a perceived difference between others work and their own (Caldwell, personal communication, 1999). In some cases, the schools are, in fact, sects and some sort of implicit “pledge of allegiance” must be made to remain ever faithful to their creed, and that includes ignoring or downplaying other modalities. That, I believe, is a general attitude in the field: each school underlines the characteristics that supposedly make it different from others, while overlooking the similarities. Freud (1930) wrote about “The narcissism of small differences” to describe the rivalry between similar ethnic groups or neighboring villages. Such narcissism leads to attitudes such as “My school is all of these, while yours is just that ” (Young, 2005a) or to the discomfort experienced by the faithful when someone says that all of us are doing more or less the same thing (Caldwell, C. personal communication, 1999).

Both the similarities and the differences between the different modalities can be explained, at least partly, by their origin. Nobody invents a method out of the void. The history of most, if not all schools, includes a synthesis of diverse methods³ (see the chapters of Caldwell's *Getting in Touch*, written by creators of diverse modalities and also the excellent histories of body psychotherapy.: Goodrich –Dunn, B. & Greene, E., 2002., Young, 2005b, 2005c, 2005d), but, at some time, the need to differentiate, to develop a distinct identity, leads to minimization of similarities and the stressing of differences small as these may be. Furthermore, many of the differences do not refer to what psychotherapists actually do, but to the specialized language they use to describe their work (Rispoli, 1997, personal communication, Caldwell, 1999, personal communication).

Summarizing: two different trends have coexisted in the field of body oriented psychotherapy in the last three or four decades. On the one hand, there has been a tendency for new schools or training programs to appear, each of them underlining the differences between their methods, theory and techniques and those employed by other schools, and on the other there has been a recent tendency to find common principles and share goals among different approaches to the work.

³ Although the founders of new schools often fail to acknowledge this fact and seldom justify the need for differentiate from other schools on a scientific basis.

The common factors.

Body psychotherapy must be understood in the broader milieu of Psychotherapy. There, rivalries between different schools have been part of the scene for decades. As with body psychotherapy the major types of psychotherapy (such as, family therapy, psychoanalysis, cognitive – behavioral, etc.) insisted in ignoring each other, or else tried to objectively prove that their method worked better than others. The rivalries between different modalities of body psychotherapy may be a necessary developmental stage, as it probably was the case with the major schools (Norcross, 1999, in Hubble et. al. 1999), but our field should learn a few things from the conclusions derived from those battles. After countless studies two general conclusions have been reached (Assay, T. & Lambert, M. J., in Hubble et. al. 1999):

1. Psychotherapy is effective.
2. There is little evidence to indicate differences in effectiveness among the various schools of therapy.

These conclusions led to research on the common factors that could explain success in psychotherapy, for if all of the schools were beneficial, the variables behind the success rates should not be looked for in what made the schools different but in what they had in common. In 1992, Lambert (in Hubble et. al., 1999: 8), proposed four therapeutic factors:

Client/ Extratherapeutic factors: The circumstances in the client's life that aid his recovery. These factors explain 40 % of the improvement of patients.

Relationship factors: These are variables such as warmth, empathy and acceptance, to name but a few, that are independent of the therapists' theoretical orientation and account for 30 % of the benefits of psychotherapy.

Placebo/hope: In every treatment, including psychotherapy and alternative medicine, people are given hope that they can be helped. That, in itself, accounts for 15% of the variance in client change.

Although technique and theoretical model have received a lot of attention by most trainers and researchers, they explain just 15 % of the improvement. In other words, the factors that distinguish the various major types of psychotherapy from one another do not seem to be as important as the founders of the different schools believed.

For many practitioners and consultants, models and techniques are precisely what define each modality of body psychotherapy. Too much time and energy are invested in teaching, learning and writing about specific models and techniques. Again, mastering techniques may be a necessary developmental stage (Kurtz, 1990)⁴. And, as I said earlier, specialized languages have been developed in order to teach the craft. Yet, if we liberate the procedures from the specific vocabularies of the various methods, we find that they are not that many, nor that different (Gendlin, E. 1999: 246).

Common ground.

Some time ago I read that people could be classified into “lumpers” and “splitters”. The former tend to lump objects into broad categories, finding similarities between things, while the latter prefer to look at differences and place objects in many different classes. Writing about this, I am reminded of nineteenth and early twentieth century naturalists who described more than seventy (!?) different species of Big Brown and Grizzly Bears in North America (Hall, 1981). Brown Bears vary in size, appearance, color of hair, habitats, food preferences and even personality, so biologists had a point in differentiating them, but the similarities between different individuals and populations (and we could add genetic evidence) convinced scientists that *all* the brown bears (*Ursus arctos*) are a single species.. In the case of body psychotherapy, there is no doubt that many modalities will continue to emerge, and of course they need to be described not only by the adherents but by third parties (i. e. researchers, reviewers or professional organizations) so that the substantial differences between them can be known and distinguished from mere “brand names”, both by experts and laypersons. The other task has to do with common factors. On one hand, we must study the specific ways in which the common factors operating in all forms of psychotherapy work in body psychotherapy and on the other hand, we must define the traits that make all of these schools variations of a single species. We should underline that, after all, the factors that make body psychotherapy differ from other, approaches account for only 15% of the outcome of a therapeutic process, so the differences between the existent modalities may mean less than we, as adherents, would like.

A necessary step towards finding a common ground in body psychotherapy is to develop a common language, one that both practitioners and consultants could understand and share, a language with as little jargon as possible,

An informal survey.

⁴ In my experience as a trainee and trainer, students crave for technique and diagnostic abilities in the first stages of their training.

Looking for common factors in body oriented psychotherapy; I sent the following e-mail (in Spanish and English) to 30 professionals of 12 different countries:

Dear Colleagues:

In the upcoming congress in Sao Paulo, I am presenting a paper on the common factors operating in body oriented psychotherapy. By that I mean the principles, concepts and techniques (if any) that body oriented psychotherapists have in common, regardless of their particular school or training. I would specifically request a list of principles, concepts and techniques employed by the therapists you know. Please do not think it has to be a long list. Just write whatever comes to your mind in less than 5 minutes. I suggest a list of no more than 10 common elements. Thank you for your cooperation.

Fernando

All of the recipients were people I know, therapists with at least 5 years of practice and experience with more than one modality of body psychotherapy. Some of them forwarded the messages to other colleagues so the message eventually reached 40 professionals. The idea was to get simple answers, to find what came to the recipients' minds when they thought about what different modalities have in common, therefore, the request was quite open, comprising principles, concepts and techniques. Some of the surveyed were not sure of what I meant by principles or the difference between principles and concepts and said so in their answers. The vagueness of the request was deliberate, so that the recipients could answer whatever came to their minds, without much thought. The sample was, of course, not representative. The message was sent again after two weeks. After a month I got 12 answers, varying in length from 2 lines to three pages.

Two months later I sent another, more specific e-mail which was answered by three therapists:

1. In your view, what do most or all body oriented psychotherapists *do*, that sets them apart from other psychotherapists?
2. What, in your opinion, do most or all body oriented psychotherapists *believe* that distinguishes them from other psychotherapists?
3. What do you think most or all the different modalities or schools of body oriented psychotherapy have in common?

Although the sample was small and in no way representative, it did include some very well known therapists. Two of them are originators of modalities which are taught and practiced in several countries and six more are senior trainers with more than 16 years of experience in their own countries and abroad.

Finding common factors on which everyone agrees was not easy. There doesn't seem to be a single factor or defining trait on which everyone agrees, or else the importance that psychotherapists tend to assign to different techniques or concepts varies as we can see in Table 1.

It is not easy to summarize such a diverse sample of answers but nevertheless, a few facts are noteworthy:

- Even if all of the recipients were asked to write about what different body psychotherapies have in common, two of them answered about the specific principles and techniques of their own school. Although they know about other approaches, they would not speak about the similarities between their approach and other modalities.
- Six mentioned Reichian concepts, such as the character armor, or segments.
- Seven underlined mind/body unity.
- Six spoke about the body containing the history of the person, or of it being a way to access unconscious memories.
- Regarding techniques five persons mentioned some type of touch and/or massage, breathing and movement.
- Four mentioned energy.
- Seven spoke about the importance of the relationship, and three of them underlined the somatic aspect of the relationship, i.e. having bodily awareness of what was going on.

But even if there is some agreement regarding theory and technique the most outstanding result is the lack of consensus. Luciano Rispoli, founder of the European School of Functional Psychotherapy said it simply: “Alter many, many years of European and international conferences, the things (that body therapies have in common) that come to my mind are not that many: Touch the patient’s body, make the patient’s body move, and use the therapist’s body.”

This survey should be considered a pilot project a starting point for future research. The sample was arbitrary and the questions were too open. It is possible that some therapists did not mention a belief or technique because they thought it was too obvious. For more reliable data, I would suggest closed questions. Further research should be made to find what body psychotherapy has in common with other major branches of psychotherapy, and on the ways in which the common factors behind the success of every form of psychotherapy are affected or enhanced by the specific procedures of body psychotherapy.

patient/client moves	6
therapist touch	5
Energy	5
Respiration	4
mind body unity	7
body conciosness	4
Reich	2
Patient, therapist relationship	7
armor, segments,	3
Body containing memory/history	6

Table 1

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Biography

Fernando Ortiz Lachica recieved a Masters Degree in Clinical Psychology from Universidad Iberoamericana, in Mexico City. He studied Psychodrama and Bioenergetics and completed training programs in Core energetics, Functional Psychotherapy and Hakomi. He has led or participated in the training of therapists across Mexico, in Italy and Guatemala. He is full professor at Universidad Autonoma Metropolitana, in Mexico City, and is the author of *La relación cuerpo mente. Pasado, presente y futuro de la terapia psicocorporal* and *Vivir con estres*, both published by Editorial Pax, Mexico. contact fernandoortizl@yahoo.com

Recovering the “Reasons of the Body” in Psychotherapy

Antonio Pribaz and Mauro Pini

Abstract

The paper briefly discusses the main historical and theoretical reasons for the distrustful attitude of many verbally oriented psychotherapies (especially classical psychoanalysis) toward the use of body methods, and the consequent disagreements (and often mutual discredit) with the body-oriented psychotherapies. Passing beyond any presumed incompatibility, the article suggests adopting an integrated approach based on an organismic perspective in order to transcend the (misleading) mind-body dichotomy.

Key words

Body Work – Psychotherapy – Psychoanalysis - Mind-body - Setting

In an ongoing debate within the complex and varied universe of the psychotherapies, it is often observed that verbally-oriented approaches and those centered on body work run on tracks that are parallel but not touching. This situation recalls the early theoretical formulations of psychology in the late 1800s; an example is seen in Wilhelm Wundt's statement concerning the principle of *psychophysical parallelism*, according to which the mental and physical processes of the human organism run parallel: the former do not cause the latter nor vice versa, but with every change in the first, a specific change also occurs in the second. It is essential to discover a language connecting the two perspectives, indispensable for avoiding self-referentialism and the ensuing risk of remaining in a sterile position that hampers further development.

The task of the therapist who uses body methods is to find points of connection between these separate, distinct worlds; this is a careful study aiming to provide some historical context for the psychoanalytic establishment's decision to exclude *a priori* the method of (non-erotic) body contact from the therapeutic setting (see: Pini, 2001). The basic misunderstanding of Freudian pansexualism, which improperly superimposed sexual desire on the need for physical contact (a position refuted by the attachment theory of John Bowlby and subject to debate following the crisis of Freudian metapsychology; see Klein, 1976; Holt, 1994) led to prejudice and the risk of “throwing out the baby with the bathwater”.

However, it must be recognized that in the beginning psychoanalysis was mainly occupied with creating a model that would not expose its flanks to the violent attacks it often provoked, since it already presented too many aspects that were clearly in opposition to the cultural climate of the time. Over a century after Freud took his first pioneering steps into the world of the psyche, we feel less timorous regarding the frontiers of psychotherapy. While maintaining a cautious attitude, we can allow ourselves to explore these territories with an attitude of intelligent curiosity based on significant experimental and clinical evidence (Smith, Clance, Imes, 1998).

The therapist who uses body work does so from choice, guided by the knowledge of the advantages and assessments of the risks, an attitude quite different from that of avoidance due to fear or prejudice. In recent years there has been considerable interest in subjects dealing with aspects of the physical: from Lowen's now-classic Language of the Body (1958) a consistent number of other publications have followed in the footsteps of the founder of bioenergetic analysis, and the earlier ones of Reich (1945). To mention several: The Body Reveals by Kurtz and Prester (1976), Bodymind by Dychtwald (1977), Dreambody by Mindell (1982), Theatres of the Body by Mc Dougall (1989), the works of Kepner (1987), those of Smith, Clance, Imes (1998) and many others.

It is striking that even authors from very different schools find themselves sharing an interest in the physical dimension, and thus consider the body to be a protagonist in their field of inquiry and in clinical intervention, as if it were a lost object which is suddenly recovered. The psychoanalytic sphere also provides scope for the need to bestow dignity on bodily events, frequently denied or considered to be epiphenomena of the psyche. Thus it is important to consider the body not only symbolically but also concretely, as in L'esperienza del corpo by Favaretti Camposampiero et al. (1998). In this book the authors explored a double utilization of the bodily phenomenon: a) the possibility of achieving an integrated sense of the Self by working toward recognizing, gathering and assembling the input of the sensory-perceptive experience with the emotions and feelings and b) the possibility of using body work to better understand the way in which patient as well as therapist participates in the construction of the therapeutic setting.

We must not forget that within the framework of the psychodynamic model, there has been interest in the body ever since the classic contributions of Ferenczi (1930, 1953) and Reich (1942, 1945), and we are also able to retrace a marked interest in that sense, though in a somewhat different way, in the subsequent works of Ogden, Bleger and Milner.

More specifically, Ogden (1989, 1991) focused on aspects of the analyst's physical countertransference. Bleger (1967) showed that when important progress occurs in the psychotherapeutic process, bodily experiences in both the patient and analyst can emerge; Milner (1969, 1987) presents an example of how the analyst can become aware of his/her own physical sensations.

Milner, a psychoanalyst with experience in art and painting, studied the non-verbal phenomena involved in painting in order to expand her direct internal sensorial knowledge. Describing sensations felt in the act of painting, the author recounts

her sense of surprise and amazement upon entering into a state of total bodily awareness every time she attempted to extend her own field of attention. Contact with a totality of bodily sensations led to a different perceptual quality, with respect to her external as well as internal experiences.

Exploring the subject of aesthetic experience, Milner stressed that it is extremely limiting to emulate psychoanalysts who bestow a merely pathological connotation on these states, considering them autoerotic or narcissistic. In this case, narcissism is a positive component that is not concentrated specifically in the sexual organs, nor does it represent a refusal of the external world, but by involving the body in its entirety becomes instead a sort of “added value”, permitting it to feel in a new and vital way.

This perspective confers dignity and value on states and sensations that had long been considered in an overly limited way by a certain type of psychoanalysis. It almost seems to echo the spirit and the letter of early Freud, who defined the ego as the “bodily entity” and used physical contact to promote patients’ free association. Milner emphasizes that by approaching an object, the artist expresses a direct, rather than a symbolic, sensorial awareness of the condition of being alive in a body. She recounts how this type of new bodily experience became increasingly present in her analytical work. It does not have to do with the classic state of “free-flowing attention”, since it is not something exclusive to the sphere of thought or mental activity, but rather implies immersing oneself in a diffuse bodily awareness. In this state the analyst discovers that ideas and “correct interpretations” that she had initially sought only in the sphere of thought, could instead arise spontaneously from this state of intimate connection with one’s own bodily experience.

It emerges that there are two different ways of perceiving the other; with the “head” and with the “body” (Ennis Brown, 1988). Brown (1990) distinguishes between psychic and organismic levels of listening, underlining the importance of integrating these two methods. The aim is to overcome an attitude crystallized in the dissociation between “observing mind” and “reacting body”, the only way to experience a truly empathetic relationship with the other.

Moreover, in a point of view that considers the therapeutic relationship to be a *bi-personal field* (Gill, 1994), patient and therapist establish a relational setting in which the psycho-corporeal experiences of one have direct and immediate repercussions on the experience of the other. For this reason it is particularly important that the therapist place himself in a position of *attention* rather than *intention*, with respect to the other. In a view that sees the body as a *revealer of processes*, the recovery of the psychosomatic unit occurs by learning to consider the body as a truthbearer. Thus we approach the idea of the body as *great reason*, of such significance in Nietzsche’s vitalistic empiricism that he considers it a starting point for the organization of human knowledge; this concept remains important and is more relevant than ever today, to the point that it practically constitutes the *leit motif* of our considerations.

This further clarifies the origin of the demand for a different language for body-oriented psychotherapies. The goal is to create channels of communication not only with professionals who use body work but also those whose main frames of reference are models of verbal psychotherapy, do not wish to consider the body only as a “heavy opacity” and a “mute limit”, but rather as a precious opportunity for exploration. Thus the body becomes a place where a sense of personal identity melts away and continuity of being takes root (Schilder, 1935).

Working with the body also signifies relating to the wholeness of the patient’s overall experience (and that of the therapist) in the here-and-now of the session, rather than limiting oneself to verbal communication; if the physical dimension is denied, there is a risk of involving the rational sphere alone, oriented more to controlling rather than to living. This perspective prompted *Organismic Psychotherapy* introduced by Malcolm Brown (1990); the use of body contact encourages one to focus on proprioceptive sensations and their relation to one’s affective experience; the perception of the “endodermic vegetative flux” expresses the process of re-unification (in the Self) of those parts that had lost any sort of connection between them.

Body contact makes it possible to experience perceiving oneself whole, which Brown (1990) defines as a diffuse condition of awareness characterized by the sensory-motor and emotional immediacy of the here-and-now and of being fully rooted in the experience of letting oneself go, moment by moment, in the sensation of the primary unity of our being. No longer fragmented into a thousand facets by the mind-body division, we embrace to the possibility of entering that underlying layer of experience belonging to a state of pre-verbal bodily unity, aim to (re-) discover of a beneficial harmony with the natural rhythms of the organism.

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Toward Mind-Body Integration: The Organismic Psychotherapy of Malcolm Brown

Mauro Pini and Antonio Pribaz

Abstract

The article introduces the main elements of Organismic Psychotherapy, an approach derived from the theories of Kurt Goldstein, who along with American psychologist Malcolm Brown devised many original applications in the field of body-oriented therapies. Organismic Psychotherapy can be categorized as a humanistic-body psychotherapy, since it attempts to integrate the main assumptions of humanistic psychology with psycho-corporeal techniques inspired by Reichian and Gestalt traditions in a single theoretical-methodological system.

Key words

Organismic Psychotherapy - Malcolm Brown - Character-muscular armoring, - Body contact -
Self-actualization

Organismic Psychotherapy was conceived and developed by American psychologist Malcolm Brown PhD., who with his late wife Katherine Ennis directed the Organismic Psychotherapy Training Institute of Atlanta. This body-oriented therapy takes as its theoretical model the ideas of German neuropsychiatrist Kurt Goldstein (1939, 1940, 1954, 1959), from whom it derived its framework.

Brown's works (see: Brown, 1973, 1979, 1990) reflect various theoretical influences. Reichian tradition, humanistic psychology, Gestalt therapy, and the thought of novelist D. H. Lawrence all converge in an ambitious attempt at synthesis in Brown's book (1990) "*The Healing Touch. An Introduction to Organismic Psychotherapy*".

The author's concept of energy differs considerably from that of Wilhelm Reich. It was clearly influenced by the postulates of Kurt Goldstein, according to whom the organism has a constant amount of energy available, equally distributed in its parts. It seeks to return to this distribution when a stimulus alters its level of tension. Thus the organism's goal does not consist so much in the charging and discharging quantities of energy, as in Reich's well-known formula *tension-charge-discharge-relaxation* (Reich, 1942, 1945), as bringing the tension to an optimum level and distributing it uniformly throughout the system (equalization).

Another difference between Brown's organismic approach and Reichian tradition concerns the origin and function of character-muscular armoring. Brown maintains that this does not develop as a defensive framework against the sexual instinct, but can be traced to the joint repression by the False-Self (on the psychic level) and (on the organismic level) by the so-called closed cortico-cerebrospinal circuits (Brown, 1990, p. 313) of the True-Self's primary emotional needs, that consist in establishing a close and meaningful relationship with the caregiver. In the Author's terminology, the term closed cortico-cerebrospinal circuits includes cognitive activity isolated from the organismic whole, which inhibits the free flow of the system's vegetative energy and obstructs awareness of the Self's primary emotional needs, leading to the formation (and preservation) of character-muscular-armoring.

According to Brown, character-muscular-armoring expresses the sum of the defensive strategies adopted by an individual during the developmental process in order to alleviate the anxiety and psychic discomfort that occur when basic needs to relate to the attachment figure are not fulfilled. Thus the origin of its onset should be sought in the vicissitudes of object relations rather than in the pulsation-defense paradigm, as Reich believed.

The creation of character-muscular armoring, which Brown divides into three phases, produces a split between the organism and the mind-brain system, which can lead to psychopathologies and at the same time functions as a defensive barrier in interpersonal relations. In the final analysis, character-muscular armor represents an overall defensive strategy of the organism. The process of armoring and the resulting characteristic patterns of chronic muscular tension may originate in the failure of the primary attachment relationship. This failure leads to the loss of the organism's capacity for self-regulation; each part functions as an autonomous entity isolated from the others, the higher from the lower, the front from the back. The body's disharmony thus reflects the overall disharmony of the Self.

In clinical practice numerous indicators of this disconnection between brain and body can be observed. An example is the contradiction between the patient's verbal and non-verbal messages, at times expressed in a stereotypical smile of clearly defensive significance, which persists even when painful or traumatic subjects are brought up in the session. At other times, what the patient relates lacks any affective resonance, and this is reflected in a state of apathy or boredom on the part of the therapist, as frequently mentioned in the literature on the treatment of psychosomatic patients (Taylor, Bagby, Parker, 1997).

Brown adopts a multi-dimensional concept of the Self by introducing four psychodynamic polarities inspired by Lawrence's writings (1923, 1968) and closely linked to physical experience. They are defined, using terminology borrowed from European existentialist psychology, as Ontological Centers of Being: Agape-Eros and Hara, located in the front half of the body (upper and lower body respectively) and Logos and Phallic-Spiritual Warrior located in the posterior half of the body (upper and lower body respectively). The four Centers possess in equal measure both a meta-psychological aspect, as

regulators of the organism's energy dynamic, and a psychological aspect, as activators of meaning, archetypal images and models of subject-world interaction.

The introduction of the four Centers of Being expresses an attempt to anchor the structural bases of the Self in the embodied dimension of the physical; in Brown's terms, if isolated from the organismic totality, psychic activity assumes the features of a compulsive mind-brain system coinciding with the definition of closed cortico-cerebrospinal circuits. This disembodied mind-brain expresses psychic activity resulting from organismic fragmentation that inhibits the free flow of the system's energy, obstructing awareness of the self's primary emotional needs.

One of Organismic Psychotherapy's most significant contributions is the introduction of two different styles of non-erotic physical contact between therapist and patient: the nurturing touch and the catalytic touch (Brown, 1990). The first style describes body contact of a steady and continuous type, aimed at causing the patient to experience a situation in which the unsatisfied primary needs of relating and holding are gratified, inducing a state of muscular relaxation and stimulating awareness of the body and any associated emotional experiences. Catalytic contact, also used by neo-Reichian schools and in Lowen's bioenergetics (1958), consists in more structured body work, including pressure on certain chronically tense muscle groups and finalized in the dissolution of character-muscular armor by means of the neuro-vegetative arousal that stimulates emotional abreaction.

Nourishing contact is the most frequently employed tool in Organismic Psychotherapy compared to other body-oriented psychotherapies; if applied competently, respecting ethical and deontological principles (see: Smith, Clance, Imes, 1998), this could create what Winnicott (1975) defines as a "safe-holding environment", that is, an environment that can contain the emotions and the split-off parts of the patient. Parallels with Ferenczi's active technique (1930, 1953) are obvious, and (on the theoretical level) it can be compared with the attachment theory of the school of John Bowlby (see: Holmes, 1993; Cassidy, Shaver, 1999).

In an article published in the *Journal of Humanistic Psychology* (1979), Brown stresses that principles regulating the use of direct non-erotic physical contact are based on gratifying a need, as opposed to treatments prevalently based on the frustration of a need, as in classic psychoanalysis. In the same article, Brown discusses Maslow's hierarchical theory of need (1954) affirming that the effectiveness of body-oriented psychotherapies aimed at the progressive dissolution of a psychologically disturbed armor presupposes gratifying the need for security and affection, located respectively in the second and third steps of the motivational scale. According to Maslow, the experience of gratification is of fundamental importance; the organism's liberation from domination by needs belonging to a specific developmental phase allows one to follow a path of personal growth leading to self-actualization, the final phase in complete individual realization.

In the initial phase of treatment, body contact is oriented towards creating a therapeutic relationship, in which the patient achieves a suitable rhythm of interpersonal communication and perceives the therapist as a secure base (Bowlby, 1988; Holmes, 2001). The therapist proceeds to focus on the patient's defenses, expressed on a psychic as well as a physical level, intervening in the pattern of muscular tension typical of his personality structure. Brown holds that working with the body also means relating to the patient's overall experience of the here-and-now of the session. More precisely, it does not deal with attacking the patient's defenses in an antagonistic conception of the therapeutic relationship (Shafer, 1983), which could provoke a psychotic breakdown, but stimulates the patient's gradual awareness of his characteristic patterns of chronic muscular tension. Brown points out that it is important to gently "challenge" the system of defenses in a non-threatening way, without provoking a reaction of wariness. In body work, the organismically-oriented therapist must always remember that respect for the other's being and for what he/she is willing to display of himself (self-disclosure) is essential at all times.

Developing increased physical sensitivity is connected with the acquisition of affect regulation skills; during therapy this is achieved by bringing the patient's attention to those parts of the body rendered less sensitive by chronic muscular tension, and employing the cognitive processing of the emotions.

Brown emphasizes the limits of the nomothetic approach in clinical psychology, and thus of the validity and utility of diagnostic categories (in particular regarding body-oriented psychotherapies of the Reichian-Lowenian type) along with the inadequacy of all pre-established techniques in dealing with the patient's subjectivity. According to Brown, adherence to rigid guidelines, although occasionally necessary in the initial phases of treatment in order to organize the non-homogeneous quantity of verbal and non-verbal information in the session, minimizes the importance of the relationship and in the final analysis finds its justification in the defensive needs of the therapist. Methods and procedures cannot be independent of the events of transference and counter-transference, since the therapeutic process is based precisely on these subjective dimensions (Bononcini, Pini, 2001).

Brown underlines the limits of body work methods of the cathartic type; if used to demolish the personality's defensive systems too abruptly, they can be extremely damaging. Therefore the therapist is obliged to respect and understand the functions of defense mechanisms and character-muscular-armor in the patient's psychic organization.

Organismic Psychotherapy does not provide a standardized series of exercises, and limits itself to describing several essential client-centered techniques, modelled on experiences emerging in the here-and-now dimension of the session. Nonetheless, Brown points out that the organismic psychotherapist's work should not be considered an arbitrary exercise based on mere improvisation and discourages any optimistic attitude regarding the duration of treatment. The dissolution of character-muscular armor requires a lengthy and complex labor of analysis and interpretation of resistances and their somatic equivalent, chronic muscular contractions. To achieve this, the therapist must possess an ample fund of knowledge and clinical experience (which he/she must, however, be ready to modify when confronted by each new personality), as well as a willingness to share the client's life experiences and offer constant empathic support.

In line with psychology's humanistic tradition, Organismic Psychotherapy aims to remove internal obstacles that impede the patient's process of self-actualization and a better integration of the personality. In Brown's perspective, self-actualization is a process of multidimensional development leading to the exploration of new emotional, behavioral and relational experiences; one emerges from a kind of "anesthesia" and stagnation to rediscover the ability to feel joy and pain. The individual opens up to a new awareness that permits modifying stereotypical behavioral patterns or dysfunctional relationship patterns based on defensive mechanisms adopted in the past and expressed at the physical level, in *character-muscular armor*. Restoring the path to self-actualization permits one to live fully in the present, plan realistically for the future, and retain full awareness of one's past.

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Biography

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A Somatic Approach to Recovering from Sexual Abuse

Judith Blackstone, Ph.D.

Abstract

This paper presents a series of somatic attunement exercises, developed by the author, called Realization Process⁵, and describes their application to the treatment of the symptoms of childhood sexual abuse in adults. It illustrates, through case studies, how inhabiting the internal space of the body, and attuning to qualities of being, such as gender, power and love within the body, can foster self-possession, self-cohesion, and self-love, as well as the ability to remain in possession of oneself while connecting with other people.

Keywords

Sexual Abuse – Realization Process – Trauma – Embodiment – Self-Attunement

Adults who have suffered childhood sexual abuse present an array of clinical symptoms, including dissociation, self-hatred, eating disorders, distorted body image, disempowerment, aversion to being touched or to sexual intimacy, anxiety and depression. This paper presents a method of somatic attunement that I have developed over the past thirty years called Realization Process, and describes how it can be utilized, as an auxiliary to verbal psychotherapeutic process, to help alleviate these symptoms. It includes a description of the method and case studies to support its effectiveness. In an eight-week pilot study at NYU Medical School, Realization Process was shown to reduce symptoms of post-traumatic stress in adult women survivors of childhood sexual abuse.

The memories of sexual abuse are often repressed or subject to “psychogenic amnesia” (Freyd, 1994, p. 307), appearing to consciousness first as fragments of images or sensations. Conventional methods of psychotherapy treat survivors of childhood sexual abuse by attempting to uncover repressed memories and then to dissipate the emotional potency of the trauma and its resulting symptoms through cognitive insight. Somatic modalities of treatment, such as Bioenergetic and Reichian Orgone psychotherapy aim at releasing the somatic rigidities and energetic blocks stemming from the abuse. Somatic Experiencing, a more recent body-based method of trauma recovery, works to discharge the effects of the trauma on the nervous system.

Realization Process can supplement conventional and body therapies by adding an important dimension that is missing from these other modalities. This is the recovery of the client’s sense of self-possession, personal strength, self-cohesion and self-love through inhabiting the internal space of the body. The name, “Realization Process” refers to the realization or “laying bare” of a fundamental dimension of consciousness within the whole body. This is not a mindfulness technique, in which the client becomes aware of the internal space of the body. It is a method of self-attunement in which the client experiences his or her essential identity as consciousness itself.

Inhabiting the internal space of the body is synonymous with mind-body integration. This integration produces a subtle, unified experience of being. The philosopher Yuasa (1987) describes this: “The ‘mind’ here is not the surface consciousness, but is the ‘mind’ that penetrates into the body and deeply subjectivizes it” (p. 105). This embodied consciousness is experienced as a homogenous mixture of awareness, emotion and physical sensation (or proprioception) reaching everywhere in the body at once. This means that awareness is not fragmented from physical sensation, as a distant observer of one’s experience. Rather, one’s observing and experiencing functions become unified. This is particularly important for people recovering from sexual abuse, which may cause severe fragmentation between observation and experience. Several of my clients remember observing themselves and their abuser from a vantage point above the bed during the abuse. This fragmentation continues in adulthood as an unconscious pattern of diffusion and vacancy, often resulting in a sense of disorientation or unreality, and difficulty focusing or concentrating.

Bessel van der Kolk writes that “the word dissociation is currently used to describe four distinct, but interrelated phenomena: (1) the sensory and emotional fragmentation of experience (2) depersonalization [feeling that you are not real] and derealization [feeling the world is unreal] at the moment of the trauma (3) ongoing depersonalization or 'spacing out' in everyday life (4) containing traumatic memories within distinct ego-states (Dissociative Disorder). . .”(van der Kolk, B. A., & Fisler, R., 1995, pp.510-511).

⁵ Description of Realization Process Research Project: I began to develop the Realization Process attunement exercises while healing myself of a back injury in 1974. Since then, I have continued to expand and refine the exercises in response to the needs of my clients and students. In the spring of 2007, an eight-week pilot research project at the Institute for Trauma and Resilience, within the Child Study Center at NYU Medical School tested the effectiveness of Realization Process for reducing symptoms of post-traumatic stress disorder in women with a childhood history of sexual abuse. I taught the Realization Process exercises, including those described in this paper. There was also an educational component to the sessions, based on a cognitive behavioral method called Skills Training in Affective and Interpersonal Regulation (STAIR), developed by Dr. Marylene Cloitre, director of the Institute. The pre and post research interviews were conducted and analyzed by Dr. Cloitre and her staff. The research showed reduced symptoms of PTSD and increased ability to regulate negative moods. We are conducting a second pilot study this fall.

By inhabiting the internal space of the body, clients are able to experience—and to be present in—their whole body at once. They are able to think, feel and sense at the same time. They also gain a sense of internal depth that helps them feel less impinged upon by other people. This gives them a sense of safety, of truly existing, and of being in possession of themselves. These are all qualities that are generally compromised in survivors of sexual abuse.

For example, I worked with a woman who had been sexually abused by a priest over the course of several years in her childhood. Then, in her early adolescence, she was raped at knife point by a man she met at a party. Rita's main symptoms were a sense of disorientation and difficulty concentrating. She was energetically diffused with an unfocused expression in her eyes. She described herself as a "chameleon," because she experienced that she became whomever she was with. She also hated being alone, fearing that someone might break in to her apartment, and also fearing that she might "disappear" if there was no one with her. After several months of practicing the exercise (described below) of inhabiting her body, Rita came to a session very excited. She told me that she had been at a meeting with some of her co-workers and had experienced herself "taking up space."

Realization Process consists of a series of exercises for deepening contact with oneself and others. This paper will present several of the exercises. The first exercise begins with the client sitting upright in a chair, usually with their eyes closed. The client is asked first to focus on their breathing. This focus helps them become calm and present enough to proceed with the exercise.

The client is then asked to bring their attention to their feet, and to inhabit their feet. To inhabit a part of the body is qualitatively different than becoming aware of a part of the body. It means that the person actually experiences him or herself inside the body. In other words, there is a difference between attention to a body part and the self-contact and internal aliveness that occurs with actually being in the body. The client is asked to take a moment to experience themselves in their feet, to register how it feels to inhabit their feet. This helps the person integrate awareness and physical sensation, and experience the subtle level of being that results from this integration. It also augments their ability to inhabit their feet, and helps create a somatic memory of the event, so that it can be easily repeated. With practice, people are able to stabilize this new learning; they have an ongoing experience of inhabiting the body.

The client is also asked to be aware of their breathing while inhabiting their feet, and to see if they can remain within their feet as they continue to breathe. Most people, when they first practice this exercise, lift up out of their feet when they inhale. To remain inhabiting the feet while breathing helps the client experience the flow of breath in their whole body, rather than just in their respiratory system. As body-mind integration is achieved, the breath becomes continuous with the energy system and flows through the whole body. Wherever a person inhabits their body, their breath/energy system can flow. This circulation provides the client with a felt sense of vitality and aliveness.

The client is then asked to inhabit, sequentially, their ankles, legs, pelvis, mid-section, chest, shoulders, arms, hands, neck, face and brain, while continuing to be aware of the breath. Then he or she is asked to inhabit their whole body at once. At this point, I often use the image that the body is a temple. The client is sitting inside the temple of the body, and breathing. Then the client is asked to open their eyes and again feel that they inhabit their whole body at once. I suggest that even though the world now appears in all its vividness, they are still sitting inside their own temple, their own body.

As will be illustrated in the following case studies, this exercise has many variations to fit the needs of different clients. For example, I often ask clients to attune to the qualities of their being, particularly in their torso. I may ask the client to attune to the quality of their gender within their pelvis, the quality of power within their mid-section, the quality of love within their chest, the quality of their own voice or their potential to speak within their neck, and the quality of understanding within their whole brain. These are not ideas about themselves, but actual feelings of being that can be accessed within the body. Attuning to these qualities helps anchor the client within their body. It also helps them feel that there is a palpable quality to their existence, something that is truly themselves that has not been taken away from them by their abusers.

The quality of gender is particularly healing for survivors of sexual abuse. The defensive tensions in the pelvis and sexual organs that often result from the abuse may constrict the quality of gender. Also, negative ideas and feelings about one's gender may arise from the abuse. The exercise is not asking for a particular male or female quality, but rather how their gender feels to the client.

I worked with a woman named Molly, who grew up in a chaotic, neglected family with many siblings and overwhelmed, ineffectual parents. Throughout her childhood, she was often awakened in the middle of the night by an older brother molesting or raping her. She never cried out for help or told anyone about the abuse, for fear of adding to her parents' burden. But she grew up feeling contempt for her own femaleness, blaming the abuse on the vulnerability of her gender. For a long time in our work together, Molly was unable to inhabit her pelvis. To do so evoked terrible images of the abuse and a sick feeling within her whole body. We spent many months just having her inhabit other parts of her body. We particularly focused on her inhabiting her feet and legs while standing, until she felt a sense of foundation. We then concentrated on her inhabiting her mid-section and attuning to the quality of power inside her mid-section. These qualities are difficult to convey in words, and like many clients, at first she said that she had no idea what I was asking her to do. The quality most accessible to people is love; almost everyone I've worked with knows what love feels like, and can access it by thinking of something or someone they love. The quality of power is also a distinct feeling in the body.

When Molly asked what I meant by power, I sat opposite her and attuned to the quality of power in my own mid-section, and asked her to match my power. She was surprised that she was able to do this; still not being able to verbalize what was actually happening. I then increased the intensity of power in my own mid-section and she did the same. After about a year, Molly was ready to attempt to inhabit her pelvis. At first she reported that it felt "dark and rotted out" in her pelvis, but

she was able to tolerate the feeling and continued to practice the exercise. Soon she was able to feel the same sense of foundation in her pelvis that she felt in her legs and feet. Around this time, Molly met a young man and began going out with him. Although she identified her orientation as heterosexual, she could not imagine allowing a man to touch her. She said that being close to a man made her feel soft and tender, and this brought up great anxiety for her. This new man in her life motivated her to address these issues. She practiced inhabiting her chest and her mid-section at the same time, attuning to the softness of her love and the strength of her power simultaneously.

Once the practitioner has won the trust of the client, it can be helpful for the client to inhabit his or her sexual organs. This constitutes a reclaiming of the organs that were violated. Since I had a strong therapeutic alliance with Molly, I suggested that she practice inhabiting her female organs, and imagine them as made of light. We talked about how she was in control of turning this light on and off, and she practiced this control as she inhabited her body. After about a month of this practice, she reported that her female organs felt “sweet.” The young man she was dating turned out to be a gentle, patient person and Molly embarked on her first intimate relationship.

At the end of the exercise of inhabiting the body, I sometimes suggest to clients that they attune to the quality of the pronoun “I” within their whole body. This deepens their sense of existing as individuals, and of connecting to their own desires and initiative. It can help clients overcome feelings of shame and vulnerability at having been overpowered. The sense of “I” is also an integrative experience, fostering self-cohesion.

When I first asked Rita to attune to the quality of the pronoun “I” she said that it made her feel too “exposed to the world.” But she was able to experience the feeling of “me” in her body. After practicing inhabiting herself as “me” for a while, she was finally able to experience herself as “I.” She said that “me” was self-enclosed and safe, but that “I” could relate with other people. I spent many sessions with Rita integrating the safety of “me” with the openness she experienced as “I,” as she inhabited her body.

It can also be helpful for the client to imagine that all of the parts of their body are made of light, or to bless or cherish each part as they inhabit it. A client named Sharon had been repeatedly molested by a neighbor from her eighth to twelfth year, and described herself to me as “damaged goods.” Sharon came from an Orthodox Jewish background and had learned to recite many different blessings as part of her childhood religious training. As she practiced the exercise, she said a blessing on each part of her body. This consecration of her body gradually replaced her image of herself as damaged beyond repair with a felt sense of her preciousness.

As I have said, inhabiting the body is body-mind integration. It produces an experience of internal spaciousness and internal sentience, as if one were made of consciousness. This sentient space feels both substantial and permeable. Inhabiting the body is also the basis of openness to the environment. Wherever we inhabit our body, that part of our body is permeable and available for experience. For example, if we inhabit our chest, we will experience the present moment both outside of ourselves and within our chest, at the same time. We will also feel fluidity, the potential for emotional responsiveness, within our chest.

When we reach a certain degree of inward contact with our body, we discover (or uncover) a very subtle expanse of consciousness that pervades our body and environment as a unity. This pervasive consciousness has been described in spiritual traditions, particularly in the East, where it has been called the “essence of being” and “the nature of mind” (see Rabjam, 2001, among many others). Although this experience has mainly been discussed in spiritual literature, it is helpful for healing trauma because it allows people to participate more fully in life without losing inward contact with themselves. The Eastern teachings are sometimes couched in language that can foster dissociation, but the actual experience of pervasive consciousness refines one’s perception, and makes the world appear more vivid and immediate. When I taught the attunement to pervasive consciousness (described below) during the research project at NYU, one of the women in the group surprised us all by announcing that she suddenly realized that the filing cabinets in the room were not important. When asked for an explanation, she said that she could now see how much more alive the people in the room were than the metal cabinets.

I teach attunement to pervasive consciousness when clients have become proficient at inhabiting their body. When Sharon had developed an ongoing sense of self-possession and begun to feel self-love, I felt she was ready for this more subtle exercise. First, she inhabited her whole body at once. I then asked her to find the space outside of her body, the space in the room (with her eyes closed). Next, I asked her to feel that the space inside and outside of her body was the same, continuous field of space, the same unified field of subtle consciousness. It pervaded her. Sharon then opened her eyes and repeated the same sequence, feeling that she inhabited her body, and that her body was pervaded inside and outside by the same continuous expanse of space. Next, I asked her to feel that the space that pervaded her body also pervaded the room, even the walls of the room. At first she left her body and energetically projected herself into the room. But this exercise is not an energetic movement, and not an expansion outward. It requires settling even more deeply within one’s body. When she did this, she was able to experience that she could be in her body, and experience the same space pervading her body and the room. She reported that when she did this, she could see a subtle radiance in the air around her. After practicing this exercise for a while, one no longer has to volitionally attune to this pervasive space. The exercise produces an effortless state of continuity between one’s internal and external experience.

Rigid, somatically anchored defenses, and the binding of emotional pain in the body obstruct our ability to inhabit the body and to attune to subtle, pervasive consciousness. These exercises can both reveal somatic holding patterns and help people release them. In particular, they can help people feel secure enough within their bodies to relinquish the somatic barriers they have erected between themselves and their environment in order to dampen the impact of experience. Also, when

clients experience that they have within them this radiant expanse of consciousness, they often recognize that no matter how much abuse they suffered, they have not been damaged in the core of their being.

Another woman, Laura, came to work with me because her father had molested her from her early childhood until she became an adolescent. Her main symptom was that she could not be touched by anyone. Even a casual pat on her arm would cause her to feel nausea and panic. As would be expected, the most traumatic aspect of the abuse for Laura was the betrayal of the two people she loved and needed most in the world, her father who used her for his own twisted needs, and her mother who turned a blind eye to the abuse through all the years of Laura's childhood. This betrayal had caused Laura both to feel unworthy of love, and to distrust the caring expression of any other human being. It has been pointed out (Frawley-O'Leary, 2002) that the term "sexually executed relational abuse" may be "the most meaningful way of conceptualizing that which we call sexual abuse."

When Laura first began to practice inhabiting her body, she protested that she could feel the abusive presences of her parents so vividly within her body that there was no room for her. It took many months of practice for her to begin to feel that she could possess herself. Still, she did not feel comfortable talking about herself with me, and she particularly shut down if I showed concern or empathy for her. Then one day, she requested that I do the exercise along with her. As we added this element of mutual exercise into our sessions, she began to warm towards me, and to talk more openly about herself. She said that she felt she could trust me because she knew that I was in my body also, so that I would not try to be in hers.

I taught Laura the exercise of connecting to another person without leaving the internal space of one's own body. I asked her to inhabit her chest, as I inhabited my chest. Then I asked her to find the internal space of her chest and my chest at the same time. When she did this, we could both feel a resonance between the feeling in her chest and the feeling in my chest. Most people who practice this exercise for the first time are surprised at how easy it is. The internal, qualitative space of our being is capable of contact; we can easily find each other from the internal space of our bodies. Laura was delighted by this new ability to stay in possession of herself inside her own body while feeling connection with another person. This contact was also a kind of touch. Touching in this way, across distance, opened the way for her to be able to accept and enjoy physical touch.

When she was accustomed to connecting with me across distance, she felt she was ready to inhabit her body while being physically touched. We then practiced with me holding my hand a few inches from her lower arm, while she concentrated on inhabiting her arm. Then, I was able to actually put my hand on her lower arm while she remained in possession of herself within her body. I also taught her how she could keep out the sensation of my touch, or let it in; that she was in control of how much she felt when she was touched. We also practiced with her touching my lower arm, so that she could feel how to touch a person within their body rather than just on the surface. I chose to practice this exercise with our lower arms, as this is a relatively non-intimate part of the body, and afforded us what I felt was the appropriate degree of physical contact for our relationship.

The last exercise I will describe is called the "core breath." Readers familiar with the *chakras* (sensitive points along the subtle vertical core of the body, and throughout the body, described in Hindu yogic and Buddhist tantric traditions) will recognize this exercise as a variation of chakra work. In Realization Process, these core points are used not only to cultivate the qualities associated with them, but also as the basis of deepened perspective, internal cohesion and connection with other people. When Anthony came to work with me, he was in his early twenties. He had been repeatedly raped by his stepfather as a child, and now felt "out of control" and abused in his promiscuous sexual encounters with older men. He appeared severely diffuse and disoriented, unable to make eye contact, diffident and apologetic in his manner. He also seemed extremely sensitive, responding and adjusting to small changes in my emotional state, without even glancing at me. After we had spent several sessions talking about his history and his current life, I taught him the core breath exercise. I asked him to find the center of his head. This is not the point in the center of the forehead usually considered the sixth chakra, but rather an area in the very center of the internal space of one's head (between the ears). As with all the core points, the center of the head can be recognized by an energetic feeling or "buzz" when one comes in contact with it. Locating the center of one's head also produces a feeling of resonance down through the whole vertical core of one's body.

Like many people who begin this exercise, Anthony first found the point too far up in his head but, with a little guidance, was able to find it exactly and to feel the resonance through his whole core. I then asked him to initiate his breath in the center of his head. This is a subtle, internal breath with a mental quality to it; it feels as if the mind is breathing within the center of the head. It also feels as if, just by breathing in the center of the head, one is breathing the whole vertical core of the body. After Anthony had found this with his eyes closed, I asked him to open his eyes and continue to breathe within the center of his head. I then asked him to notice how he could experience the room not just from the surface of himself, but from this core of himself.

Anthony recognized that this was a major shift from his usual way of being. He said, "I feel like there's space between me and the room." Being in the core of the body deepens one's sense of perspective. Instead of feeling directly impinged upon by the environment, objects and people seem to be further away. Over the next few weeks, he repeated this exercise with a point in the core of his chest and the core of his pelvis, initiating the subtle, "mental" breath and experiencing the room from within these points. This helped him feel more centered in his body, and gradually, along with the verbal aspect of our sessions, to feel more centered in his life. He talked about how he had always felt he had to do whatever other people wanted him to do. He felt that they were already in his body, displacing him, so there was no way to get away from them. When he remained in his core, however, he could feel that there was room for him to exist. He said that, for the first time in his life, he could see other people as separate from himself, that he could actually look at them and see who they were. He was surprised

to find that the men who had dominated and coerced him into sex did not seem as powerful when he actually looked at them. This enabled him to feel his true responses to them, and to say “no” when he did not want intimacy with them. This, in turn, gave him the courage to remember his stepfather and to begin to process the intense and complex emotions that he had felt towards him as a child.

Summary

In this paper I have showed how the Realization Process exercises can help heal many of the symptoms of childhood sexual abuse in adults. They can help people experience the deep inward contact with themselves that is the basis of self-possession, self-cohesion, and self-love. They can also help people remain in possession of themselves while experiencing contact with other people.

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Biography

Judith Blackstone, Ph.D. developed Realization Process over the past thirty years and teaches workshops and teacher trainings in it throughout the United States and Europe. She has also been a psychotherapist in private practice for twenty-five years. Her books include *The Empathic Ground: Intersubjectivity and Nonduality in the Psychotherapeutic Process* (SUNY Press, 2007), *Living Intimately*, *The Enlightenment Process* and *The Subtle Self*. Her work is based in New York City and Woodstock, NY. Email: blackstonejudith@aol.com.

Subtle Touch, Calatonia and other Somatic Interventions with Children and Adolescents

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Abstract

In this article the authors briefly introduce the method of Pethö Sándor, MD, "Calatonia and Subtle Touch", which has been utilized in Brazil for over 40 years by a large community of body psychotherapists. An introduction to the particularities of working with children and adolescents within this method is discussed. Maria Irene Crespo Gonçalves and Maria Amélia Pereira report their experience with Subtle Touch, Calatonia and other relaxation techniques, with minor offenders, abandoned and abused children and pre-school children, in a school setting.

Keywords

Calatonia – Children – Jung – Body Psychotherapy – Petho Sandor

Introduction

Anita J Ribeiro and Ana G Rios

*"If we are to reach real peace in this world...we shall have
to begin with children"*
– Mahatma Gandhi

Pethö Sándor, MD, used the term psychophysical reorganization and psychophysical integration (Sándor, 1974) to indicate the process involved in reinstating an individual's capacity for self-regulation. According to Sándor (Sándor, 1974), his gentle bodywork coupled with Jungian psychotherapy would foster the reinstatement of physical, emotional and cognitive self-regulation. Sándor understood self-regulation as the ability of an individual's organism – in its physical, emotional, and cognitive aspects - to spontaneously adjust to find its optimum state of activation in response to a given moment or challenge. Sándor utilized Jung's (Jung, 1968; Jung, 1953 - 79) concepts of psyche and its relationship to the body as a foundation for his work. Jung emphasized throughout his writings the capacity of an individual's ego to "override" the psyche's and the body's ability to self-regulate, leading the organism to be "out of balance" (Jung, 1968; Jung, 1953 - 79).

Sándor named his many gentle interventions Subtle Touch, and one particular technique applied to the feet, Calatonia. Sándor's philosophical stance with regard to his interventions was similar to current health psychology, which focuses not exclusively on the study of disorders and illnesses, but on enhancement of the individual's psychological health and optimization of development. Although Sándor was a practicing body psychotherapist and teacher, he encouraged the use of his interventions in prophylactic work, in multi-disciplinary areas (educators, doctors, speech therapists, etc), and in enhancement of existential horizons (personal growth, group dynamics, etc), beyond the confinements of a psychotherapist's office. His requisites were that practicing professionals took the necessary training and underwent a personal experience with the method.

Before discussing bodywork interventions for children, we have to emphasize the importance of the child therapist's integrity and ethics. Even debilitated adults undergoing therapy — subject to apparently unilateral relationships, where the therapist may exert greater authority or specialized knowledge — can avail themselves of defense mechanisms, interrupting therapy when feeling some form of invasion or discomfort. Children and adolescents are more vulnerable, trusting, and unable to protect themselves in the same way an adult would do. Therefore, we can never refrain from carefully observing our actions, motivations, intentions, and assessing carefully and respectfully the effects of bodywork interventions on the child under our care.

Bodywork with children usually involves a different approach from those used with adults. A large number of body psychotherapy methods for adults include extensive interpretation or verbal processing of body language, body scheme, and repressed emotional or cognitive issues that are represented or stored in the body. Some methods are invasive and directive, and children and adolescents should be spared those interventions, as they do not have a fully developed ego to endure emotionally and integrate cognitively those issues elicited through bodywork.

Therefore, the body psychotherapy for children and adolescents, as proposed by Pethö Sándor, should not rely on verbal interpretation because of their cognitive and emotional limitations. The integrative aspect of the body psychotherapy, which will absorb the somatic impact after bodywork, can be processed through play therapy or art therapy (especially with adolescents), along the lines of Jungian symbolism and understanding (Kalsched, 1996). Play therapy and art therapy (Oaklander, 1988) aid children and adolescents in exercising a new ego attitude, now strengthened by the reorganization of a body scheme free of anxiety, fear, and somatizations. In addition, the absence of pressure to process

somatic content cognitively allows children and adolescents to surrender to the bodywork less defensively.

Childhood and adolescence are transitional phases marked by strong changes in the physical body, as well as in the emotional and cognitive arenas. Even in children and adolescents with a history of appropriate attachment, nurturing, validation, and family relations, the peculiar psychosocial complexity and demands of daily life may cause stress and negatively impact their development (Greene and Walker, 1997). In adolescence especially, the body is experienced in the light of a new set of social expectations and interpersonal relationships with a disturbing self-consciousness, hypervigilance and derogatory self-criticism. There is a perceived lack of control regarding the body due to hormonal cycles, growth, sexuality, changes in shape and appearance (Lipowski, 1975), and impulses related to the blending of physical and emotional aspects, which can be translated into “urges”. These overwhelming experiences tend to enmesh teenagers in a conflict for detachment from the body (negation) or surrender to its impulses (lack of control). The body becomes a source of mixed feelings and anxiety. The absence of tools to understand and relate to the body leaves adolescents helpless to cope appropriately with this critical developmental phase. Because they are non-invasive, pleasant, and conducive to introspection, most Subtle Touch interventions result in increasing engagement and receptivity.

Conventional physical activities for children and adolescents, such as martial arts, sports, dance, etc, address only the body’s capabilities and performance, rather than body awareness, body self-regulation and psychophysical reorganization. Those activities lack introspection and self-observation, which are instrumental in developing appropriate contact with bodily sensations and impressions, without feeling threatened by those perceptions. Bodily sensations are subjective experiences (Lipowski, 1977) and children and teenagers need to become familiar and comfortable with them to feel “at ease” within their bodies and gain a sense of appropriate mastery (versus a tense control and vigilance) and well-being.

Children often look for body contact — the same as other mammals’ offspring. After an in-depth intake and history, the therapist must define the sequence of interventions that will promote trust, engagement and healing. A history of trauma and abuse will certainly require a stronger, well built rapport with the therapist before touch can be applied.

There are several ways of starting the therapeutic bodywork with children, such as teaching children about their bodies in amusing ways that are simultaneously playful experiences. Children reveal natural curiosity about various body parts and their features, being able to play with their sensations, or explore new movements and skills, remaining surprisingly focused for a long time. For example, we can ask the child to name the different body parts, experiencing moving each joint separately, measuring body part sizes or their own heights, observing their shadows projected on the wall or on the floor. Or they might enjoy tracing the shadow contours with chalk, feeling its volume, how its shape can be altered, contracting to occupy the least possible volume or stretching to reach the largest span. We can draw their body contour on a large piece of paper on which they lie, painting each part separately, talking about their features and functions.

Usually children enjoy stamping their hands and feet on paper, to model them in clay, or even to imprint them in mud or sand. Often bodywork techniques in children are used — at least during initial stages — adjusting them to the child’s spontaneous playing routines until they get used to the procedures, establishing a relationship of trust with the professional. When a child is out of breath — from a soccer match or sword fight with the therapist— we can work with breathing while the child rests before a new activity. We can massage the feet or scalp, telling stories at the same time, as well as work their hands while helping to wash them. We can work hand tonus and make it conscious by molding clay, making cakes, threading small beads, embroidering, among many other activities, also asking them to pay attention to existing tensions in their shoulders and other parts of the body.

Body limits are being tested all the time, when trying to achieve maximum stretching, strength, and speed possible. Competitions — such as arm wrestling, tug of war, track and outdoor games, swinging, activities involving tree or wall climbing — where one experiences various kinds of body-space adjustments will allow children to develop an understanding of their body outlines (the images we have of our own bodies) improving their effectiveness. More important than discovering the body’s effectiveness as a tool is that children through pleasurable experiences establish positive affectionate relations with their own bodies — also known as body-esteem — the precursor of self-esteem in its most tender form.

During games using balls, darts, or bow and arrows, for example, children will pay attention to their posture when we show them — by talking, touching, imitating, or drawing — how it can be improved for greater success in the chosen activity. Some children like dancing, others try learning to walk on stilts, or imitating animal moves. Through the integration of the body in each session, children will slowly become more receptive to specific bodywork techniques.

Particularly for adolescents, group routines are very well accepted, as they ‘normalize’ the use of bodywork and body awareness (instead of self-consciousness) among peers as part of age appropriate routines. In addition, individual techniques utilized in Subtle Touch such as Calatonia, fractional decompression and movement with small and larger joints are instrumental to dissolve tensions, to provide containment and mobilization of stagnant energy.

These interventions, which induce psychophysical reorganization, can help prevent and treat adolescents’ maladaptive behaviors, such as eating disorders, substance abuse, self-harming behaviors, etc. Maladaptive behaviors can be understood as faulty attempts to control anxiety, emotional pain and discomfort.

Children and adolescents with a history of trauma, physical and/or sexual abuses come to psychotherapy with negative feelings about the habitual repertoire of physical affection. Many times, those who abused them or allowed abuse also tucked them in, hugged, kissed and cuddled. Therefore, they need to recover the freedom of experiencing their body without being pressured for displays of affection, which many times occur in therapy, as part of a normal nurturing attitude toward children. As normal affection has been contaminated by previous experience of abuse, mixed feelings emerge even in positive and restorative relationships with appropriate caretakers. Because Subtle Touch interventions, while being soothing and

nurturing, do not suggest a context of personal affection, they give the children an opportunity to positively experience their body, to regain control of interactions and to restore a sense of well-being without being overwhelmed by mixed feelings. Then, from a regained sovereignty over their sacred territory, the display of affection will reemerge spontaneously, as it becomes the child's choice to initiate it from a body that now feels validated and respected.

Here are presented the works of a body psychotherapist with institutionalized children (orphanage) and of a psychopedagogue with pre-school children in a school setting.

IN SEARCH OF HAPPINESS

Bodywork with Institutionalized Children and Children in Residential Programs: How Bodywork Can Contribute Toward the Transformation of Residual Violence and Abandonment into Hope and Connectedness

Maria Irene Crespo Gonçalves

In 1986, after graduating from the specialization course in Psychomotor Therapy (currently renamed “Jungian Psychotherapy and Bodywork Techniques” based on Pethö Sándor’s method), I was invited to develop a program at FEBEM⁶ that applied relaxation and bodywork techniques (Sándor, 1974) for institutionalized children and to train the professional staff (social workers and psychologists) to implement it.

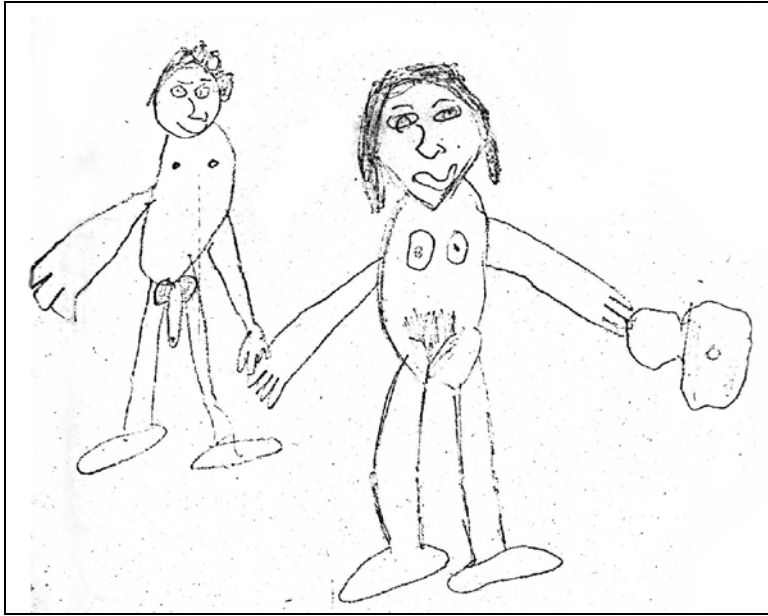
Initially, there were two groups of boys from the Male Screening Unit, in the city of Tatuapé (Great São Paulo, Brazil). Each group included five boys ages 10 and 13, who were seen twice a week, for 2 hours. The group was named “Body Awareness” and in the first session, the boys drew a human figure. After a month of group work, they would be requested to draw a human figure again, as a means to evaluate the process.

At first, the boys were resistant to the proposed activities; they were not able to concentrate and they fought among themselves. However, as the rapport with the therapists developed, there was a decrease in resistance. The boys showed interest in massage with a tennis ball, blind-goat game, ‘dancing on the walls’, group stroking, ‘vibration of the limbs’, ‘live mattress’, Jacobson and Michaux relaxations (Sándor, 1974).

The work was intended to develop body awareness, respect for self and other people’s body and personal space, which in turn was presumed to help them improve their interpersonal relationships. It was noticed that the boys started to experience and integrate into their routine a touch that was different from their habitual physical contact, which had been rough, aggressive and malicious. Through the comparison between “before and after” drawings of their human figure, the therapists were able to justify the bodywork to the directors of the facility as a legitimate means to achieving body awareness and social skills (Farah, 1985).

Until that moment, the bodywork was perceived by staff, caretakers and educators as eliciting inappropriate sexual behaviors, and within the FEBEM the “taboo of touch” prevailed. In the drawings (number 1 and 2) of one of the boys we verified that in drawing number 2 - drawn after a month of bodywork - a better distribution of psyche energy and sexual libido became evident. With bodywork comes a general awareness of all the parts of the body, decreasing thereby the fixation on the pelvic area and its sexual contents.

⁶ *Fundação Estadual do Bem-Estar do Menor (FEBEM) – Foundation for the Wellbeing of Minors*



Drawing 1

Note in drawing number 2, the better definition of arms and legs, the “appearance” of knees, and the new attitude of positive contact between male and female figures, in comparison with previous lack of contact in drawing number 1, where the male figure “stalks” behind the female figure, almost in a “predator” attitude.

With the first group, a curious incident occurred, which highlighted some of the implications of bodywork with children and adolescents.

Usually the boys were accompanied by a monitor when they walked from their unit to the building where the activities took place. One day, the monitor did not show up and the therapists were alone with the children. After finishing the group activity, while chaperoning them back to their unit, one of the boys attempted to escape. Due to the high security system, escaping would be impossible. Nevertheless, the other boys of the group ran after the “fugitive” and brought him back to the therapists. As we walked back to their unit, one of the oldest boys said to the “fugitive”:



Drawing 2

“You can’t do that; the “auntie” (therapist) will have problems because of you. Have you thought about it? She can lose her job. How is she going to support her family, then?”

The older child demonstrated an ability to empathize and relate to somebody else’s life situation, which is only possible when there is attachment and bonding. In addition, he was able to move to an age appropriate stage of moral development, leaving behind a non-committal attitude. The incident was considered a spontaneous validation of the work.

The project at FEBEM lasted three years, and during that period at FEBEM there was an opportunity to run several 'body awareness' groups in different units. The receptivity of the children and adolescents for bodywork always amazed us, as did the strong energy that emanated from those institutionalized children. That energy, if not made conscious and reoriented toward creativity and self-realization, would certainly lead to self-destruction, as there was no traditional outlet for their energy. Those children did not have a family, a neighborhood, a school, friends, pets, etc., and their energy was emotionally 'untamed' and un-lived due to lack of stable relationships with others.

After the positive experience with children at FEBEM, I decided to find other agencies that had a more stable commitment to children in foster care.

In 1996, I contacted the *Casa Jesus Amor e Caridade* (Jesus' House of Love and Charity), also known as *Larzinho* (Little Home), founded in 1995 by a group who adopted the structure of a residential program (group home), closer to a family model.

The Larzinho housed fifteen children of both genders, referred by the court system due to abuse or abandonment. The children were assigned to the program prior to four years of age, remaining in the program until they were returned to their families, adopted, or able to be independent (adults).

I volunteered time at the Larzinho and started by working with two girls who presented emotional and psychomotor disturbances. They had been previously hospitalized due to abuse by their biological mother. One girl was eighteen months, and presented with convulsions, sleep disturbance, irritation and crying spells. The other girl was two and a half years, and was hospitalized for malnutrition, anemia, and eye problems due to malnutrition. Although she had had two eye surgeries, she lost sight in her right eye. I applied several bodywork techniques to the girls, including the Shantala (Leboyer, 1976), vibration of the spine and movements to the joints. When they were asleep, I applied fractional decompression - a subtle touch technique that covers the whole body - and sang lullabies to them. After the first four sessions, there was a decrease in sleep disturbance and improved mood; the two girls were noticeably happier and more engaging.

After the marked improvement of the children in such a short time frame, the bodywork gained interest and support from both caretakers and children. The children sought and preferred the most delicate touch, those made with feathers or water drops. They spread water gently, either by blowing air softly or using a small paintbrush, usually around the bellybutton. There has never been any sexual or inappropriate touching since the children learned the gentle contact through bodywork.

Emerson, a four-year-old boy with a genetic skin disorder epidermolysis bullosa, characterized by devastating blistering of the skin, displayed great interest in bodywork with water drops, and he spread the drops on his body. Through this simple technique, Emerson began to cry less during bathing time, a painful moment for him, and started to bathe on his own. The bodywork and the homeopathic treatment contributed immensely to Emerson's recovery. Consequently, he achieved an autonomy that the illness had taken, as Emerson had had to depend heavily on adults.

Thus, through different modalities of touch (Delmanto, 1997) – such as vibration on the spine, blowing or touching with feathers – the children integrated the bodywork into their routine. The bodywork and a nurturing attitude dissolved old residues of abandonment and helped to restore the positive mother archetype, facilitating appropriate psycho-affective and motor developments.

In addition, the caretakers showed interest in learning the bodywork techniques, and they started to have bi-weekly meetings for training, supervision, and case discussion. They also received and experienced the bodywork in a group. This approach has contributed to the integration and harmony of the staff with the philosophy of the work done with the children.

Subtle Touch for Pre-School Children

Maria Amélia Pereira

Understanding the connection between body and development, we offered the application of the Subtle Touch method of Dr. Pethő Sándor (Sándor, 1974) as prophylaxis in the prevention of developmental problems and enhancement of emotional regulation. Observing the impact of this work in the children at Casa Redonda (Round House Preschool) for twenty three years (2006) has led to the documentation of it in videos, photos, and narratives.

Within a playful atmosphere, the bodywork (Delmanto, 1995) emerged naturally, and to our surprise, each day it occupied a more significant role within our daily activities at the pre-school. The fast and contagious way in which the children assimilated the bodywork confirmed to us the necessity to this approach. The hunger for delicate physical contact manifested very concretely when many children came to the staff asking to be "the next one", as they saw a child being worked on with Subtle Touch. They said emphatically: "Now me!", "I am next", "I want more", "Again", etc., and remained silently waiting for their turns.

A mat on the grass, a tree's shade, the quietude of nature or the sound of birds singing joined us - the child and the facilitator - in the surrendering to the serenity and depth of the moment of bodywork. Thus, in the midst of the playful activities and games, the bodywork gained its space and time naturally. Boys and girls took turns requesting "massage", as they called it, including it in their repertoire of play.

When I had a line of three or four children waiting for their turn with bodywork, I requested that one of them help me treat the other children. I was surprised by their readiness to engage in bodywork, always done appropriately and respectfully (documented in pictures and video).

The fact that they themselves had already experienced the bodywork, and had developed a patient attitude of observing another child being touched while waiting for their turn, seemed to be an especial preparation for the 'job'. Their hands had the expertise to reproduce the right touch and sequences, under the staff's surprised supervision.

This process extended itself to the families of these children, as many mothers approached the preschool staff to request that they be taught the techniques. The school has offered Subtle Touch experiential classes to parents since 1997, broadening the benefits of the work to the community.



As each child experienced Subtle Touch, delivered as Dr. Sándor had instructed - as if it were a new "play" - the immediate psychophysical reconditioning become apparent. This was evidenced by physical signs such as an expansion of the breathing, a calming of the respiratory rhythm, muscular relaxation, reported well-being, etc. Those physical reactions and reorganization were conducive to deep contemplation, which usually brought up a spontaneous metaphorical or philosophical attitude in the children. The positive results and meaning of this work with the children are shown in many ways, and has been fully documented. We chose three stories, which demonstrate the positive impact of the bodywork in the children.

A Touch for Contemplation

Lying on a mat, a four-year old boy was awaiting me.

We started the bodywork with rotations of the small joints of his toes, done within his breathing rhythm.

He would turn his head from side to side, scratch his eyes, at times stretching out and pulling up his legs until slowly he started to yawn. His eyes became distant. His muscles were so relaxed that his body seemed stuck to the floor.

Silence surrounded us.

He finally said, "You know I'm going to be bigger than my dad? I'm going to be as big as that tree." He was pointing to an enormous pine tree behind me.

"Good heavens! You are going to be that big?" I said.

"Yes", he answered. "I am going to be that huge."

More silence. I continued with the touch on his feet. He started to talk again.

"You know, I'm not going to be as tall as the top of the tree. I'm going to grow up to there." He was pointing to a level about half the height of the pine tree.

We were silent again.

After a while, almost towards the end of the touch session, he started to speak again.

"Did you know that everybody thinks that God is bigger than everything? But he isn't," he affirmed.

Intrigued, I asked, "Who is bigger than God?"

"Life! Life is bigger than God. Life is everything. Everything is life. I think life is God."

Once more, silence between us, this time as immense as his words.

I finished the movements with his feet. He calmly rose and made his way toward more play with his peers.

Will To Live

"I am next," said the six-year-old girl, coming closer to where I was initiating a sequence of bodywork on another child.

She sat close to our mat, calmly waiting for her turn.

Her peers called her to play with them and she answered: "Not now, later," and waited silently, observing what I was

doing.

Something very important was happening there, because her patience to wait for her turn was out of the ordinary. The time she remained observing my hands working on another child certainly worked on her as a preparation, receptivity, and openness to the bodywork she would receive afterward.

As soon as the other child left, she lay on the mat and closed her eyes - a behavior not common in children her age. There were moments I thought she had fallen asleep, such was her quietude.

I finished the sequence of touches she always liked and she requested, the “blow on the spine” and the “blow around her belly button”, she opened her eyes slowly as if she were coming from far away. She smiled mysteriously and stretched her body, just like a little baby waking up in peace.

“Are you sleepy?” I asked. She used to always answer that question by saying: “No. Now I’ll play.” However, this time, her body seemed to refuse to leave the mat. She tossed and turned, until she finally sat and looked at me. She then said, “Did you know I had a big fear?”

“What fear?” I asked.

“When I was in my mom’s tummy I thought I was going to die inside it.”

“How did you feel it?”

“There was a thing tightening me, crushing me, like I was drying up. I was going to dry up and die.”

I was silent. She crawled into my lap.

“Good thing I was born soon and did not die. It was my mom who died.”

I hugged her.

“How nice that you are alive, little girl! And that big fear, where did it go?”

“Now I am not scared. I only had it in my mom’s tummy. I did not want to die inside my mom’s tummy. It would be bad. I think my mom knew I did not want to die with her. I wanted to live. Now, I have two moms, one who lives in heaven and one who lives on earth.”

She stood up from my lap and called the other children to play “dead/alive”, a game she had been playing daily for the past two weeks. (This child was born prematurely through C-section due to her biological mother’s terminal illness during pregnancy. Her mother died shortly after the child’s birth.)

Of Feelings and Cockroaches

One morning, a four-year-old girl approached me and said:

“Can you massage me? I wanna take out a cockroach that is inside here”, she pointed at her heart.

Since this child had arrived that morning, she was restless, constantly arguing with other children. Every activity she started, she abandoned in the middle, which was not her habitual behavior.

Coincidentally, that day marked one week since her parents had traveled, and she had been home with her brothers, under the responsibility of a trusted couple of servants.

I heard her request and found it surprising that she attributed that capacity to the massage. I asked her, “Why do you want the massage now?”

“I wanna take a cockroach out of me.”

I told her to get a mat, find a shady place to lie down, and wait for me, as she usually did when we did relaxation.

I finished up some clay artwork with another child and went to look for her. I thought she would have forgotten about the massage and would be involved in play with other children.

I was surprised to find her resting on her mat under a tree, waiting for me. I sat by her feet and initiated a massage on them. I asked her, “The cockroach is still inside you?”

“It is right here inside me”, she said convincingly, pointing at her heart.

“What is it doing there?”

“It is tickling me in a bad way, I don’t like it. And everybody is fighting with me today.”

“Then, let’s do it”, I said, “Let’s help the cockroach come out of there.”

She said, “Do it here,” pointing at her belly.

I made the first touch, sliding my hand softly in small clockwise rotations around her bellybutton, amplifying the circle and increasing the pressure in the superior region of the abdomen, close to the diaphragm.

When I finished the touch, she turned her belly down and said, “Now on my back.” I started to blow on her spine, going up slowly vertebra by vertebra. When I reached the seventh vertebrae, she said, “Enough. The cockroach is gone.”

She stood up straight, light as a bird, and went to play with her friends, spending the rest of the time peacefully.

For one more week, during her parents’ absence, she requested a massage each day upon arriving at school in the morning.

This child demonstrated that her body achieved a sense of balance and stability through the touches. The request for a massage came spontaneously as a resource to “cleanse” a physical discomfort caused by her feelings of insecurity and anxiety due to her parents’ absence. She felt the discomfort as the “strange presence of a cockroach” in her heart.



Stories like those reported above substantiate evidence that Subtle Touch and Calatonia can be used in many settings, such as nurseries, daycare, hospitals, and within the daily routine of families, as long as the appropriate training is given, and the proper ethical attitude of respect and acknowledgment of the child's need is developed. *

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- Jung, C. G. (1952-79) *Collected Works Vol. 7*. (Bollingen Series XX) trans. R. F. C. Hull: eds. H. Read, M. Fordham, and G. Adler. Princeton, N.J.: Princeton University Press, 20 vols. Pg. 115 "A wrong functioning of the psyche can do much to injure the body, just as conversely a bodily illness can affect the psyche; for psyche and body are not separate entities but one and the same life. Thus there is seldom a bodily ailment that does not show psychic complications, even if it is not psychically caused." Pg. 296 "The body, its faculties, and its needs furnish of their own nature the rules and limitations that prevent any excess or disproportion. But because of its one-sidedness, which is fostered by conscious and rational intention, a differentiated psychological function always tends to disproportion."
- Jung, C. G. (1952-79) *Collected Works Vol. 8*. (Bollingen Series XX) trans. R. F. C. Hull: eds. H. Read, M. Fordham, and G. Adler. Princeton, N.J.: Princeton University Press, 20 vols. Pg. 344 "Since the psyche is a self-regulating system, just as the body is, the regulating counteraction will always develop in the unconscious. ...Its regulating influence, however, is eliminated by critical attention and the directed will, because the counteraction as such seems incompatible with the conscious direction. To this extent the psyche of civilized man is no longer a self-regulating system but could rather be compared to a machine whose speed-regulation is so insensitive that it can continue to function to the point of self-injury, while on the other hand it is subject to the arbitrary manipulations of a one-sided will."
- Jung, C. G. (1968) *Analytical Psychology - Its Theory and Practice*. New York: Random House Trade Paperbacks. pg 8: "Consciousness is very much the product of perception and orientation in the external world. It is probably localized in the cerebrum, which is of ectodermic origin and was probably a sense organ of the skin at the time of our remote ancestors. The consciousness derived from that localization in the brain therefore probably retains these qualities of sensation and orientation." pg 10: "What is that ego? The ego is a complex datum, which is constituted first of all by a general awareness of your body, of your existence, and secondly by your memory data; you have a certain idea of having been, a long series of memories. Those two are main constituents of what we call the ego. pg. 123 "The dreams are the reaction to our conscious attitude in the same way that the body reacts when we overeat or do not eat enough or when we ill-treat it in some other way. Dreams are the natural reaction of the self-regulating psychic system." (Jung, C. G., "Analytical Psychology - Its Theory and Practice," Pg. 190 "I am not altogether pessimistic about neurosis. In many cases we have to say: 'Thank heaven he could make up his mind to be neurotic'. Neurosis is really an attempt at self-cure, just as any physical disease is partly an attempt at self-cure. We cannot understand a disease as an *ens per se* any more, as something detached which not so long ago it was believed to be. Modern medicine - internal medicine, for instance - conceives of disease as a system composed of a harmful factor and a healing factor. It is exactly the same with neurosis. It is an attempt of the self-regulating psychic system to restore the balance in no way different from the function of dreams - only rather more forceful and drastic."
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* The pictures taken during the bodywork with children suggest the essence and meaning of the touch. Those pictures belong to our collection of pictures about "Being a Child".

Biography

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The Somatics of Touch

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Abstract

In this paper we will discuss the scientific knowledge and hypotheses on the physiology of the body-mind effect of touch. Touch has a physiological base that influences psychological processes. We present an example of the benefit of touch in working with a client in a therapy session which is then followed by a short description of a pilot project on the effect of a specific way of touching on students in several training situations. The physiology of different ways of touching is reviewed and cutting edge research regarding body-mind unifying theory is mentioned.

Keywords

Touch – Research – Psycho-neuro-endocrinology

Example 1: A client in a psychotherapy session.

A 47 year old female client talked about difficulties in her marriage in the course of her third session. In the ensuing dialogue the therapist expanded on one of the issues. Suddenly the client had difficulty expressing herself verbally, she shivered, her eyes/pupils dilated, the dialogue nearly stopped - the client withdrew from the contact and was much less present. No change could take place unless the contact was re-established. The job of the therapist then is to decide on an appropriate action as contact was necessary for any change to take place.

The therapist chose to ask the client to stand on her feet. Then the therapist put one hand on her back giving her a reassuring calming supportive touch. The effect on the client was a normalization of her breathing, her shivering decreased, eye contact was re-established and it became possible to have a dialogue about what happened. In this case touch was used consciously to bring about a situation where both teaching and therapy could take place.

Example 2: Obtained from groups in an educational setting

In a pilot study that is still running we have 437 subjects so far participating in educational groups during the last 4 years. Among these subjects we observed the effects of a simple touch exercise.

Working together in pairs we have A placing one hand on the back of B, B specifying exactly where and how they want this hand placed on their back. After 1-2 minutes B is asked to state how he/she feels inside.

After completing the exercise the participants are presented with a list of statements about the effect. They are then asked to choose one statement from this list, or if they do not find a statement that fits the effect this exercise has on them they can add their own statement below the list.

The top 5 of the most frequently chosen answers are:

- Feeling more calm and at ease
- Feeling more present and alive
- Feeling more centered
- Feeling stronger with higher self esteem
- Feeling more in touch with ones emotions.

In both the therapeutic and educational examples we found a measurable psychological effect caused by a bodily intervention.

THE PSYCHO-NEURO-ENDOCRINOLOGY OF TOUCH.

What is happening at the biological level when we touch?

An abundance of psycho-neuro-endocrine research has emerged in recent years, most of which is experimental and carried out in animals, generally with rodents (Pert 1985, Pauk 1986, Uvnäs Moberg 2000, Vázquez 1998). In humans the majority of studies concern massage, acupressure, biofeedback and other methods of the growing field of energy medicine

(Leivadi 1999, Oschman 2000, Ironson 1996). We are not aware of any studies on specific neuro-endocrine effects of different types of touch.

The following section therefore focuses on the general biological effects of gentle (non-invasive) touch.

From the skin to the brain

Sensory afferent nerves bring information to the central nervous system from receptors in the skin. There are two main types of receptors: receptors for fine touch/proprioception and receptors for pain/temperature. Both types of receptors generate two nervous impulses.

- One is carried to the central nervous system by thick, coated nerve fibres (A-delta-fibres) travelling rapidly through the spino-thalamic tract to the thalamus and from there on to the cortex of the brain (Brodal 1977). These rapidly travelling impulses allow the CNS the option to activate inhibitory nerve impulses in case the signal is considered painful or "too much" (Rosenfeld 1994). This rapid system might also activate the autonomic nervous system.
- Slow acting C-tactiles in uncoated nerves transport the other nervous impulse. This part of the system is ontogenetically the oldest. New research suggests that C-tactiles are able to catch the unconscious aspect of a stimulus; one might call it the intention behind the touch! (Olausson 2002, Wessberg 2003).

All incoming signals cross the body midline at different locations in the medulla i.e., signals from the right arm are processed in the left part of the brain and vice versa.

From the brain to the body

The outgoing (efferent) part of the nervous system consists of somatic motor nerves and autonomic nerves. The autonomic system regulates the internal organs without our conscious mind taking part in it. The autonomic nervous system is divided into:

- The sympathetic nervous system, exits the spinal cord in the thoracic and lumbar regions of the spinal column. The sympathetic nerves are activated by motion and are regulating the flight and fight response, primarily through the neurotransmitter nor-epinephrine (nor-adrenaline).
- The parasympathetic nervous system comes from the brain stem and the sacral section of the spinal cord. The parasympathetic nerves are actively engaged in rest and peace and primarily use the neurotransmitter acetylcholine (Uvnäs Moberg 2000).

Responses in the brain

The thalamus might be considered an enormous information processing centre. It is connected with both the higher areas of the brain (the cortex) and the lower levels; the brain stem, the hypothalamus and basal forebrain, the hippocampus, and the limbic system. Information is processed in all of these neural connections, but most of it is done through neurotransmitters and other peptide substances (Damasio 1996 & 1999). With the elicitation of hypothalamic peptides, endocrine responses emerge in the pituitary and in some other internal glands, e.g. the adrenals. Some of the peptides synthesized in the pituitary are transported to higher levels of the CNS acting partially as neurotransmitters.

Neurotransmitters, peptide substances and hormones all act upon receptor molecules in different body tissues, including the brain. Some of the substances have different types of receptor molecules in different tissues. The newest line of research in neurotransmitters has identified the astonishing fact that most neurotransmitters are not only produced in the CNS but also in nearly all parts of the peripheral tissue (Pert 1997). The consequences of this might be that manipulation of peripheral tissues, e.g. muscles and joints elicit a more local production of neurotransmitters. The powerful effect of acupuncture on internal organs is one example of this hypothesis.

PSYCHO-NEURO-ENDOCRINE SUBSTANCES

Let's take a look at some of the most important substances involved in the mechanisms of touch; oxytocin, endorphin, the neurotransmitters and the steroid hormone cortisol. Nearly all of the body's hormone systems are in some intriguing ways implicated in the response to touch, but here we will concentrate on the most important ones.

Oxytocin

The most important substance is probably the pituitary hormone oxytocin. Oxytocin is produced in supraoptical and paraventricular nuclei in the hypothalamus and transported to the posterior lobe of the pituitary reaching the blood circulation from there.

Some of the oxytocin-producing cells in the hypothalamus elicit their effect as a neurotransmitter transporting the substance to;

- the hippocampus (the place where memory is stored and the stress system is regulated),
- the substantia nigra (the main centre for the production of dopamine, which has its main effects on focusing, rewarding and emotional responses),
- the raphe nuclei (the main centre for the production of serotonin, which has its main effect on the general mood) and
- the locus coeruleus (the main centre for the production of nor-epinephrine which among other effects is involved in alertness and aggression).

For decades the only known effect of oxytocin was its ability to attach itself to receptors in the uterus causing contractions and thereby eventually causing the expelling of the baby. Later it was found that oxytocin, apart from working in the pregnant uterus, also elicits the contractions of the female orgasm. In recent years research in both animals and humans has shown that oxytocin has several other effects as well. (Uvnäs Moberg 1998, 2000, Sachser 1998, Pert 1997, Komisaruk 1998, Henry 1993b).

Oxytocin has many biological effects including lowering of pulse rate and blood pressure, redistribution of body heat, stimulation of digestion through stimulation of gastrin, somatostatin and insulin. It also has an effect on the part of the autonomic nerve system that is involved in digestion (the vagal nerve), stimulation of wound healing, stimulation of pituitary production of prolactin, growth hormone and ACTH. The stimulation of ACTH initially increases the production of cortisol in the adrenal cortex. However the general effect of oxytocin is to stabilize the cortisol at a constant low level through a feedback loop mechanism.

There are behavioural effects of oxytocin. Animals display less anxiety and more curiosity, which provides them with courage to establish non-aggressive social contact with other animals. The mating behaviour speeds up and intercourse then produces even more oxytocin in both female and male animals (a mechanism that most likely also promotes the motility of egg and sperm). Maternal behaviour is promoted even in animals that have not given birth. This behaviour is not only directed towards the animal's own offspring but also toward other youngsters. Social memory improves, for instance recognition of others. Even learning abilities show improvement as demonstrated with the ability to retain useful information in a non-stressful environment. Oxytocin also reduces pain. Animals react less towards a painful stimulus, i.e. the pain threshold increases.

The production of oxytocin in the body is stimulated by gentle touch as well as being in good relationships, sex, delicious food and drinks, pleasurable exercise (most likely connected to the interconnection between the endogenous opiate system and oxytocin) and by stillness, i.e. in meditative mindfulness. So as you can imagine, oxytocin is able to show us all that is good for us!

The endorphins

The endorphins are morphine-like peptide substances produced in the brain and in nearly all kinds of peripheral tissues. Stressful and harmful stimuli immediately produce an increase in the endorphin levels in the body. The function of this is obvious, to mitigate pain in order to be able to flee from or fight against stressful stimuli. The endorphins also form the crucial component of the freezing response seen in inescapable stressful situations where you don't feel pain at all - at least you can die without suffering! (Henry 1993a, Kolk 1994, Nabeshina 1992, Rosenfeld 1994)

Endorphins are also produced in great amounts through non-noxious stimuli like TNS, acupuncture, acupressure, and massage, and through movement, especially running longer distances (Thoren 1990). This is actually the primary pain reducing mechanism of these therapies. Endorphins are not only acting as painkillers but have psychoactive effects as well; one becomes more at ease, gets a feeling of flying and of endurance ("I can go on like this forever") and especially one is more able to defocus one's emotional responses in the situation. This makes it easier not to become overwhelmed by emotions (Pert 2000).

The endorphins are intimately connected with oxytocin. Oxytocin actually seems to stimulate the production of endorphins while some of the endorphins suppress a further increase in oxytocin (quite helpful if a person is not supposed to fall asleep!) (Daddona 1994).

The neurotransmitters

As described above in the section about oxytocin, different brain neurotransmitters are being released in response to touch (to confuse us all, nowadays neuroscientists are finding "brain" neurotransmitters in nearly all types of peripheral tissues (Pert 2000).

Dopamine and serotonin are the most promising candidates to explain the clinical experience that touch renders a client more focused and emotionally stable and that it has a positive effect on the general mood of a client (Damasio1996).

It is interesting that the neurotransmitter nor-epinephrine which generally is seen in connection with the sympathetic stress response, also shows an increase under the influence of touch. The reason for this is that nor-epinephrine has the ability to control the "positive" side of alertness, the ability to stay awake and stay focused.

Cortisol

Cortisol is a steroid hormone produced in the adrenal cortex. Cortisol is important for the acute response to stress, for instance it mobilizes glucose which then is transported to the working muscles and the brain. When the stress response becomes chronic, the dark side of this mechanism shows up. Chronic elevated cortisol levels result in high blood pressure, cardiac illness, the development of type 2 diabetes, and even dementia-like conditions in the brain and depression (Henry 1993a, Henry 1998, Kolk 2000, Vázquez 1998). It is therefore important that several studies in both animals and humans have shown unambiguously that gentle touch and massage lower the cortisol level in the body (Field 1996, 1997a, 1997b, 1997c, 1999a, 1999b, Pauk 1986, Leivadi 1999).

SUMMARY OF THE BIO-PSYCHOLOGICAL EFFECTS OF TOUCH

Touch is the single most efficient method to reduce anxiety and create a sensation of ease and trust. This is due to the combined effect of the neurotransmitters oxytocin, the endorphins and serotonin, indicating that psychotherapy without touch comes close to being unethical!

From a therapeutic viewpoint another aspect of touch is the ability to strengthen the social interaction and contactability between client and therapist. This is achieved through oxytocin supported by dopamine in a session where touch is used. The effect is seen in both client and therapist. The goal of therapy of course is to teach the client to transfer this ability to his life outside the therapeutic setting.

Touching promotes a client's learning abilities through the combined action of an increased oxytocin level, decreased cortisol level and a shift in the autonomic nervous system from sympathetic activation or a more neutral position towards parasympathetic activation.

Touching establishes the ability of the client to be more focused and present mainly through the release of dopamine and nor-epinephrine.

Touching also heightens the client's capacity for enduring high intensity situations.

Oxytocin helps the client to experience the intensity as less dangerous. The endorphins elicit a feeling of 'getting high' in intense situations. Nor-epinephrine helps the client to be alert. Dopamine provides the sense of reward in this situation. Even cortisol has positive effects in a situation of short-term stress, namely when one has to act in a high intensity situation.

The combined effect of the above mentioned impact of the neurotransmitters is that the client's containment ability and experience of self-esteem and personal dignity is increased. The therapist and/or teacher must therefore consider using touch in all situations where the above themes are active.

DIFFERENT WAYS OF TOUCHING IN BODY PSYCHOTHERAPY

It is important that psychotherapists are consciously aware of the impact of the touch they choose to use and that touch forms a part of the whole therapy process. This is especially so when the goal in psychotherapy is to help the clients psychologically in learning to stand on their own two feet, to experience this feeling in all parts of themselves, and to help the clients in developing their ego / self (Bentzen 1997).

In body oriented psychotherapy the different schools all have their own ways of differentiating touch. In the Bodydynamic system we distinguish different qualities in the muscles in regard to their responsiveness to touch. We differentiate between hyper- and hyporesponsive muscles, which represent totally different psychological issues (Fich 1997, Bernhardt 1997a). Moreover, in the analysis of the muscles we make a differentiation in the psychological content of each single functional muscle (Bernhardt 1997b, Bernhardt 1997c) The different ways of touching as described below thus have a different impact depending on which muscle is touched and which quality of the muscle is addressed. Here we will describe the general way of touching in the Bodydynamic system as one example of ways to touch in the world of body psychotherapy.

Touch as biofeedback

The intention is to help the client sense him/herself, which helps to integrate insights and to hold on to these insights. Example: a client is not able to sense any impact from an otherwise good experience. There is no impact or change in her body and hardly any insight into the benefit of what is happening. When this is the case the client's body awareness is very close to zero.

One typical scenario is that the therapist places her hand on a particular muscle group of the client and asks the client to activate those muscles. Experience shows that being touched on those muscles makes it easier for the client to sense the muscles that are going to be activated, easier than when there is no touch. Imagine a client who is collapsed in the sternum with the head placed forward. If the therapist places one hand on the sternum and asks the client to move the sternum forward (under the hand) it helps the client to get hold of the movement and the muscles involved, which have to do with sensing "needs".

Another scenario is that the therapist has placed her hand on a place on the body of the client (connected with the theme that they are working on). Now when the client states a sentence, both the therapist and the client can sense the connection, because the muscles under the hand will become active, alive. This allows the client to start consciously using these muscles when she runs into the issue at hand. When the hand is not there or is in another place on the body nothing happens.

In all scenarios it is important that the hand of the therapist is neutral and well bounded, in order to help the client to develop her own sensations and find her own words. If the therapist has a more unbounded contact style it becomes more difficult for the client to differentiate and stand up for herself.

Boundary increasing touch

In the therapy session the intention is to help the client sense her boundaries. The client needs to be more assertive in setting her boundary, be able to sense in her body when other people overstep it, and when to say STOP (based on a bodily reaction). The therapist places his hand on muscles that are related to boundaries, of taking space or similar issues. The therapist helps the client to sense these muscles and experience that these muscles can "push" the therapist's hands away. He helps the client to verbalize the actions and the insights.

Another way may be a firm stroking of the same muscles at the level of the skin - outside the clothes of the client - so that the client is helped to sense his skin as the physical boundary of his body.

Working with a client on these issues involves touching the triceps (which support the ability to say NO or STOP), the middle part of the deltoid (which supports the ability to ask for more space psychologically) and the back part (posterior) of the deltoid (which supports the ability to get rid of burdens, or sense the ability to endure).

Stimulating touch

The intention of this kind of touch is to provoke a psychological as well as physical reaction from a client who at a specific moment in the therapy session is holding back (or has given up) any or most of a reaction. The therapist consciously touches, holds that touch and pushes/stimulates muscles that are active in the theme that is being worked on.

An example is a client who is talking about her "closed heart". Here the therapist might choose to place her fingers on top of the serratus anterior superior muscle (left side), to provoke the muscle to respond and provoke the client to talk more about the issue of shutting down her heart. One advantage of a provocation in this manner is that it the therapist can help the client to stay focussed on the original topic by provoking associated muscles.

Supportive touch

Here, the intention is to give the client an experience of being okay, of not being alone (contact is possible, no matter the problem) and that other people love you (unconditionally).

This type of touch can be used on many areas of the body. Most typically it is done on the back. It can be done in different places in the back. The psychological theme here is being "backed" by another human being (the parents).

The therapist places a very steady hand - often it is warm, or it becomes warm - on the back of the client. This is done of course when "backing" is missing. The results are similar to those in our pilot study in the beginning of this paper. It is easier for the therapist to give the "right" support if, while he is giving this supporting touch, he is saying inside himself "I am here", "you can lean on me", "I will support you" - in just the same way one would support a little child unable to sit alone. At a later stage the therapist may say these sentences out loud while touching.

Another way of providing supportive touch is where the hand gives "a little push" that says "I am here, you can do it yourself", as a way of getting the message across for what needs to be said. This way of touching is comparable to a parent really *being* there when a child falls (e.g. in the process of learning to ride a bicycle), helping the child to get up quickly and giving it the next push out into the world.

Many of our clients are not used to being "backed" or supported by their parents, so when "the going gets tough" in the session an obvious move is to support these clients. Giving the client consistent support in the back helps her to stay focused and contained and to keep describing what goes on inside.

Energy producing touch

In this case the intention is to give clients with little resources more energy. One way of doing this is to stroke the client's body with a well-bounded and light touch, faster and faster, while focusing on the surface of the skin (clients are always dressed, preferably in soft clothes). This is most likely activating the C-tactile cells as described above and pure experience tells us that this way of touching activates the energy in the body.

This can also be done through different ways of 'slapping' the skin or using the lateral edge of the palm. The technique chosen depends on whether one wants to "evoke" finer or coarser vibrations depending on the quality of the muscles.

Holding (containing)

The intention is to help the client experience that it is possible to contain a state of high intensity and still stay in contact. We have many examples of clients that regress into early childhood and get in touch with sadness and fear. One therapy intervention is to sit on a mat with the client's back against your front holding your arms around the client safely. When anger is involved the holding might be firmer, so the client experiences that the therapist is able to contain the anger.

Strain – Counterstrain

Here the intention is to teach the client different ways of moving, body awareness and releasing energy blockages. The therapist touches or holds on to the client while the client is doing different movements and/or stretches. The advantage is that the client experiences contact while he is exploring his body awareness and that he can verbalize the insights and sensations to the therapist.

Massage

In the area of massage there are many ways of touching. Most of these ways are intended to either relax the body or to heighten aliveness in the body.

There are forms that make use of non-verbal massage. Some forms are mixing massage and verbal exchange while others combine massage with psychotherapy. A number of these forms recognize the concept of hyper- and hypotensive muscles.

If our clients need a massage we normally refer them to a massage therapist, but if they arrive in a session in a state that is so depressed or energized that it becomes difficult to do therapy, we prefer to spend some time bringing them into balance, before continuing the session.

Clients who are in a depressive state need to increase tension in their system, so we ask these clients to do specific movements that include the depressed muscles, while we provide resistance. The basic rule in giving resistance is to give it in a way that the clients succeeds in making the intended movement fully, while at the same time the resistance has to be tough enough that fulfilling the movement is difficult for the client.

Clients that are "overly energized" need to relax their system. Here we ask the clients to lie down on a mat while we stretch their muscles (using force and specific techniques). Stretching the muscles in this way releases the tension and brings the energy down.

PTSD

In working with PTSD - shock trauma issues - we are prepared to use all of the ways of touching mentioned above, all in the service of helping the client to resolve the traumatic issue and build new resources in order to gain a higher quality of life (Jorgensen 1992, Ollars 1995). We are also prepared not to touch depending on the kind of shock trauma the client has been exposed to. When the skin and the boundaries have been penetrated in the original shock trauma we generally do not touch the client before a considerable amount of work on safety has been done. This work includes learning how and when to keep boundaries (when and where and how to say stop, etc.) physically as well as energetically.

Ethics and touch

There exists an extensive body of literature on this topic so here we just want to state the obvious, namely that therapists **MUST** be able to keep their own boundaries and to sense and respect the client's boundaries - no matter what the issue (Macnaughton 1997).

Clients often have difficulties concerning their boundaries in relation to the issue that they want to work with. So although the therapist asks the client if it is ok to touch, the answer most often will be YES. Specific tensions occurring in different places in the body as well as a lessening of the contact between the therapist and the client indicate however that the

client in fact should be answering NO to this question. Therefore it is important that the therapist is aware of the subtle reactions in the client and also needs to be able to sense in his own body the "YES-NO" reaction present in the client's body.

THE CUTTING EDGE: NEW THEORIES EXPLAINING THE IMPACT OF TOUCH.

In recent years two outstanding biomedical scientists, Candace Pert and James Oschman individually have described integrative concepts on how all parts of the human body and mind interconnect and how touch influences the system via hormonal, neurological and psychological networks.

Candace Pert, the discoverer of the endorphin receptor in the brain and the body, in her book "Molecules of Emotion" (Pert 1997) describes the concept of a biochemical information network as the agent of the relationship between touch, body and emotions. James Oschman, renowned scientist in biophysics, in his book "Energy Medicine" (Oschman 2000) describes the concept of an electro-magnetic and structural information network as the agent in the relationship between touch, body and emotions. Together they are now working on a unifying theory to explain how traumatic personal experiences are stored in these information networks and how this results in different degrees of malfunction in body and mind. Moreover, experimental studies are being carried out regarding the ability of therapeutic touch to regenerate the malfunctioning networks. This might be the breakthrough for science based body psychotherapy. The work of Pert and Oschman provides an excellent basis for understanding the often dramatic effect on psychological and somatic symptoms brought about by energy based healing systems e.g. acupuncture and therapeutic touch. However, in order for a healing to result in personal growth, in dissolving old patterns and building new resources it is necessary to verbalize and integrate the experiences and insights gained into a personally meaningful framework in the client. This is what body oriented psychotherapy is about.

Contributors:

LM provided the theoretical basis for this article
 EJ collected the data and was responsible for the writing process
 KM participated in the writing of the psychoneuroendocrine section
 RvD participated in the revision and finalizing the article for publication

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Touch In Therapy and The Standard of Care in Psychotherapy and Counseling: Bringing Clarity to Illusive Relationships

Ofer Zur, Ph.D.

Abstract

The question of touch in therapy has been debated since the inception of the field early in the last century. The main concern about physical contact in therapy has focused on the sexually exploitative therapists and the concern that a client may interpret touch as having sexual intent. Ignoring years of clinical and developmental research, many risk management experts, traditional psychoanalysts, consumer protection agencies, insurance companies and malpractice attorneys have promoted the notion that any touch beyond a handshake is clinically inappropriate, unethical or below the standard of care. Drawing on the faulty slippery slope theory that even appropriate boundary crossings are likely to lead to boundary violations, they assert that even scientifically proven, appropriate and clinically helpful touch is likely to lead to unethical, sexual touch. The aim of this paper is to clarify the relationship between professional, therapeutic touch and the standard of care. To achieve this goal the paper defines the standard of care in psychotherapy, and details the elements of the standard and articulates what the standard is and is not. It then briefly reviews the clinical research on touch in therapy and identifies the different types of touch employed in therapy. The paper then articulates, in detail, how non-sexual, clinically appropriate and therapeutic touch falls within the standard of care of psychotherapy and counselling. Additionally, the paper discusses issues, as they relate to touch in therapy, of theoretical orientation, codes of ethics, risk management, differences between sexual and non-sexual touch, and it reviews the idea of the slippery slope. Finally, the paper outlines how therapists, who appropriately use touch in therapy, can demonstrate compliance with the standard of care.

Keywords

Touch – Standard of Care – Non-sexual Touch – Ethics – Risk Management

Introduction: Forces and Influences in the Battle of Touch

While touch has been part of most healing traditions throughout human history, it has been controversial in western medicine and more so within the field of psychotherapy and counseling (Aposhyan, 2004; Smith, Clance, & Imes, 1998, Totton, 2005; Young, 2005). The main concern around the issue of therapeutic touch has been that psychotherapists and counselors may use their power and influence to sexually exploit their clients (Pope & Vasquez, 2007; Rutter, 1989). The second concern has been that a client may interpret touch as having sexual intent. As a result, since the field's inception, the application of touch in psychotherapy has been one of the most hotly debated topics (Hunter & Struve, 1998; Zur, 2007). Whilst Freud initially endorsed the use of touch as part of psychotherapy, he changed his position entirely in the early 1920s when he became worried how the use of touch might tarnish the reputation of the new field. The issue erupted when Freud, back in 1931, scolded his star student and disciple, Ferenczi, for letting a female client kiss him (Young, 2005). Freud felt that physical contact would lead to sexual enactments, and, by his own admission, he was equally concerned with the reputation of psychoanalysis, thus forcing the issue of touch to go underground. Ferenczi refused to stop touching his clients altogether and was subsequently expelled from the ranks of orthodox psychoanalysis (Fosshage, 2000). Wilhelm Reich (1972), who developed the most comprehensive method of clinical touch, was, like Ferenczi, one of Freud's inner circle and prominent in the prestigious International Psychoanalytic Association (IPA). He, too, was ousted from the International Psychoanalytic Association for his professional stance on touch in therapy.

As Fosshage (2000) asserts, while Freud's rule of abstinence on touch has, thus, predominated in the psychoanalytic literature, there have been more notable exceptions where physical touch is seen as not only appropriate, but as necessary when dealing with periods of severe regression (Balint, 1952; Winnicott, 1958), with psychotic anxieties and delusional transference (Margaret Little, 1990), and with disturbed patients (see Mintz, 1969, who describes the work of Fromm-Reichman and Searles). However, as psychoanalysis emerged, an analytic ideology was created around the prohibition of touch. It was based on the conviction that any touch is likely to gratify sexual and instinctual infantile longings or drives, subsequently contaminating the analytic container and nullifying the possibilities for analysis to help the clients work through their issues (Langs, 1982; Simon, 1994).

The conflict around the use of touch in therapy has stayed with the field since that time. In recent years the primary tension is between, on one side, the long-established scientific knowledge that has consistently proven that touch is essential for healthy human development and human relationships and, on the other side, the ethical concerns with exploitative and harmful sexual touching of clients by therapists. A great amount of scientific data has been acquired in the last half century on the importance of touch for human development, bonding, communication and healing by the classic work of Bowlby (1969), Harlow (1971) and Montagu (1986) and more recently, the extremely prestigious Field (2003). The clinical use of touch in therapy has also been studied extensively and has conclusively determined that touch can enhance the therapeutic alliance as well as increase a sense of trust, calm and safety (Smith, et al., 1998). Touch has also been shown to be effective in the treatment of depression, anxiety, PTSD and other mental disorders and conditions (e.g., Aposhyan, 2004; Field, 1998, 2003; Hunter & Struve, 1998; May, 2005; Young, 2005). On the other side there is a major concern, raised mainly by risk management experts, ethical review boards, insurance companies and consumer protection agencies, that nonsexual touch can

lead to sexual touch and exploitation of clients (Bersoff, 1999; Gabbard, 1994; Pope & Vasquez, 2007; Rutter, 1989; Simon, 1991, 1994). There is little 'evidence' for this fear, though – as in any profession – an occasional therapist has been successfully charged with inappropriate touch.

Another rift in the field stems from different therapeutic philosophies. On one side there are the analytic practitioners, on another side there are those who focus on biological-pharmacological intervention, and who advocate a hands-off approach for philosophical-clinical reasons. On another side of the debate are humanistic, group, family, cognitive-behavioral and feminist therapists who see value in appropriate touch and other boundary crossings, such as self-disclosure, gift exchange, bartering and dual relationships (Williams, 1997; Zur, 2007). These greatly outnumber the first group. Bodypsychotherapists, many of whom use touch as a primary clinical tool, obviously believe in the importance of touch in general and in its scientifically established clinical utility in particular (Aposhyan, 2004; Nordmarken & Zur, 2004; Young, 2005).

Several psychotherapists' surveys over the years revealed that 87% of therapists touch their clients (Tirnauer, Smith, & Foster, 1996), 85% hug their clients (Pope, Tabachnick, & Keith-Spiegel, 1987) and 65% approve of touch as an adjunct to verbal psychotherapy (Schultz, 1975). In a more recent survey Stenzel & Rupert (2004) reported a decrease in the general reporting of the use of touch in therapy, which they, reasonably, partly attributed to the increase in the dominance of risk management training. They also reported a significant increase in reporting of female therapists touching female clients. The reported decrease may also be the result of a biased sample as more therapists are not only trained in risk management but also have been intimidated by it and, therefore, are less likely to admit to touching clients, by either refusing to participate or by declining to admit to touch practices.

Some of the negative and frightening messages regarding touch, that psychotherapists have been inundated with, come from prominent therapists, many of who are psychoanalytically oriented. One example is Menninger who asserts that physical contact with a patient is "evidence of incompetence or criminal ruthlessness of the analysts" (cited in Horton, Clance, Sterk-Elifson, & Emshoff, 1995, p. 444). Simon, in a similar vein, instructs therapists to "Foster psychological separateness of the patient. . . interact only verbally with clients. . . minimize physical contact" (1994, p. 514). Wolberg (1967) agrees: "Physical contact with the patient is absolutely a taboo (since it may) mobilize sexual feelings in the patient and the therapist, or bring forth violent outbursts of anger" (p. 606). These extremely small, but biased perspectives, have created an inappropriately weighted bias, both in the profession's and in the public's mind.

Similarly to the psychoanalytic attitude towards touch in therapy, strong messages were pronounced by risk management or defensive medicine experts who often place touch at the top of the 'Do not do' list. "From the viewpoint of current risk-management principles," Gutheil & Gabbard stated, "a handshake is about the limit of social physical contact at this time" (1993, p. 195). Similarly, the popular Web site, WebMD (1992), announces "A Hug-Free Zone: The threat of lawsuits, the already strong language in the APA code, and the general litigiousness of society have prompted many therapists to erect barriers between themselves and their clients when it comes to any physical contact. No more hugs for a sobbing client. No encouraging pats on the back" (section 2, Para. 1). Risk management has been defined in realistic and pragmatic terms by Gutheil & Gabbard (1993) and Williams (1997, 2003) as the course by which therapists refrain from implementing certain interventions because they may be misinterpreted and questioned by boards, ethics committees and courts. Obviously, these practices almost exclusively serve to protect the practitioners, not the consumers. At the core of the risk management injunctions against touch in therapy is the belief in the 'slippery slope'. This is the idea that failure to adhere to hands-off, rigid standards, will most likely lead to therapist-client sexual relationships.

Historically, the 1960s and 1970s witnessed a general increase in litigious attitudes in the culture at large and in the rise of defensive medicine and risk management practices in the field of medicine, including psychotherapy and counseling. Following the sexual revolution of the 1960s and sexual digressions by some sections of Gestalt Therapy and Humanistic Psychology at Esalen in California, risk-management teachings have strongly encouraged psychotherapists to avoid almost all forms of touch and most other boundary crossings or deviation from analytic hands-off practices. The concern during this time, as is also reflected in the professional associations' codes of ethics, was that any deviation from analytic-type practices are likely to lead to sexual and other violations of clients by permissible therapists. A 'bogy-man' attitude had therefore been created, based almost totally on bias and fears of litigation.

At the end of the 20th century and the beginning of the new millennium, there have been two significant and contradictory forces that have affected the relationships between boundaries in general, including touch and the attitudes towards therapeutic boundaries, and the perception of the standard of care. On the one hand, risk management, in regard to touch issues and other boundary considerations, has continued to be a concern for professional organizations and consumer protection agencies. On the other hand, there has been a significant increase in the number of publications that associate boundary crossings with increased therapeutic effectiveness (e.g., Younggren & Gottlieb, 2004; Zur, 2007). During this period of time we also see shift within the analytic community towards more openness towards the clinical utility of touch. In addition to Fosshage (2000), other reports of the facilitative use of touch have emerged in the analytic literature by scholars, such as Bacal (1997), Hamilton (1996), LaPierre (2003), and McLaughlin (1995). As articulated below, a similar shift has taken place regarding touch in therapy as illustrated by the 1998 American Psychologist publication of Field's article, "Massage therapy effects," and several other publications (e.g., Hunter & Struve, 1998; Smith, et al., 1998; White, 2002; Young, 2005) along with the establishment of United States Association of Body Psychotherapists Journal and the European Association of Body Psychotherapists, which both advocate that properly trained, body-oriented psychotherapists are not only the only people 'qualified' to touch, but that a body-oriented approach, which might involve touch, is considerably as effective, and some (i.e., Young, 2005) say even more effective than a psychotherapy that totally ignores or that does not relate to the

patient's body in any way

Therapeutic Boundaries and Touch in Therapy

Boundaries in therapy, including the boundary issues that involve touch, are extremely important. They define the therapeutic fiduciary relationships and distinguish psychotherapy from social, sexual, business and many other types of relationships, also having a direct impact on the effectiveness of therapy. There are two types of boundaries. One type is where boundaries are drawn around the therapeutic relationship and involve issues of fees, privacy and confidentiality, and place and time of therapy. Boundaries of another sort are drawn between therapist and client, rather than around them. Touch between therapist and client is an obvious boundary of this latter kind as well as therapists' self-disclosure and giving and receiving gifts (Gutheil & Gabbard, 1993). Touch between therapist and client represents one of the most recognized psychotherapeutic boundaries, as it reaches across the professional-interpersonal space separating therapist and client (Zur, 2007).

Boundaries in therapy have been regarded as the "edge" of appropriate behavior (Gutheil & Gabbard, 1993) and involve two types of boundaries: boundary crossings and boundary violations. A boundary violation occurs when a therapist crosses the line of decency and integrity and misuses his/her power to exploit a client for the therapist's own benefit. Therapist-client sexual relationships are a prime example of boundary violations. Such violations may also involve any exploitive business or other relationships and are always counter-clinical, unethical and are often illegal. In contrast, boundary crossings involve courtesy or ritualistic gestures, such as a handshake or a pat on the back. They have been defined as any deviation from traditional psychoanalytic practices (Zur, 2007). Boundary crossings also involve clinically effective interventions and are part of a well-constructed treatment plan, such as clinically and ethically appropriate self-disclosure, home visits, gift exchange or bartering (Herlihy & Corey, 2006; Lazarus & Zur, 2002). As will be articulated in this paper, while boundary violations are inherently unethical and always below the standard of care, boundary crossings are neither unethical, nor below the standard of care.

Boundary crossings are often an integrated part of most practiced therapeutic modalities, such as humanistic, somatic, cognitive, behavioral or group therapy. Following are just a few examples of beneficial boundary crossings and the corresponding theoretical orientations that are likely to support them. Behavioral therapy readily endorses flying on an airplane with a fear-of-flying client as part of an exposure or in-vivo intervention. Cognitive, behavioral and cognitive-behavioral therapies endorse self-disclosure as a way of modeling, offering an alternative perspective or exemplifying cognitive flexibility. Humanistic, feminist and existential therapies endorse self-disclosure as a way of enhancing authentic connections and increasing therapeutic alliance, the best predictor of therapeutic success. A client-initiated handshake at the beginning or end of a session, an appropriate and encouraging pat on the client's back, supportive handholding or a nonsexual hug can be exceedingly clinically helpful. They are all considered boundary crossings and are endorsed by most therapeutic modalities. Not to put a consoling arm around a client who has suddenly burst into tears, might be seen, not only as uncaring, but in fact a rigid application of therapeutic boundaries. Additionally, specially trained body psychotherapists, such as Reichian or bioenergetic therapists, who use thoroughly researched and established hands-on techniques, are also engaged in therapeutic boundary crossings.

Dual relationships are a type of boundary consideration that often has been misunderstood and mischaracterized. Dual relationships take place when therapists and clients engage in additional social, business or professional relationships other than the traditional one-on-one therapist-client relationship (Lazarus & Zur, 2002). Sexual relationships between therapists and current clients are obviously totally inappropriate dual relationships and are also boundary violations, always counter-clinical, unethical and illegal in most states (Pope & Vasquez, 2007). Non-sexual and non-exploitative social and other dual relationships are often unavoidable in rural communities, university and college campuses and other small communities, and they can also be beneficial to therapy (Herlihy & Corey, 2006; Schank & Skovholt, 2006; Younggren & Gottlieb, 2004; Zur, 2007). While ethical or unavoidable dual relationships are technically boundary crossings, exploitative dual relationships, including sexual dual relationships, are definitely boundary violations. It is important to understand that therapeutic and ethical touch, like clinically appropriate boundary crossings, such as self-disclosure or making a home visit (done exclusively for clinical reasons and are not involved in a secondary relationship), are neither dual relationships nor unethical.

The difference between boundary crossings and boundary violations, when it comes to touch, often relates to the differences between sexual and non-sexual touch (Pope, Sonne, & Holroyd, 1993; Zur, 2007). Some differentiations between sexual and nonsexual touch in therapy focus on the areas touched (i.e., hand vs. genitals), others focus on whether the intent is to sexually arouse the client or the therapist, and yet others propose an encompassing view that "erotic touch" is any behavior that leads to sexual arousal (e.g., Brodsky, 1985). A few analytically oriented scholars take the extreme position that - in the context of transference - even what attempts to be a nonsexual touch is almost inevitably sexual or erotic. (Gabbard, 1996; Wrye & Welles, 1994). However, this is a perspective that is almost exclusive to the pure, traditional psychoanalysis. Help with differentiation between sexual and nonsexual touch in therapy comes from one of the key studies that found correlations between nonsexual touch and sexual touch. The study showed that the sexual boundary violation was positively correlated, not with touch per se, but with the frequency that therapists touched clients of the opposite sex in comparison with the frequency of touch of clients of the same sex (Holroyd & Brodsky, 1980). The important conclusion of these findings was that therapists' own attitudes towards touch and whether they tend to generally sexualize all forms of touch is the determining factor in

whether they are likely to blur sexual and nonsexual forms of touch. Therefore the most productive preventative measure is probably good therapist education in appropriate use of therapeutic use of touch.

As was noted above, professional attitudes towards therapeutic boundaries in general has shifted significantly during the end of the last century and the beginning of the 21st century. An increase in the number of publications that associate boundary crossings and touch to increased therapeutic effectiveness has linked them to the most commonly practiced theoretical orientations, such as cognitive, cognitive-behavioral and humanistic psychotherapies (Williams, 1997). Illustrating the shift in mainstream psychology and counseling towards more context-based and less rigid attitudes towards boundaries is the flexibility advocated by American Psychological Association's (APA) revised code of ethics of 2002 and similar changes included in the American Counseling Association's (ACA) code of ethics of 2005. Just as telling is the fact that American Psychological Association (APA) and American Counseling Association (ACA) have published several texts in the beginning of the 21st century that have taken a clear, flexible and context-based stance in regard to therapeutic boundaries (i.e., Herlihy & Corey, 2006; Knapp & VandeCreek, 2006; Schank & Skovholt, 2006; Zur, 2007). Additionally, during this period there was an increased realization of the potentially immense clinical usefulness or benefit of ethical professional touch (Field, 1998, 2003; Hunter and Struve, 1998; May, 2005; Smith, et al., 1998; Young, 2005). In the beginning of the new century there were a few influential papers that re-introduced the importance and clinical utility of touch within the analytic context (i.e., Fosshage, 2000; LaPierre, 2003; Schore, 2003; Toronto, 2001). The inception of the *United States Association of Body Psychotherapy Journal* in 2002 has been a significant additional, continuous and extensive contribution to the professional literature on clinical, ethical and legal issues that pertain to touch in therapy. An additional rich resource of body psychotherapy has become available through European Body-Psychotherapists (2006).

The Standard of Care

The standard of care is one of the most important constructs in medicine and mental health. It guides practitioners in their practices, provides a minimum professional standard and is an essential element in malpractice suits and hearings of state licensing boards. Because the standard of care is both important and elusive, it is the subject of much debate and controversy. Surprisingly, there is no one national or universally accepted standard of care that can be found in any agreed upon text. The standard of care is primarily determined in courts by juries, judges and by licensing board hearings, which often rely on the testimony of expert witnesses. In these hearings attorneys on both sides routinely present conflicting expert testimonies about the standard of care (Gutheil, 1998; Hedges, Hilton, Hilton, & Caudill, 1997). The fact that there are hundreds of different psychotherapeutic orientations (Lambert, 1991) and as many different types of settings, communities, cultures and subcultures, make the concept of a psychotherapeutic standard of care extremely complicated and controversial (Caudill, 2004; Williams, 1997). It seems that beyond "do no harm," "do not engage in sexual relationships with current clients" and "preserve clients' dignity and protect their privacy when possible," there is very little agreement on what falls within the accepted understanding of standard of care.

The standard of care is a legal term and has been defined as the customary professional practice in the community. It describes the qualities and conditions that prevail or should prevail in a particular (mental health) service and that a reasonable or average practitioner follows. Most commonly, the standard is defined in legal terms as, "that degree of care which a reasonably prudent person would exercise in the same or similar circumstances" (Black, 1990, p. 1405). As a legal term, the standard of care is subject to state laws and, accordingly, the official definition of the standard of care varies somewhat from state to state. Massachusetts case law, for example, defines the standard of care as, "the average reasonable practitioner at that time and under the circumstances and taken into account the advances in the field" (Gutheil, 1998, p. 44). The standard of care is thus largely a standard of reasonable care and thus is a professional duty of psychotherapists to their clients once the therapist-patient relationship has been established (Simon, 2001). Several scholars emphasized that the standard is based on community and professional standards, and as such, professionals are held to the same standard as others of the same profession or discipline with comparable qualifications in similar localities (Bersoff, 2003; Caudill, 2004; Doverspike, 1999; Woody, 1998).

It is very important to understand that the standard of care is a minimum and reasonable standard. It is neither an ideal standard nor a standard of perfection (Gutheil, 1998). It calls on practitioners to act in a reasonable, average or "good enough" manner rather than in ideal or perfect ways. An error in judgment or simply making a common, careless mistake does not automatically put a therapist's actions below the standard of care (Simon, 2001). However, making a careless mistake or several careless mistakes that probably would not have been made by reasonable practitioners does put a therapist below the standard of care. Gross negligence, which is an extreme departure from the standard of care, has been differentiated from a simple departure from the standard and from common or normal, unavoidable mistakes or errors in judgment.

Basic Elements of the Standard of Care

The standard of care is derived from the following six elements: State law, Licensing board regulations; Professional organization codes of ethics; Case laws; Consensus of the professionals; and Consensus in the community.

Statutes

Each state has many statutes, such as Child Abuse, Elder Abuse, Domestic Violence Reporting and other laws. If the statute mandates that therapists do not act or should act in a certain way, such as reporting a suspicion of child abuse, acting against that prohibition, or neglecting to so act, is clearly below the statutory standard of care.

Licensing board regulations

In most states there are extensive regulations governing many aspects of mental health practices. These often include rules for continuing education, supervision, etc. Some licensing boards have adopted numerous additional regulations that range from how to engage in e-counseling or telehealth, to how to respond to a client who discloses in therapy that he or she had sexual relations with a former therapist. In all states and in The District of Columbia, there are strict regulations against a therapist having sexual relationships with a current psychotherapy client.

Ethical codes of professional association

The codes of ethics of professional associations are another important component of the general standard of care. However, they are also controversial in regard to the standard of care. In most situations codes of ethics of professional organizations apply to members and non-members of the professional association. APA (2002), NASW (1999), ACA (2005) and AAMFT (2001) ethical principles apply to all licensed psychologists, social workers, counselors and marriage and family therapists, respectively, regardless of whether they are members of the organizations or not, unless there is a state law or board regulation stating otherwise. Some states adopted other professional organizations' codes of ethics as their standard. An example is California Board of Behavioral Sciences (CA-BBS), which regulates California Marriage and Family Therapists (MFTs), adopted the California Marriage and Family Therapists Association (CAMFT) code of ethics as their standard rather than AAMFT code of ethics.

Translating most codes of ethics, licensing board regulations or using them to clarify the standard of care can be a complex and challenging task. The codes are generally not specific about which behaviors are prohibited, and most codes include aspirational goals, which must be viewed differently than the enforceable ones (Bersoff, 1994; Fleer, 2000; Williams, 2003). While many state licensing boards have adopted the codes of ethics of major professional organizations as their enforceable guidelines, the APA Ethics Code of 2002 clearly states, "The Ethics Code is not intended to be a basis of civil liability" (p. 1061). In other words, the codes of ethics are not supposed to be simply equated with the standard of care, which is the basis for civil liability.

Another area of uncertainty is whether practitioners who practice in a more specialized field, or present themselves as specialists, are to be held not only to national professional organization ethical standards (i.e., AAMFT, ACA, APA, NASW, NBCC) but also to standards put forth by their specialty (i.e., child custody evaluation, forensic psychology), specialized professional association (i.e., US Association of Body Psychotherapists (USABP), Academy of Sports Psychology) or institution they are closely affiliated with (i.e., Jung Institute of San Francisco, Gestalt Institute of Los Angeles, The Reichian Institute of Sacramento).

Case law

Case law is one of the cornerstones of the standard of care. No case is more famous for having created a duty (to warn) for psychotherapists than the Tarasoff decision of the California Supreme Court in *Tarasoff v. Regents of the University California* (1976).

Consensus of the professionals

In a field that is comprised of hundreds of therapeutic orientations and even more jurisdictions, consensus among professionals is hard to come by. Thus, it follows that consensus among professionals is a rather vague aspect of the standard of care. It is primarily derived from a wide range of diverse professional publications (Younggren & Gottlieb, 2004), professional association guidelines and presentations at professional conferences. An additional complexity of this part of the standard is what has been called the "respectable minority." This doctrine may apply when there is significant support for a certain type of treatment of a certain disorder, or if the scientific or research support of the technique is not well established (Reid, 1998, Simon, 2001).

Consensus in the community

While some scholars emphasize the general, unified or global aspects of the standard of care across settings, others emphasize the importance of community, local culture and setting in determining the standard. Following the latter line of thought, consequently, different setting and communities, which abide by different cultural customs and values, have different standards. For example the exchange of gifts and attending ceremonies and rituals are normal and expected in Hispanic or American Indian communities but not necessarily in an upper class suburban clinic (Lazarus & Zur, 2002; Zur, 2001). Complex dual relationships between therapists and clients are inherent, and, in fact, mandated by law, in the military and are common in rural areas but are infrequent in urban areas (Zur, 2007).

What the Standard of Care is Not

The standard of care has often been viewed in several inaccurate ways, some of which have had a direct implication in understanding the relationship between touch and the standard of care. Following is a non-exhaustive list of what the standard of care is not:

It is not a standard of perfection.

It is the standard based on the average practitioner and on reasonable or “good enough” actions. Caudill (2004) describes it as a ‘C’ student’s standard. Simply making a common or ordinary mistake or common error in judgment does not automatically put a therapist’s actions below the standard of care (Simon, 2001).

It is not an either/or standard.

Compliance or non-compliance with the standard of care has gradations or shades of deviation from the standard. Most commonly, three terms have been used to describe the range of practices: gross negligence; simple departure from the standard of care; and mistakes or errors in judgment. Gross negligence has often been defined as an extreme departure from the ordinary standard of practice in the community. Gross negligence often involves a pattern of systematic and/or extreme departure from the minimum and reasonable standard of practice. Gross negligence is almost always one of the key components of malpractice suits and licensing board hearings. The next level, a simple departure from the standard of practice, has been called “ordinary negligence.” The third level, the most common one, is a simple mistake or error in judgment, which is an unavoidable part of human nature and of the practice of psychotherapy and does not constitute departure from the standard of practice.

It is not guided by risk management principles.

One of the most significant errors by expert witnesses, attorneys, courts and licensing boards has been confusing the standard of care with risk management principles (Lazarus & Zur, 2002; Williams, 1997). While the standard is based on legal-professional-communal principles, risk management guidelines are primarily enforced to reduce the risk of malpractice accusations for therapists (Williams, 2003; Gutheil & Gabbard, 1993; Zur, 2007). While the standard of care focuses on what is good for the patient, risk management guidelines have come to focus, too often, on preemptive protection of therapists and reducing insurance companies’ financial liability.

It does not follow any particular therapeutic modality or theoretical orientation.

The standard of care is theoretically blind and philosophically neutral. It is not based on psychiatric, biological, analytic or any other therapeutic modality or theoretical orientation. Attorneys and experts have often presented the psychoanalytic guidelines as the basis for the standard of care (Williams, 1997). Gutheil (1989) accurately pointed out: “It seems that professionals who belong to a school of thought that rejects the idea of transference, behaviorists, or psychiatrists who provide only drug treatment, are being held to a standard of care they do not acknowledge” (p. 31).

It is not determined by outcome.

Interventions by therapists who do not violate the law or board regulations and utilize “good enough” decision-making processes are most likely to fall within the standard of care, even if the outcome is negative. An unfortunate outcome, such as

suicide, divorce or depression, does not necessarily translate to substandard care (Baerger, 2001; Simon, 2001).

It is not permanent or fixed.

The standard of care is a dynamic standard that continues to evolve over time. Obviously, new statutes and new case laws change the standard. Then, as more practitioners practice in new or modified ways, the standard changes, too. HIPAA law is an example of how new regulations, significantly, impact the standard of care (Zur, 2005). The continuously revised professional ethics codes, publication of new research findings, new practice guidelines or new theoretical breakthroughs all can affect the standard.

Touch in Psychotherapy

The importance of touch for human development, communicating, bonding and healing has been scientifically studied and documented for the last half century by culturally iconic figures, such as Bowlby (1952), Harlow (1971) and Montagu (1986) and more recently by Tiffany Field (1998, 2003). Ample research has demonstrated that tactile stimulation is extremely important for development and maintenance of physiological and psychological regulation in infants, children and adults (Field, 1998, 2003; Heller, 1997; LaPierre, 2006). Touch has been an essential part of ancient healing practices and is reported to have been an integral part of health care practices and medicine since the beginning of time (Levitan & Johnson, 1986; Smith, et al., 1998). In his seminal work, *Touching: The Human Significance of the Skin*, Ashley Montagu brings together a vast array of studies shedding light on the role of skin and physical touch in human development. He goes on to illuminate how the sensory system, the skin, is the most important organ system of the body. "Among all the senses," Montagu states, "touch stands paramount" (1986, p. 17), and he concludes: "When the need for touch remains unsatisfied, abnormal behavior will result" (1986, p. 46). Indeed, touch deprivation has been consistently linked to aggression, delinquency, social isolation and depression in children and adults (Field, 2003).

Recent research has demonstrated that touch triggers a cascade of chemical responses, including a decrease in urinary stress hormones (i.e., cortisol, catecholamines, norepinephrine, epinephrine) and an increase in serotonin and dopamine levels (LaPierre, 2006). The shift in these bio-chemicals has been proven to decrease depression (Field, 2003). Touch is, obviously, good medicine. It also enhances the immune system by increasing natural killer cells and killer cell activity, balancing the ratio of cd4 cells and cd4/cd8 cells. The immune system's cytotoxic capacity increases with touch, thus helping the body maintain its defense against pathogens (Field, 1998).

The utility of psychotherapeutic touch has been extensively documented. Generally, touch has been reported to effectively reduce stress, anxiety, dissociation and depression, and can be very effective in the treatment of Post Traumatic Stress Disorder. It has also been repeatedly reported that touch in therapy positively influences bonding between therapists and clients and increases the therapeutic alliance, the best predictor of positive therapeutic outcome. At this point we must differentiate between 'therapy' and 'psychotherapy'. While there are many therapies that legitimately involve touch, like physiotherapy and massage, they are not considered psychotherapy. Accordingly, the focus of this paper is on psychotherapy or counseling. Obviously, psychotherapy, per se, does not necessarily involve touch even though most therapists (85%) hug their clients rarely or sometimes (Pope et al 1987) and almost all shake hands with their clients (Smith, et al., 1998). Body psychotherapy defines itself as involving the potential for appropriate professional touch (Young, 2005) and, accordingly, most body psychotherapists are specifically trained to employ touch as part of psychotherapy.

While review of the literature of the effectiveness of touch in mental health services is beyond the scope of this paper, extensive reviews of the research on touch can be found in the works of Durana (1998), Field (2003), Heler (1997) Hunter & Struve (1998), May (2005), Marten (2006), McNeil-Haber (2004); Nordmarken and Zur (2004), Smith, et al., (1998) and Young (2005).

In this article touch refers to any physical contact occurring between a psychotherapist and a client or patient in the context of psychotherapy. Generally, there are three types of touch in psychotherapy: touch that is used as an adjunct to verbal psychotherapy, systematic touch that is used by specially trained body psychotherapists, and inappropriate touch. Following are detailed descriptions of the three types of touch in therapy.

The first type of touch

The first type of touch includes touch employed as an adjunct to verbal psychotherapy. These forms of touch are intentionally and strategically used to enhance a sense of connection with the client and to sooth, greet, relax or reassure the client. Their use is also intended to reduce anxiety, slow heartbeat, physically and emotionally calm the client, or assist the client in moving out of a dissociative state. It also includes culturally appropriate touch. Therapeutic touch, in this context, most often includes a hug, light touch, handholding, or rubbing and the places of contact are usually on a client's back, shoulder or arm. Based partly on formulations by Downey (2001), Nordmarken and Zur (2004), Smith, et al., (1998) and Zur (2007) these forms of touch may fall under the following categories:

- **Ritualistic or socially accepted gestures for greeting and goodbye or arrival and departure:** These gestures figure significantly among most cultures and include handshakes, a greeting or farewell embrace and other culturally accepted gestures.
- **Conversational marker:** This form of light touch on the arm, hand, back or shoulder is intended to make or highlight a point and can also take place at times of stillness, with the purpose of accentuating the therapist's presence and conveying attention.
- **Consolatory touch:** This important form of touch, holding the hands or shoulders of a client or providing a comforting hug, is most likely to enhance therapeutic alliance.
- **Reassuring touch:** This form of touch is geared to encouraging and reassuring clients and usually involves a pat on the back or shoulder.
- **Playful touch:** This form of touch, mostly of hand, shoulders or head, may take place while playing a game with a child or adolescent client.
- **Grounding or reorienting touch:** This form of touch is intended to help clients reduce anxiety or dissociation by using touch to the hand or arm or by leading them to touch their own hand or arm.
- **Task-oriented touch:** This involves touch that is merely ancillary to the task at hand, such as offering a hand to help someone stand up or bracing an arm around a client's shoulders to keep the client from falling.
- **Corrective experience:** This form of touch may involve the holding of an adult or rocking of a child by a therapist who practices forms of therapy that emphasize the importance of corrective experiences.
- **Instructional or modeling touch:** Therapists may model how to touch or respond to touch by demonstrating a firm handshake, holding an agitated child or responding to unwanted touch.
- **Celebratory or congratulatory touch:** The therapist may give a pat on the back or a congratulatory hug to a client who has achieved a goal.
- **Experiential touch:** This form of touch usually takes place when the therapist conducts an experiential exercise, such as teaching gestures during assertiveness training or in family sculpturing, in which family members are asked to assume certain positions in relationship to each other.
- **Referential touch:** This is often done in group or family therapy when the therapist lightly taps the arm or shoulder of a client, indicating that he or she can take a turn or be silent.
- **Inadvertent touch:** This is touch that is unintentional, involuntary and unpremeditated, such as an inadvertent brush against a client by the therapist.
- **Touch intended to prevent a client from hurting him- or herself:** This type of touch is intended to stop self-harming behaviors, such as head banging, self-hitting or self-cutting.
- **Touch intended to prevent someone from hurting another:** This form of touch is intended to stop or restrain someone from hurting another person, as sometimes happens in family, couple or group therapy, or when working with extremely volatile clients.
- **Touch in therapist's self-defense:** This form of touch is used by a therapist to physically defend himself or herself from the assault of a violent client by using self-defense techniques that restrain clients with minimum force.

(Zur, 2007, p. 173-174)

The second type of touch in therapy includes:

- **Therapeutic touch by body psychotherapists:** This is different than the use of touch as an adjunct to verbal psychotherapy. Most somatic and body psychotherapists, who are specially trained in these modalities, regularly use touch as part of their theoretically prescribed clinical interventions and these psychotherapies can include Reichian (LaTorre, 2005; Reich, 1972), Bioenergetics (Lowen, 1958), Somatic Experiencing (Levine & Frederick, 1997), Rubinfeld Synergy, Hakomi, Biodynamic Psychotherapy, Biosynthesis, amongst the many other modalities described by Barshop (2005), Aposhyan (2004) and others. The history of body psychotherapy has been reviewed by Young (1997) and the definition articulated by United States Association of Body Psychotherapy (USABP) (2006) and European Association of Body-Psychotherapy (EABP) (2006).

The third type includes inappropriate forms of touch, and is in contrast to the aforementioned forms of touch. The following three forms of touch in psychotherapy are unethical, considered as boundary violations and, depending on the state, often illegal (Smith, et al., 1998; Zur, 2007). They are counter-clinical and should always be avoided. They include:

- **Sexual touch.**
- **Hostile or violent touch.**
- **Punishing touch.**

While this paper focuses on touch that is initiated by the therapist, it is quite usual for clients to initiate touch. Most common client initiated touch is a handshake. McNeil-Harber (2004) discussed touch that is initiated by children-patients

usually differentiates between aggressive or oversexualized, inappropriate touch and appropriate touch. When a client initiates or requests touch, the therapist must use his or her clinical judgment to ascertain whether providing or withholding touch is ethical, and if it is clinically advantageous in each therapeutic situation.

In summary, touch has been indisputably important for human development, bonding and healing. Touch is being extensively employed in a variety of ways as an adjunct to verbal psychotherapy and in many long established and well researched body psychotherapy modalities.

Therapeutic Touch and the Standard of Care

With the demystification of the standard of care and the summary of the general issues involved in psychotherapy, it is now appropriate for a discussion of the specific application of the elements that comprise the standard of care to non-sexual touch in psychotherapy. As sexual touch between therapists and current clients is always unethical and illegal in most states, the discussion below, like the focus of this paper, is on non-sexual touch.

When it comes to the standard of care, it is very clear that there are neither statutes nor licensing board regulations nor ethics codes of any major professional association that prohibit non-sexual, clinically appropriate touch. State and federal laws, licensing board regulations and professional organization codes of ethics do not even mention, to say the least, regulate or prohibit non-sexual, ethical therapeutic touch. As was noted above, state and federal laws, board regulations and codes of ethics are all modality neutral. Therefore, the applications of touch as an adjunct to verbal psychotherapy (e.g., supportive touch at times of distress, appropriate hug at the end of a session) are treated by federal and state laws, licensing boards or codes of ethics no differently than any other appropriate boundary crossing (e.g., self-disclosure, gifts). Similarly, somatic and body psychotherapy interventions (e.g., Bioenergetics, Orgonomy, Somatic Experiencing) are treated by federal and state laws, licensing boards and codes of ethics no differently than any other therapeutic technique (e.g., Cognitive-behavioral, Gestalt).

Evaluating the issue of case law is highly complicated when it comes to touch in therapy. The main reason for this is that experts testifying for plaintiffs have often erroneously argued that non-sexual touch is likely to lead to sexual touch and, therefore, is below the standard of care. (Zur, 2007) Another common erroneous argument has been the fact that patients who have reported they were aroused by a therapist's touch meant that the touch-intervention was below the standard of care (Williams, 2000). While the former argument is based on the fallacious slippery slope argument, the latter one erroneously claims that therapists are to be judged by the outcome of treatment rather than by the process of decision-making and adherence to laws and regulations. To my knowledge there has not been any case law that mandated the avoidance of all non-sexual touch in therapy.

The standard of care element that refers to consensus among professionals is highly relevant to therapeutic touch. As was cited above, there is a vast body of literature that supports the importance of touch as an adjunct to verbal psychotherapy (see summaries in Fields, 2003; Hunter & Struve, 1998; Smith, et al., 1998) and as a discipline of its own, as embodied in body psychotherapy. The "respectable minority" provision discussed above is also highly relevant to touch in therapy as it establishes that the many less established and less researched varieties of body psychotherapy, and the many forms of ethical touch, which is employed as an adjunct to verbal psychotherapy, do not necessary fall below the standard of care.

The part of the standard of care that states that it is also bound by community norms is also applicable to touch in psychotherapy. Practicing in certain Latin, African American, French or Jewish communities or rehabilitation centers often involves culturally or community-appropriate touch between therapists and clients. A full-body hug, or a peck on both cheeks ("European kiss") is often the culturally appropriate greeting ritual within these communities or settings. This element of the standard of care clearly establishes that different settings and communities, which abide by different cultural customs and values, often have different standards including different therapeutic standards of care in regard to touch. For example, extensive physical touch may be employed in adventure therapy or sport psychology. The community standard is also applied where therapists are working in certain settings that focus on somatic or body psychotherapy. For example, therapists who practice in training institutions that focus on Reichian therapy or Somatic Experiencing are likely to use these touch-based techniques extensively. To comply with these professional standards, special informed consent forms in regard to touch may be asked for from clients in such settings.

As was discussed above, the standard is neither guided by risk management principles of avoiding touching a client beyond a handshake, nor by the physically distanced approach of the psychoanalytically based modalities. Therefore, risk management and analytic yardsticks are not applicable to appropriate, ethical and clinically driven therapeutic touch.

Highly relevant to the issue of touch is the fact that the standard of care is not determined by outcome. Like the example above, where a client's suicide does not necessary mean that the therapist operated below the standard of care, a client's sexual feelings in response to a therapist's touch does not necessarily mean that the therapist was engaged in sexual touch. What is relevant to the standard of care is the therapist's clinical rationale for the touch, the client's consent, as well as the clinically appropriate evaluation of the impact of the touch and the therapist's appropriate follow up. Also relevant is the therapist's ethical decision-making process that led to the touch and understanding how the touch fits within the original treatment plan. In other words, the sheer fact that a client felt sexually aroused does not mean that the therapist operated below the standard of care. As with any other intervention, it is the responsibility of the therapist to conduct competent evaluation of the effect of the touch by observing the client, asking the client for feedback or by other means. If a therapist realizes that the touch resulted in unintended sexual arousal, it is his or her responsibility to attend to that in a clinically appropriate manner.

This may include discussing it with the client, stopping or changing the touch, or other clinically appropriate responses.

Ethics of Touch

The question of the ethics of touch has often been raised in relation to therapeutic touch. As with the APA Ethics Code (American Psychological Association, 2002), ethics codes of all major psychotherapy professional associations, such as American Association for Marriage and Family Therapists (AAMFT, 2001), American Counseling Association (ACA, 2005) National Association of Social Workers, (NASW, 1999), neither specifically mention nor prohibit the use of appropriate, non-sexual touch in therapy. All psychotherapy professional codes of ethics view sexual touch with a current client as unethical. The answer to whether touch is ethical is simple and clear: clinically appropriate touch in psychotherapy is neither unethical nor below the standard of care.

Historically, unethical sexual touch in therapy received extensive attention (i.e., Pope, 1990; Pope, Sonne, & Holroyd, 1993; Rutter, 1989; Simon, 1994), but towards the turn of the 20th century and into the 21st century increased numbers of publications have attended to the ethics of touch (i.e., Durana, 1998; Herlihy & Corey, 2006; Hunter & Struve, 1998; Marten, 2006; McNeil-Haber, 2004; Nordmarken & Zur, 2004; Smith, et al., 1998; White, 2002; Young, 2005; Zur, 2007). These publications discuss the importance of taking into consideration client factors, such as history of abuse, gender, culture, attitude towards touch, presenting problem, as well as the setting of therapy, therapeutic modality employed, nature of the therapeutic relationship and therapist's training, culture, gender and attitude towards touch. Appropriate use of consultation and client consent is also emphasized.

Obviously, the ethics of touch has received the most extensive coverage in the Ethical Guidelines of the U.S. Association of Body Psychotherapy (USABP, 2001). It clearly articulates the ethical guidelines for the use of touch in therapy, the importance of informed consent and concerns with respect, diversity, consultation, record keeping, treatment plans and many other pertinent issues for ethical touch in psychotherapy. Most body psychotherapists use actual touch as their primary tool in psychotherapy, and, therefore, an extra focus on the ethics of touch is called for in their therapist's training (Caldwell, 1997; Durana, 1998; LaPierre, 2003; Phillips, 2002; Smith, et al., 1998; Young, 1997).

Partly in respond to testimonies by psychoanalytically oriented and risk management expert witnesses against boundary crossing in general, including testimonies disparaging clinically appropriate and ethical touch, APA Ethics Code of 2002 introduced a much-needed clarity to the issues when it provided a definition of "reasonable." In the Introduction and Applicability section it states:

The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably*, *appropriate*, *potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time. (p. 162)

Clearly, one of the intentions of this statement is this: no longer will courts and licensing boards, who define the standard of care, use any one particular modality or orientation as the yard stick, and by which measure interventions that are rooted in other disciplines: this means analytic or risk management principles legitimately may not apply to a body psychotherapy situation. The APA statement acknowledges that some clinical situation boundary crossings, such as gifts, bartering or dual relationships, may be appropriate, clinically beneficial and unavoidable. This statement is as relevant to touch in psychotherapy and clearly implies that the evaluation of the appropriateness of touch in therapy must be according to the ". . . prevailing professional judgment of psychologists engaged in similar activities in similar circumstances . . ." which means the "prevailing professional judgment" of other psychologists who use touch with similar client populations and in similar settings. For the first time this paragraph actually makes it unethical for a testifying psychologist-expert to use psychoanalytic, psychopharmacological or other therapeutic orientations to determine that clinically appropriate and ethical touch, supported by other established orientations, is below the standard of care.

Risk Management Practices, Slippery Slope Claims, Sexualization of Touch, and Risk-Benefit Analysis

At the core of the risk management injunction against touch in psychotherapy is an assumption about a 'slippery slope.' This refers to the idea that failure to adhere to hands-off, rigid standards, will most likely lead to therapist-client sexual relationships. This process is described by Gabbard (1994) as follows: ". . . the crossing of one boundary without obvious catastrophic results (making) it easier to cross the next boundary" (p. 284). This fear-based view has been most dominant in the discussion of employing or incorporating touch in psychotherapy as it asserts that a pat on the back, hand-holding, non-sexual supportive or a greeting hug are all just the first downhill steps towards inevitable deterioration of ethical conduct and towards sexual relationships. Pope (1990), whose endorsement of the slippery slope idea has significantly contributed to its

popularity, stated: ". . . non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships" (p. 688). Similarly, Strasburger, Jorgenson, & Sutherland (1992) conclude, "Obviously, the best advice to therapists is not to start (down) the slippery slope, and to avoid boundary violations or dual relationships with patients." (p. 547-548). Also in agreement is Simon (1991), who decrees: "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself" (p. 614). These poignant restrictive statements summarize the slippery slope idea and its derivative risk management stance that the chance of exploitation and harm is significantly reduced or nullified by simply refraining from engaging in any boundary crossing, including any form of non-sexual touch, regardless of its clinical effectiveness. This is a false argument and contains an unproven non-sequitur.

A careful review of the 'slippery slope' argument reveals that it is founded primarily on the (somewhat paranoid) assumption that any boundary crossing, however trivial, inevitably leads to boundary violations and sex (Lazarus & Zur, 2002; Zur, 2007). The slippery slope argument claims to get support from the fact that most sexual exploitations of clients have started with non-sexual or ethical boundary crossing. Whilst it may be true that abusive therapists might have introduced themselves with a handshake, it does not follow that this leads to sexual relationships, and a vastly significant number of therapists have also introduced themselves with a handshake, to no ill effect.

Furthermore, to assert that self-disclosure is likely to lead to social relationships, that an appropriate hug is most likely to end with intercourse, or accepting a gift is the first step towards inevitable inappropriate business relationships is irrational and illogical. Sonne (1994) discusses how a therapist and client who are sport teammates can easily move their relationship to encompass activities, such as carpooling or drinking. She concludes that, "With the blurring of the expected functions and responsibilities of the therapist and client comes the breakdown of the boundaries of the professional relationship itself" (p. 338). Along these lines Woody (1998) asserts, "In order to minimize the risk of sexual conduct, policies must prohibit a practitioner from having any contact with the client outside the treatment context and must preclude any type of dual relationships" (p. 188). The risk management literature is saturated with articles and books describing therapists' behaviors (e.g. self-disclosure, hugs, home visits, socializing, longer sessions, lunching, exchanging gifts, walks, playing in recreational leagues) that the authors contend are precursors to or are on the slippery slope to sexual or other harmful dual relationships (Borys & Pope, 1989; Craig, 1991; Koocher & Keith-Spiegel 1998; Lakin, 1991; Pope, 1990; Pope & Vasquez, 2007; Rutter, 1989; St. Germaine, 1996).

The belief in the slippery slope is a part of the more widespread cultural and professional problem, which includes risk management experts' tendency to sexualize boundaries in general and touch in particular (Dineen, 1996; Zur, 2007). This so-called 'prudence' is akin to prudery, where the sin lies more in the eye of the beholder than in the mind of the enactor. It must be challenged wherever it tries to circumscribe. But there is also a wider issue, why do touch taboos exist and why is there such touch illiteracy. Field (2003) notes that social attitudes to touch have changed, from the 'laying-on' of hands (common in the Bible, Middle Ages and still found in some religions), to touch becoming sexual in the 19th century (as everything was, even the sight of a woman's ankle), to touch being now "more associated with criminality is increasingly frequent court cases on sexual harassment, sexual abuse, child-care hysteria and kindergarten and lower grade teachers' avoidance of any form of touch beyond a handshake.

When it comes to touch in therapy, the slippery slope idea basically claims that there is no meaningful differentiation between non-sexual touch and sexual touch because one inevitably or very likely leads to the other. Again, there is little real evidence put forward for this claim. In a critical examination of the slippery slope argument, Zur (2000) reflects that to assert, as most proponents of the slippery slope idea do, that self-disclosure, a home visit, a hug or accepting a gift are actions likely to lead to sex is like saying that doctors' visits cause death because most people see a doctor before they die. Lazarus calls this thinking "an extreme form of syllogistic reasoning" (1994, p. 257). We learn in school that sequential statistical relationships (correlations) cannot simply be translated into causal ones. Despite the popularity of the term, the 'slippery slope' is a paranoid, baseless and illogical construct claiming that any deviation from risk management or rigid analytic guidelines is likely to lead to harm, exploitation and sex.

While all risk management and most ethics texts appropriately emphasize the important risk-benefits analysis for touch or any other clinical intervention, very few address the risk-benefits analysis of "in-action" or the avoidance of certain interventions (Zur, 2007). While risk-management focus is, obviously, on risk avoidance and most ethical decision-making processes emphasize the risk-benefits analysis of touching, rarely mentioned is the equally important risk-benefit analysis of avoiding touch at all cost. Along these lines the author has reflected on his experience of avoidance of touch at all cost:

For example, I have been working with a woman who, 10 years prior to our first session, lost her infant son in an automobile accident. In an emergency appointment with a psychiatrist right after the death of her son, as she sobbed uncontrollably, she begged him to hold her. He refused, citing something about professional boundaries. Instead, he prescribed Valium. Eight years later, addicted to Valium and alcohol, she began therapy with me. After an intense few months of therapy, we visited her son's grave. It was the first time she had visited the grave. There we stood, holding each other and both weeping as she finally started facing her baby's death and grieving for him and for her years lost in drugged denial. While the psychiatrist followed risk management guidelines to perfection, he also may have inflicted immense harm. Did he sacrifice his humanity and the core of his professional being, to heartless protocol? (Nordmarken & Zur, 2004)

Risk-benefit analysis of actions or inactions brings to the forefront the contexts of therapy (i.e., client factors, setting, therapy and therapist factors). Such risk-benefits must be included in treatment planning for the use of touch or any other interventions. The rarely acknowledged fact is that all clinical interventions also contain risk. As a matter of fact, any human action as well as any human inaction is associated with some level of risk. Therefore, a thorough risk-benefit analysis does not

simply reject boundary crossings, such as touch, because it involves risk, instead they invite therapists to ask the question, “Do these risks outweigh the benefits?” or “Are these risks justified?” Therapists must always take into consideration that they can actually *do* harm through inaction and the avoidance of touch in the attempt to avoid harm (Fay, 2002; Lazarus & Zur, 2002).

When it comes to risk management in regard to touch, the question then becomes, “*what can be done to reduce any inherent risks to a reasonable and appropriate level?*” The ‘solution’ to the ‘problem’ (which exists in a very small minority of therapists, and thus the risk is very small) is not to restrict all therapists by penalizing codes, but simply to ensure they are educated better and aware of appropriate boundaries, and perhaps even supervise them a little more regularly.

There is an additional sociological question, “*Why are behaviors and interventions, such as touch, that are known to be clinically helpful, as well as very natural elements of human interaction, being looked at as suspicious and driven underground?*” The answer lies partially in the concept, practice and teaching of defensive medicine or risk management. Reflecting on the analytic touch taboo, Lapierre asserts, “From this perspective, the touch taboo and the resulting touch illiteracy limit our psychotherapeutic horizons and rob us of effective, perhaps critical, forms of clinical reparation interventions and interactive couple and caregiver education” (2003, p. 5). This paper demonstrates that from a standard of care point of view ethical touch, which is based on a thorough risk-benefit analysis and is a result of a sound ethical decision making process, inevitably falls within the standard of care.

Touch in Context

The clinical application of touch in psychotherapy can only be understood within the context of the therapy. Accordingly, whether therapeutic touch falls within the standard of care, or not, can also be understood within the context that it is employed. Touch, when viewed through the prism of client factors, therapeutic setting, therapeutic orientation, therapeutic relationship and therapist factors, can have radically different contextual meanings (Hedges, et al., 1997; Koocher & Keith-Spiegel, 1998; Phillips, 2002; Smith, et al., 1998; Young, 2005; Zur, 2007).

Former APA president and leading ethicist Gerry Koocher provides a vivid example of how professionals tend prematurely to judge touch and other boundary crossings without taking the context into consideration.

On occasion I tell my students and professional audiences that I once spent an entire psychotherapy session holding hands with a 26-year-old woman together in a quiet darkened room. That disclosure usually elicits more than a few gasps and grimaces. When I add that I could not bring myself to end the session after 50 minutes and stayed with the young woman holding hands for another half hour, and when I add the fact that I never billed for the extra time, eyes roll.

Then, I explain that the young woman had cystic fibrosis with severe pulmonary disease and panic-inducing air hunger. She had to struggle through three breaths on an oxygen line before she could speak a sentence. I had come into her room, sat down by her bedside, and asked how I might help her. She grabbed my hand and said, “Don’t let go.” When the time came for another appointment, I called a nurse to take my place. By this point in my story most listeners, who had felt critical of or offended by the “hand holding,” have moved from an assumption of sexualized impropriety to one of empathy and compassion. (2006, p. xxii)

Following are descriptions of the five factors that can help to define the relationship to touch in the context of therapy.

Client factors

This factor includes client’s age, gender, presenting problem, diagnosis, personality, personal touch history, culture and class. They are all highly relevant to the meaning and potential healing effect of touch in therapy. What is particularly appropriate and effective with one client may be clinically inappropriate and even damaging with another. Letting a young child jump into the therapist’s lap in the midst of family therapy may be very appropriate, but it is generally not permissible with an adult client. Reaching out gently and respectfully to hold the hand of a grieving mother may not have the intended positive effect if the same is done in early stages of therapy with a survivor of sexual abuse. The client’s past experiences with touch are important and so are their present attitudes towards touch. Elements of personal space are defined within a culture and affect the interpretation of therapeutic touch. In this context a therapist’s touch, or lack of touch, may be seen as distant, respectful or invasive depending on the socialization, culture and experience of the individual client (Aponte & Wohl, 2000; Smith, et al., 1998; Sue & Sue, 2003).

Gender issues are also extremely important in understanding the context of touch. Touch in psychotherapy occurs between therapists of both sexes and their female and male clients as well as same-sex therapist-client dyads (Brodsky, 1985). Research has confirmed that women respond more positively to touch than do men (Hunter & Struve, 1998). From birth, American females receive more affectionate touch from males, and females are given greater permission to touch either gender and be touched by either gender. They are more likely to have and expect a broader repertoire of touch, and they are less likely than men to perceive sexual intent in men when touched by them (Downey, 2001; Smith, et al., 1998). The use of

touch with survivors of childhood trauma has been much debated. Whereas some authors assert that touch in any form should never be used with this population, many others agree that the clinically appropriate and ethical use of touch with survivors of childhood abuse, when applied cautiously, can be invaluable in helping them heal and recover from their traumatic experiences. The concern is that there is a possibility that touch used with these clients may recreate, evoke or retraumatize previous client-experienced dynamics of victimization (Lawry, 1998). Cornell (1997) stated that once a strong therapeutic alliance has been formed, “the use of touch will evoke, address and hopefully help correct such historical experiences and distortion” (p. 33). What seems to be of the highest importance is that the client must want to be touched and understand the concepts of choice and personal empowerment before it is clinically or ethically appropriate to begin the use of touch in session. Research has also found that sexually abused clients were more likely to attribute a corrective or educative role to touch in therapy than were non-abused clients. Of these clients, 71% reported that appropriate touch repaired self-esteem, trust and a sense of their own power or agency, especially in setting limits and asking for what they need (Smith, et al., 1998).

Consistent with the pattern in the general culture, therapists tend to touch young clients more often than they do their adult clients, and female therapists touch child clients more often than do male therapists (Hunter & Struve, 1998). Research has demonstrated that when the staff of an adolescent treatment program modeled nonsexual, nonviolent touch and incorporated physical contact as an acceptable aspect of the milieu, the adolescents demonstrated a marked decrease in violent and sexual behaviors (Dunne, Bruggen, & O’Brien, 1982). Touch is usually contraindicated for clients who are actively paranoid, hostile and aggressive or who implicitly or explicitly demand touch (Durana, 1998). Most people experience some diminution in physical faculties and perceptual skills as they age, but the sense of touch generally remains intact and is valued as increasingly important as a source of contact and communication. The soothing, affirming experience of touch is most important at the beginning and end of one’s life and generous, nurturing touch can gently facilitate the process of aging and dying with dignity (Hollinger, 1986).

Setting factor

The setting of therapy is profoundly important in evaluating the efficacy and meaning of touch. Some settings, such as prisons, are likely to restrict touch, whereas clinics for children or hospice are likely to encourage it. Obviously, sport psychology, adventure therapy, such as rope courses or flying trapeze, and adolescent programs that involve sports and camping, often involve extensive forms of touch (Zur, 2007). Practicing in different cultural milieus is likely to result in different attitudes and use of touch. Latino or Middle Eastern clients are likely to endorse and expect physical touch more than Northern European, Japanese or North American clients (Smith, et al., 1998). With levels of class and authority, it often moves from higher to lower; that is, a higher ranking individual may initiate touch of a subordinate but not vice versa. The same is true of male-to-female interaction in some societies (Halbrook & Duplechin, 1994). Touch, as an aspect of group therapy or in a therapeutic community, is probably more accepted and more often found than in one-to-one therapy.

Therapeutic Relationship (therapeutic alliance) factors

The therapeutic relationship between therapists and clients, or the nature and quality of the therapeutic alliance, are among the most important factors determining the potential efficacy of the use of touch in therapy. A therapist-client relationship of trust and of long duration is more likely to create a familiar and safe context for effective use of touch in therapy. In contrast, a shorter or conflictual or confrontational relationship is less likely to be conducive to it. The relationship between touch and the therapeutic alliance seems to be bidirectional, as appropriate and “in-tune” touch significantly enhances positive therapeutic alliance (Horton, et al., 1995; Smith, et al., 1998) and, in return, creates a further atmosphere of trust and the possibility of the further use of clinically appropriate touch. Given that most research studies indicate that the therapeutic alliance is one of the most significant factors in respect of efficacy, one can then argue that, where appropriate and enhancing, touch can be seen as a significant factor in promoting the alliance and thus the efficacy of the therapy. It may even follow that ‘lack of touch’ might diminish efficacy and thus standard of care.

Therapeutic orientation

As with any boundary consideration, therapeutic orientation or modality is exceptionally relevant in the clinical usefulness of touch in therapy. Body psychotherapists with clinical orientation, such as Reichian (Reich, 1972) or Bioenergetics (Lowen, 1976), often use touch as their primary tool in psychotherapy. In contrast, most traditional psychoanalysts are generally opposed to any form of touch in therapy (Menninger, 1958; Smith, et al., 1988; Wolberg, 1967). Generally, humanistically oriented therapies are more likely to endorse appropriate, non-erotic touch as they view it as an enhancement of the therapist-client connection (Hunter & Struve, 1998; Williams 1997). Rogers (1970) discussed the value of touch and specifically described how he soothed clients by holding, embracing and kissing them. Gestalt therapy incorporates numerous forms of touch as an integral part of therapy (Perls, 1973). Gestalt practitioners place a special importance on nonverbal communication and nonverbal intervention. Unfortunately, gestalt practices in the 1960s and early 1970s, under

Perls's leadership, went too far and at times included unethical sexual touch in conjunction with therapy (Hunter & Struve, 1998). Family therapists, including Satir (1972), often use touch as an element of engaging clients in therapy (Holub & Lee, 1990). Behavioral and cognitive-behavioral therapists are likely to incorporate touch or any boundary crossing into therapy if it fits with their interventions, such as modeling or reinforcement (Zur, 2007). Orientations, such as feminist and group therapy, support the clinically appropriate use of touch (Milakovitch, 1993; Williams, 1997). A few modern analysts, such as Fosshage (2000), have differed with mainstream analytic doctrine and advocate the incorporation of clinically responsible use of touch in psychoanalytical and psychodynamically oriented therapies.

Consistent with the theoretical literature, Holroyd and Brodsky (1977) found that humanistic psychologists were more likely to engage in non-erotic touch than those of other orientations. Similarly, Pope, et al., (1987) reported that therapists of differing theoretical orientations have very different beliefs about the effect and practice of touching clients. They reported that 30% of humanistic therapists indicated that non-erotic hugging, kissing and affectionate touching might frequently benefit clients in psychotherapy. In contrast, only 6% of psychodynamic therapists indicated the same. Whereas most psychodynamic therapists thought touch could be easily misunderstood, humanistic therapists did not share this view. Similarly, Milakovitch (1993) compared therapists who use or do not use touch and reported that therapists who use touch are likely to subscribe to a humanistic theoretical orientation, whereas therapists who do not use touch usually subscribe to a psychodynamic orientation. Clients choosing those therapists might have similar differences.

Therapist Factors

Therapists' culture, age and professional socializations are likely to affect their utilization of clinical touch. Older therapists were professionally socialized to practice with less fear of boundary crossing, are not trained in risk management practices and are more likely to use touch more casually than younger ones whose training included much more focus on risk management and defensive medicine (Williams, 1977). Therapists' own cultural background is very likely to affect their personal comfort with touch and, therefore, its use in the clinical settings. Milakovitch (1993) compared therapists who touch and those who do not touch and found that besides the therapeutic orientation factor, therapists who touch obviously value touch in therapy and believe that gratifying the need to be touched is important. Therapists who do not touch believe that gratifying the need to be touched is detrimental to therapy and the client. Unlike therapists who do not touch, therapists who touch, were more likely to be touched by their own therapists and had supervisors and professors who believe in the legitimacy of touch as a therapeutic tool. Therapists who touch were more likely to experience body psychotherapies as clients than therapists who do not touch.

Gender of therapists (and clients) seems to impact the use of non-erotic touch. Stake and Oliver (1991) found that female psychologists reported more touching of female than male clients. Male psychologists, on the other hand, reported more touching of male clients on the shoulders, arm, hand or knee, but more touching of female clients in ways such as hugging, holding hands, or touching face, hair or neck. These findings seem consistent with Holroyd and Brodsky's (1977) finding that non-erotic touching occurs more frequently in female dyads than male dyads.

Demonstrating Compliance with the Standard of Care

Compliance with the standard of care, in general, as well as with touch issues means that therapists have acted in a professionally reasonable manner and followed community and professional standards as have others of the same profession or discipline with comparable qualifications in similar situations. Due to the professional and public concern with therapeutic touch, demonstrating compliance is very important. One of the primary ways for therapists to demonstrate compliance with the standard of care is accomplished primarily by means of documentation in clinical records (Caudill, 2004; Hedges, 2000; Gutheil, 1998). Good records go hand in hand with quality care.

At the minimum, records for each client, couple or family should include: Diagnosis impression (does not need to be a DSM diagnosis, it can be developmental, familial or other impressions), initial assessment of mental status, details of the presenting problem, relevant biographical background information, treatment planning, including rationale for treatment, and revised treatment plans, as necessary, progress notes and termination notes. When therapists choose not to use widely used, mainstream or standard interventions, they must articulate their clinical rationale for their choice of treatment and demonstrate their awareness and consideration of different treatment options. Extra documentation is often required in cases of emergencies, crisis intervention, violence and abuse situations, mandated reporting, extensive touch, dual relationships and abrupt termination. Signed informed consents might be considered as more important when it comes to body psychotherapy practices and other therapies that employ touch extensively. Finally, consultations on relevant clinical, legal and ethical cases should be utilized when necessary and documented as part of the records (Younggren & Gottlieb, 2004). Consultation with experts is one of the best ways to establish that the standard of care was met (Younggren & Gottlieb, 2004). Such consultations with experts, or regular supervision, allows the psychotherapist to demonstrate that the clinical intervention he or she is engaged in is reported to be similar to what other reasonable psychotherapists would do under similar circumstances.

One way for psychotherapists to evaluate if their conduct is within the standard of care is to ask themselves several questions, such as: Does my conduct violate state or federal law or licensing board regulations? Does my conduct breach an

ethical principle? Is there a court ruling that imposes a duty on me that is relevant to my conduct? What is the best way to help this particular client, taking into consideration the context of the professional relationship? What should I do to help? What should I not do to help? What are the ramifications of not doing certain things? And what would an average peer, who uses a similar theoretical orientation, working with a similar type of client, with a similar diagnosis or problem, in a comparable type of community, say about my conduct? When appropriate, the records should reflect therapist's responses or contemplation of these questions. Many of these questions will also get asked in regular supervision, which in some settings is seen as a useful and necessary adjunct to the therapy.

Ethical decision-making in psychotherapy has received much attention because a thorough decision-making process is the important phase in the development of a treatment plan and essential for demonstrating compliance with standard of care. Many texts have focused on the principles of ethics in psychology (e.g., Beauchamp & Childress, 2001). As with the general principles of the American Psychological Association (2002) Ethics Code, many ethicists view the following five moral principles as the foundation of ethical decision making: *autonomy*, *nonmaleficence* (i.e., do no harm), *beneficence* (commitment to benefit the client), *justice* and *fidelity*. Several texts outline ethical decision-making for psychotherapists as being broad and inclusive (e.g., Canter, Bennett, Jones, & Nagy, 1996; Corey, Corey, & Callahan, 2003; Herlihy & Corey, 2006; Knapp & VandeCreek, 2006). Other texts focused on ethical decision-making and guidelines with regard to boundary crossings (i.e., Corey, et al., 2003; Gutheil & Gabbard, 1993; Herlihy & Corey, 2006; Knapp & VandeCreek, 2006; Koocher & Keith-Spiegel, 1998; Reamer, 2001; Welfel, 2002). Then some others have provided more specific guidelines, such as those for handling nonsexual touch (Durana, 1998; Hunter & Struve, 1998; McNeil-Haber, 2004; Nordmarken & Zur, 2004; Smith, et al., 1998; Zur, 2007) and some explore the whole issue of ethical touch in psychotherapy (Young, 2005; Zur, 2007).

Demonstrating compliance with the standard of care around touch issues is essentially no different than any other intervention. What may be more relevant to the employment of touch is the issue of consent. Consent to minor and intermittent touch, such as pat on the back or a hug at the end of the session, can be implied or achieved verbally or non-verbally if client initiates it or seems to respond positively. Any consistent touch beyond a handshake, such as greeting and departing hugs or hand holding that is repeated in each or most sessions may be documented in the record with a brief note of explanation for its clinical rationale. Systematic employment of body psychotherapy methods requires both signed written consent by client and clear documentation of the methods employed in the clinical records.

Summary

The standard of care is a legal term and has been defined as the customary professional practice in the community. It describes the qualities and conditions that prevail, or should prevail, in a particular mental health service, that a reasonable or average practitioner follows. Most commonly, the standard is defined in legal terms as "that degree of care which a reasonably prudent person would exercise in the same or similar circumstances" (Black, 1990, p. 1405, in Baerger, 2001). It is very important to understand that the standard of care is a minimum and reasonable standard, not a standard of perfection. The standard of care is neither determined by the outcome of therapy, nor is it based on analytic or risk management principles. It calls on practitioners to act in a reasonable, average or "good enough" manner rather than in ideal or perfect ways. The standard of care is derived from the following six elements: State law, licensing board regulations, professional organization codes of ethics, case laws, consensus of the professionals and consensus in the community.

Touch in psychotherapy is a boundary issue. While sexual touch with current clients is boundary violation and always below the standard of care, non-sexual, clinically appropriate touch is a boundary crossing and has wide utility in the treatment of anxiety, depression, trauma and many other mental ailments. Clinically appropriate and ethical touch clearly falls within the standard of care. Clinicians who employ touch in therapy must make sure it is clinically appropriate given the client's history, age, gender, sexual orientation, culture and presenting problem. They also must take into consideration the type of setting, the quality of the therapeutic relationship, their own comfort and attitudes towards touch and, of course, their training and scope of practice. Consulting with experts can be very beneficial and obtaining some form of consent from their clients is ~~very~~ important. When using techniques that involve touch, it is essential to ensure that appropriate training and supervision has been received. Extensive and systematic use of touch may require signed written informed consent and a rationale given in the clinical records.

In summary, when touch in psychotherapy is employed in clinically and ethically appropriate ways, it clearly falls within the standard of care and has high clinical utility for healing a wide range of ailments and mental disorders.

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Biography

Ofer Zur, Ph.D. is a licensed psychologist, forensic and clinical consultant and a pioneer of the managed-care-free private practice movement in Sonoma, CA. His teaching and writing focus on private practice, ethics, critical thinking, boundaries and dual relationships. His publications include the ground breaking book *Dual Relationships and Psychotherapy*, coedited with Arnold Lazarus, the bestselling *HIPAA Compliance Kit*, and the *Managed-Care-Free Private Practice Kit*. His most recent book is *Boundaries in Psychotherapy*. Dr. Zur's interest in therapeutic ethics arises from his outrage regarding the harm inflicted on clients by the practice of distant, dogmatic, inflexible and ideologically rather than client base therapies. Contact: drzur@drzur.com.

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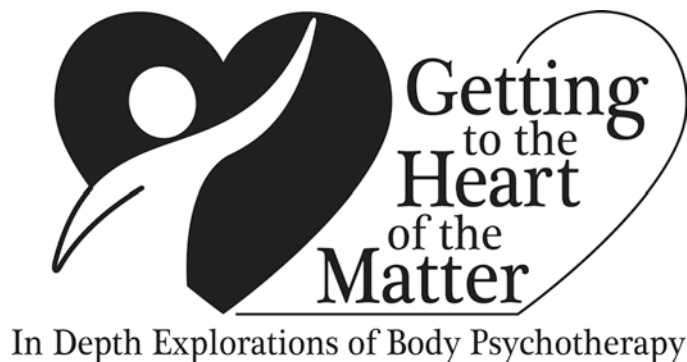
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