

**the usa
body
psychotherapy
journal**



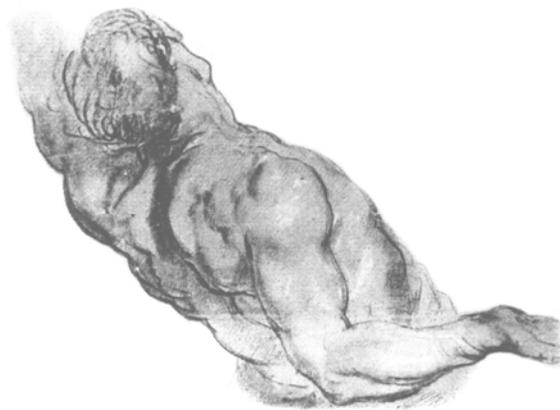
Back Issues and Subscriptions Available at
www.usabp.org

Volume 8 Number 2 2009

The Official Publication of
THE UNITED STATES ASSOCIATION FOR
BODY PSYCHOTHERAPY

Table of Contents

Editorial Jacqueline A. Carleton, Ph.D.	3
The Science of Body Psychotherapy: The Science of Body Psychotherapy Today Part 1. A Background History Courtenay Young	5
Mindfulness-Based Somatic Psychotherapy Ronald A. Alexander Ph.D. and Marjorie Rand Ph.D.	16
The Self Behind the Symptom: The Energies of Inner Selves and Body Symptoms Judith Hendin, Ph.D.	21
Part 1. The Adolescent Brain: A Decade of Research Deborah Harkin, Ph.D.	31
The Continuing Evolution of Touch in Psychotherapy Anastasia D. McRae, M.Div., MSW	40
Use of Eidetic Imagery in Exercise Motivation Katy Swafford, Ph.D.	47



©2009 USABP

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 humani

The Continuing Evolution of Touch in Psychotherapy

Anastasia D. McRae, M.Div., MSW, LSW

Abstract

The following article is a brief overview of the touch taboo in psychotherapy and the gradual use and acceptance of touch use in psychotherapy as evidenced through empirical research.

Keywords

Touch – Psychology – Body Awareness

As if in an echo of their often conflicted predecessors, writers and researchers involved in the dialogue about the use of touch in psychotherapy are divided. In both theory and empirical research, we find, on the one hand, a focus on past and possible future abuses of touch -- ranging from sexual misconduct and other inappropriate boundary violations to situations where touch would be clinically contraindicated. On the other hand, we have recognition of the crucial place of touch in human development. Research through much of the twentieth and early twenty-first centuries shows conclusively that the absence of touch or its negative use affects the emotional-mental maturation --even survival-- of infants, and that appropriate physical contact has a significant role to play in helping trauma survivors recover (see, for example, Harlow, 1959; Spitz, 1945).

The taboo regarding touch in psychotherapy is still very much a part of the ethical concerns of the mental health profession though it is no longer as strictly adhered to as it once was. Due to a number of strands of thinking throughout the history of psychotherapy along with findings from various other disciplines, attitudes about the use of touch, the body, and body awareness in treatment are changing (Anderson, 2007; Fosshage, 2000). Unfortunately, with the change in attitude, there may not have been a corresponding increase in dialogue and training needed to enhance the ethical use of touch and body awareness.

In general, therapists are better prepared to handle situations competently when they have been prepared to deal with an issue before it appears in their clinical practice. Education about touch is especially important since an unexamined practice of touch can so easily lead a therapist into serious difficulty (Sanderson, 1995, quoted in Tune, 2001).

Though findings show, and opinions point to, a need for adequate training and increased self-awareness on the part of the therapist in relation to the use of touch and body awareness (Durana 1998; Horton, et al., 1995; Ketray & Reviere, 1993; Smith, 1998a; Strozier et al., 2003) the bulk of the literature to date neglects to include the voices of those mental health professionals who have engaged in additional training in these areas. Quantitative research involving clinicians who are professionally trained to use touch and body awareness is particularly absent from the literature.

While there is much theoretical work written on the use of touch in psychotherapy, within the body of limited empirical research there is no consensus for or against the use of touch, though it is obvious that touch in the psychotherapy and psychoanalytic treatment room actively continues as both event and concern. This is a look at pertinent empirical and theoretical literature about touch and body awareness used as therapeutic tools in psychotherapy. It is a brief exploration of both the reverberations of the taboo on touch use in psychotherapy and past and current arguments in favor not only of the use of touch but also of body awareness in general, as crucial components of psychological healing. The purpose of the study, from which the current article is taken, was to survey the differences in reported practices and attitudes of mental health professionals who use touch and body awareness with and without additional training (see USABPJ, Volume 7, Issue 2, 2008).

The Touch Taboo

Even if the history of the proscription of touch in psychotherapy is easily traced back to Sigmund Freud and the early days of psychoanalysis (Kertay & Reviere, 1993), it would be remiss to overlook the much longer and influential history of mind-body duality in Western thinking and culture in general. This dichotomous way of thinking about the human being had its beginning in antiquity and has been the topic of much philosophical and

theological debate since then. In the writings of Augustine, Aquinas, Newton, and Descartes we find the most well-known of the roots of this debate, though they are but a very few of the voices that contributed to the current state of affairs (Kelsey, 1973; Smith, 1998b). Freud's stance against touch in psychoanalysis was very much a part of his contemporary culture and of the larger cultural history wherein the religious authorities had, it is suggested, forfeited the body to science and claimed the spirit as its dominion during the Enlightenment (Kelsey, 1973). By abandoning touch, Freud effectively left the body to medicine while carving out a different space for his fledgling science in the realm of the mind, thereby continuing the tradition of thinking of the human in terms of spirit-mind-body separation (Smith, 1998b).

Freud did not start out condemning touch. Quite the contrary, as is noted in most writing on the subject, he used touch early in his work with patients to explore whether pressing the patient's head during hypnosis could help the patient "abreact" trauma (Greene, 2001; Geib, 1982; Kertay & Reviere, 1993; Ventling, 2002). Freud came to conclude that the patient's ability to adequately use the transference in treatment was impeded if touch were a component. He reasoned that touch would gratify the patient's infantile need for the parental figure, now activated by the therapeutic transference, and take away the frustration the patient must experience in order to heal from earlier disruptions to the psyche (Greene, 2001). Freud was also concerned about ethical violations by some of his contemporaries who carried their use of touch into the realm of sexual and romantic relationships with their patients (Geib, 1982; Ventling, 2002). In an attempt to minimize possible harm to patients, to solidify the therapeutic boundaries of, and to remove any obstacles to his burgeoning discipline, Freud banned touch within all legitimate psychoanalysis, the precursor of psychotherapy (Totton, 2003; Ventling, 2002).

The Touch Taboo Today

Freud's ban against touch in psychoanalysis spread to all branches of psychotherapy and continues to affect the practices of many psychotherapists. For some mental health professionals continued adherence to the ban translates into no touch whatsoever; for others, minimal touch is appropriate. Gutheil and Gabbard (1993) recommend that handshakes be the extent of touch allowed in therapy, partially because of the litigious nature of our society and partially because of very real sexual misconduct and other boundary violations by some therapists (Gutheil & Gabbard, 1993; Hetherington, 1998; Holroyd & Brodsky, 1977; Pope, 1990; Stake & Oliver, 1991). In response to these boundary violations, the American Psychological Association (APA) and the National Association of Social Workers (NASW) both prohibit sexual relationships between therapist and client along with any physical contact that would potentially harm the client. Neither organization explicitly prohibits touch altogether, however. Unlike the APA, the NASW ethics code does include a specific section on physical contact. In Section 1.10 of the Social Workers' Code of Ethics, the organization states that: Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact (NASW, 2006, p. 13).

The dialogue surrounding touch in psychotherapy has focused to a great extent on sexual misconduct and risk management precautions; though, while the cautions are important, they "seem to reinforce a view of all touch as sexual in nature and create an atmosphere of suspicion surrounding the use of touch" (Stenzel & Rupert, 2004, p. 332). As a result, meaningful conversation or research about non-erotic touch is hindered, or inadvertently suppressed (Stenzel & Rupert, 2004). On the issue of touch leading to sexual acting out, there is no empirical correlation between the use of touch and sexualized misconduct (Holroyd & Brodsky, 1980), though research has found that opposite-sex dyads present more possibility for misunderstanding touch incidents (Gutheil & Gabbard, 1993; Holroyd & Brodsky, 1977; Stake & Oliver, 1991).

Another consideration to factor into possible misunderstandings and boundary violations is the power dynamic involved in the use of touch with specific reference to who is allowed to touch whom. In the general American culture, men, adults, medical professionals, and those in higher social standing are allowed more touch freedom than those considered in some way inferior to those listed. Although research shows that women touch others more, it is necessary to note that in the data gathered women are generally touching other women, not men (Holroyd & Brodsky, 1977; Strozier, Krizek, & Sale, 2003; Stenzel & Rupert, 2004). Therefore, in terms of power differentials, women, children, the elderly, and people considered in lower social standing (perhaps economic, racial, bodily, or for reason of sexual orientation) are granted less freedom to touch (Alyn, 1988). Some suggest that touch in psychotherapy may be detrimental in the context of the hierarchically structured therapeutic relationship because the client may not feel he or she has the possibility to deny touch initiated by the therapist, thereby locking the client into unclear and harmful exchanges (Alyn, 1988). Therapists who advocate touch with clients recommend that the client initiate the touch or that the therapist ask permission prior to the touch, thereby eliminating some of the tension of the power dynamic and curtailing negative effects of the touch (Durana, 1998; Gelb, 1982; Greene, 2001; Horton, Clance, Sterk-Elifson, & Emshoff, 1995; Torracco, 1998).

Perhaps it is for some of the above reasons that in their recent study, Stenzel and Rupert (2004) found in a national sample of 470 practicing psychologists that almost ninety percent reported never or rarely touching clients during sessions and eighty percent only shook hands with their clients sometimes. Confirming the prevalent research, the study found that therapists claiming humanistic, Gestalt, and existential theoretical backgrounds touched more than those with psychodynamic training. Though most ask permission to touch, fifty percent report never or rarely explaining touch with clients. Seventy-three percent reported some type of discussion with supervisors or teachers that presented touch as harmful, while fifty-six percent were involved in discussions with supervisors in which touch was presented as beneficial. Stenzel and Rupert concluded that handshakes are the most common form of touching, saying that the attitude among those responding to their survey was cautious (Stenzel & Rupert, 2004).

Use of Touch

Freud's was not the only opinion about the use of touch in psychoanalysis during his time. Among his close circle of friends and colleagues, Freud encountered disagreement with his views, most notably from Wilhelm Reich and Sandor Ferenczi who both continued to use touch in their work with patients after Freud's pronouncement against it (Fosshage, 2000; Kertay & Reviere, 1993; Tune, 2001; Ventling, 2002). Reich suggested that the body was an important factor in psychological healing because of what he came to call "body armoring," a process that occurred as a result of bodily accidents and illness, emotional stress, and trauma. The body, as Reich saw it, was a holding vessel for experiences; if negative effects of experiences were not dispelled in a healthy fashion, they became part of a rigidified physical defense system that caused both maladaptive emotional and physical responses to new situations. The idea of body armoring is the basis of some current ways of working with the body in psychotherapy (Totton, 2003; Ventling, 2002).

More recent shifts in thinking about the use of touch in psychotherapy have been occasioned by a myriad of converging ideas in the past few decades, not the least of which have been the changing in psychotherapy itself from a positivistic to relativistic science, from an exclusively intrapsychic to a relational and interpersonal model (Fosshage, 2000). Among the ideas affecting the shifts in perspective include the findings and questions from research into the nature of the mother-infant attachment (Bowlby, 1958; Winnicott, 1963), what contributes to healthy child development (Ainsworth & Bowlby, 1991; Erickson, 1950; Piaget, 2002), neurological research on normal development (Damasio, 1994; Schore, 2003; Siegel, 2001) as well as how development is affected by trauma at various life stages (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006; Schore, 2003; van der Kolk, 1994).

In normally developing humans, the sense of touch is the first to develop. As the skin is the largest human organ, touch is integral to the growth and development of the individual (Montagu, 1971). Research by Spitz (1945) and Harlow (1959) pointed to the importance of human touch in both psychological and physical development. Harlow's experiments with infant monkeys and surrogate mother monkeys, some made of wire-mesh and others with cloth, showed that touch is perhaps as crucial to human infant survival as food (Harlow, 1959). Spitz's (1945) work with infants and their imprisoned mothers came to similar conclusions about the need for adequate touch. Both experiments demonstrated that without adequate touch the subjects failed to thrive.

Touch is an important element in human development, not only in the lives of infants but throughout the life cycle (Bar-Levay, 1993; Orbach, 2003a; Turp, 2000). Human contact plays a major assisting role in the growth of movement patterns and a sense of self in the world by allowing for the evolution of a "secure base" from which the infant, child, then adult, can orient oneself (Turp, 2000). Bowlby's (1958) attachment theory, though it does not mention touch as such as an important vehicle, seems based on the notion that enough of a certain kind of touch and touching by the primary caregiver creates lifelong effects on the child and the manner in which he or she will interact in relationship with others. Like Harlow's monkeys who were unable to mate successfully once matured (Harlow, 1959), children who receive not enough or confusing contact, expressly physical in this instance, develop maladaptive ways of connection. In *Language of the Body*, the basis for what later became Bioenergetics, Lowen (1971) suggests that one maladaptive pattern exerts itself in the condition of schizophrenia wherein the patient is unaware of himself as a body-self in relation to other body-selves.

Use of Touch Today

Smith (1998a) designed a taxonomy that offers some clarity of definition as it regards touch in psychotherapy. He identified seven types of touch, five of which he labeled as acceptable: inadvertent or unintentional touch, as in bumping into someone by mistake; touch as a conversational marker, as in placing a hand on a shoulder for emphasis; socially ritualized touch as in handshakes at greeting or parting; as an expression of comfort or care, as in holding the hand of a grief-stricken person; or touch as technique, as in conducting physical contact in a specified theoretically informed manner in which the practitioner has received training (Smith, 1998a).

It is evident that therapists do indeed touch their clients in non-erotic ways, if only in the formal greeting of handshakes (Gutheil & Gabbard, 1993; Holroyd & Brodsky, 1977; Milakovich, 1998; Stenzel & Rupert, 2004; Stake & Oliver, 1991). Therapists using touch with patients cite a variety of therapeutic benefits for doing so, including facilitating greater client self-disclosure and bond with therapist (Clance & Petras, 1998; Durana, 1998; Jourard & Friedman, 1970); reparation of human contact-attachment disorders (Liss, 1977; Wilson, 1982); grounding a client in the present moment (Clance & Petras, 1998; Geib, 1982; Leijssen, 2006); accessing pre-verbal material (Bar-Levav, 1998; Liss, 1977); providing an emotionally corrective experience (Durana, 1998; Kupfermann & Smaldino, 1987), along with calming or consoling the client in times of distress (Mandelbaum, 1998; Torracco, 1998).

Goodman and Teicher (1988) suggest that if the rationale in talk therapy is to develop new neuronal pathways in the brain, then the definition of therapy could widen to include other ways of exploring these new pathways, such as the use of touch and body awareness, specifically for the patient who suffers from arrested development:

The development of neuronal circuitry runs parallel to the psychotherapeutic definition of rehabilitation: small graduated steps of learning under the guidance of a psychotherapist. Touching for the undeveloped personality may serve the same purpose” (p. 498).

Like many others, Goodman and Teicher make a distinction between which patients will benefit from the use of touch in treatment and which patients will not (see Durana, 1998 for a detailed discussion).

Though it is generally agreed that touch should not be used with all patients, with some populations, such as children – especially quite young children—it is very difficult not to involve some level of touch (Cowen, Weissberg, & Lotyczewski, 1983; McNeil-Haber, 2004). In those instances, decisions about the touch needs of the child should be of the highest consideration (Aquino & Lee, 2000; McNeil-Haber, 2004). One nationwide study with ninety-one licensed clinical social workers, eighty-three percent of whom were women, found that ninety-five percent of the respondents used touch at least some of the time with clients, most often shaking hands or touching a client’s shoulder, arm or, back (Strozier et al., 2003). Respondents reported touching children and the elderly more than adults and adolescents (Strozier et al., 2003), and were more likely to touch physically ill clients and those of their own gender. Respondents in this study were least likely to use touch with clients diagnosed with borderline personality disorder (34%), the opposite sex (25%), clients with boundary issues (13%), or those diagnosed with schizophrenia (12%) (Strozier et al., 2003). Eighty-two of the 91 social workers in their study reported receiving inadequate training from classes or placements to deal with issues of touch with clients (Strozier et al., 2003). While the results of this study cannot be generalized to a larger population of mental health professionals, it does highlight the decisions clinicians make regarding touch with adults and the levels of training available to them surrounding the use of touch.

In phone interviews conducted with eighty-four respondents using a non-random sample, Milakovich (1998) reported ten areas of difference between therapists who touch and those who do not, four of which point to the importance of both personal and professional experience with touch as indicators of the respondents’ use of touch in psychotherapy treatment with patients. Milakovich (1998) found that those who reported touching had experienced touch from their own therapists; had supervisors and teachers who validated touch in treatment; had experienced body therapies and body-oriented psychotherapies; and had training in therapeutic modalities using touch (more than fifty hours). These results coincide with other findings (Geib, 1982; Stenzel & Rupert, 2004) and theory (Durana, 1998) asserting that touch experiences of therapists and the type of training and supervision encountered professionally each have a direct impact on their use of touch in the therapy room.

While there is no research on the efficacy of touch as a modality within psychotherapy, per se, there are data on patients’ experiences of touch in psychotherapy. Geib (1982) surveyed ten female patients who had been in treatment with male therapists for at least ten months. She focused on the patient response to clearly non-sexual physical contact (Geib, 1982). From the data, Geib (1982) formulated four factors relating to positive client response to touch in verbal psychotherapy: therapist gave client a sense of control of touch; therapist responded to

client's need; encouraged discussion about the touch; and made sure touch was congruent with state of the relationship, i.e., the touch employed responded to appropriate intimacy established in the relationship (Geib, 1982). The four respondents who found touch in therapy problematic, though overall they rated the therapy as favorable, listed reluctance to jeopardize positive feelings by revealing negative ones engendered by touch (feeling unable to express anger, guilt about anger); perception of therapists as needy and vulnerable; and a return to family of origin dynamics (Geib, 1982).

Horton, Clance, Sterk-Elifson, and Emshoff (1995) expanded and tested Geib's four factors in their research with 231 patients. Positive perception of touch in therapy correlated with three of Geib's factors: patients felt touch was congruent with their issues; that the therapist was sensitive to their reaction to the touch; and the patients felt they could be open with the therapist about the touch incident (Horton et al., 1995). Respondents also reported that touch communicated acceptance (47%) and created a feeling of closeness (69%). Horton et al. (1995) found that the therapeutic alliance was positively affected by the use of touch, though thirteen percent of the sample did report negative effects. The study found that patients dealing with isolation, depression, intimacy issues, and abuse were helped by touch. They also reported that respondents felt affirmed, respected, and more bonded to the therapist because of the touch offered in the therapy.

Ethics

Touch is an undeniably powerful communication modality with many possibilities for both healing and misinterpretation in the context of psychotherapy. Though there is potential for misunderstanding or misuse of touch in clinical work, many writers have said that touch is not, however, a topic to be avoided. "The matter of touch is so important and pervasive that the question may not be whether or not therapists *should* touch their patients, but rather *how* touch is utilized and processed in therapy" (emphasis in original) (Kertay & Reviere, 1993, p. 39). Pope, Sonne, and Greene (2006) suggest that not talking about touch in classrooms, supervision, and consultation is harmful to both therapists and patients alike. The absence of dialogue hampers mental health professionals and students in their ability to develop professional ethics and self-understanding that could help guide the clinician when a touch event occurs in their practice, and perhaps lessen the likelihood of unethical or confusing contact for patients (Pope, Sonne, & Greene, 2006).

Kertay and Reviere (1993) offer a three-tiered ethical approach to the use of touch: once both client and therapist have concluded that the touch is not harmful and is part of the necessary therapeutic relationship, concerns of theoretical soundness then come into question. Durana (1998) adds that the therapist's understanding of her or his own responses, motivations, and attitudes to touch, along with the dynamics of power, gender, and how boundaries play in the use of touch are also ethical concerns. While Durana (1998) points out the need for proper training in his clinical guidelines for the use of touch, Smith (1998) goes further in his taxonomy of ethics by positioning training as the first ethical consideration, saying that if the training has been inadequate in terms of theory or supervision, then the therapist should not use touch with patients. Additionally, Smith (1998a) asserts that touch should be in the best interest of the patient and ego-syntonic for the therapist.

Body-Oriented Psychotherapy

Of the seven categories outlined by Smith, touch as technique is unique in that it involves extensive training on the part of the clinician. Although we have little research involving bodywork and psychotherapy, we do have information on the use of alternative therapies by the general population. In the past two decades there has been a huge increase in use of body therapies, herbal therapies, spiritual modalities, and special diets among Americans, with estimates that more than one third use these avenues (Elkins et al., 2005). With this large a number of the population turning away from the standard medical community, or at the very least seeking different methods as added components to their care, it is hard to imagine that more research on the combination of bodywork and psychotherapy is not available. Elkins et al. (2005) notes that only thirty-four percent of the respondents told their psychotherapists about their use of an alternative therapy (Elkins et al., 2005).

What is now known variously as body psychotherapy, body-oriented psychotherapy, Hakomi, Rubenfeld Synergy Method, the Rosen Method, Rolfing, somatics, or bio-energetics, to name a few, all have, in some way, their beginnings in the work of Wilhelm Reich and Sandor Ferenczi. From Reich emerged students in various parts of Europe who founded the Neo-Reichian Body Psychotherapy Institutes in Norway, Sweden, Germany, and the United States. Alexander Lowen and John Pierrakos formed bioenergetic analysis while those opposed to this way of working, David Boadella and George Downing, created biosynthesis and body psychotherapy, respectively

(Ventling, 2002). There was also Fritz Perls, founder of Gestalt therapy and Peter Geissler in Austria, founder of psychoanalytic body-oriented psychotherapy (Ventling, 2002). All the schools address the body through techniques including body awareness, mindfulness, and touch (Ventling, 2002).

Body Awareness as Technique

Touch is but one method on a continuum of modalities in psychotherapy treatment from verbal to non-verbal (Leijssen, 2006). Body awareness as a technique utilized in psychotherapy does not necessarily include actual touching. In fact, many proponents of body awareness do not advocate touch as a technique *they* use professionally (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006, 2006; Rothschild, 2000; Orbach, 2003b). Various techniques designed to bring attention to bodily sensations, unconscious movements, and feeling states in the body are positioned along the continuum between verbal treatment with no allowance for the body and treatment wherein touch is a component (Leijssen, 2006).

The incorporation of body awareness in psychotherapy can serve as one barometer of the state of the client's transference and any counter-transference on the part of the therapist, thereby allowing for a richer, though not flawless, attunement to non-verbal or preverbal cues (Field, 1989; Orbach, 2003a; Shaw, 1996; Totton, 2003). Allowing a place for the body in psychotherapy treatment, body awareness here is defined as making use of both the therapist and patient's physical reality, more precisely:

...the expressions of the body of the patient in the form of anatomical shape, gestures, looks, e.g., eye contact, physical contractions/relaxation, and of the sensations of the body as felt and expressed by the patient in various forms like feeling hot/cold, pain, nervousness, sadness, anger, fear, joy, emptiness, etc.” (Ventling, 2002, p.4).

Bodies in their own right, not only as symbolic registers, can serve as a pathway to greater here-and-now responses to patients as well as invite more clarity into ways patients respond to the therapist's physical presentation (Orbach, 2003b; Petrucelli, 2007). This can be especially the case when working with clients with eating disorders, self-harming behaviors, physical trauma of any kind, life-threatening illnesses, and otherwise somatically-presented concerns (Ogden, 2006; Orbach, 2003b; Petrucelli, 2007).

One area of recent interest is the call for heightened use of body awareness in trauma therapies. Van der Kolk writes:

Physiological arousal in general can trigger trauma-related memories, while, conversely, trauma-related memories precipitate generalized physiological arousal. It is likely that the frequent re-living of a traumatic event in flashbacks or nightmares cause a re-release of stress hormones which further kindle the strength of the memory trace. (van der Kolk, 1994, p. 9).

Spearheaded by advances in neurobiology, researchers like Bessel van der Kolk, Alan Schore, and others have written, revisiting Reich's theory regarding body armoring to some extent, that the body stores emotional trauma (Ogden, Minton, & Pain, 2006; Schore, 2003; van der Kolk, 1994). These researchers call attention to the necessity of treating the client's body and mind as interwoven aspects of the person in pursuit of health and wholeness of the individual.

Orbach (2003a) believes therapists must bring conscious awareness of how their bodies are in fact already an integral part of the therapeutic relationship, writing that “our patients are already using our bodies just as they are using our psyches” (p. 13). She further suggests that the process of engaging in embodied practice also offers therapists an opportunity for greater self-care and knowledge through mindful attention to themselves, physically and emotionally (Orbach, 2003a).

One unique quality of body-centered or body-oriented psychotherapists, and therapists using body awareness in their treatment is their ability “to feel comfortable with their own embodiment, and comfortable with physical contact—relaxed and undeprived enough to trust their own ability to hold appropriate boundaries without refraining from touch altogether” (Totton, 2003, p. 118).

References

- Ainsworth, M. S., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist*, 46(4), 333-341.
- Alyn, J. H. (1988). The politics of touch in therapy: A response to Willison and Masson. *Journal of Counseling & Development*, 66(9), 432-433.
- American Psychological Association. (2002). *Ethical principles of psychologists and code of conduct*. Washington, D.C.: Author.

- Anderson, F. S. (Ed.). (2007). *Bodies in treatment: The unspoken dimension*. New York: The Analytic Press.
- Aquino, A. T., & Lee, S. S. (2001). The use of non-erotic touch with children: Ethical and developmental considerations. *Journal of Psychotherapy in Independent Practice, 1*(3), 17-30.
- Bar-Levav, R. (1993). A rationale for physical touching in psychotherapy. *International Journal of Psychotherapy and Critical Thought, 1*(1), 5-7.
- Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psycho-Analysis, 39*, 350-373.
- Clance, P. R., & Petras, V. J. (1998). Therapists' recall of their decision-making processes regarding the use of touch in ongoing psychotherapy: A preliminary study. In E. W. L. Smith, P. R. Clance, & S. Imes (Eds.), *Touch in psychotherapy: Theory, research, and practice* (pp. 92-108). New York: Guilford Press.
- Cowen, E. L., Weissberg, R. P., & Lotyczewski, B. S. (1983). Physical contact in interactions between clinicians and young children. *Journal of Consulting and Clinical Psychology, 51*(1), 132-138.
- Damasio, A. R. (1994). *Descartes' error: Emotion, reason, and the human brain*. New York: G. P. Putnam.
- Durana, C. (1998). The use of touch in psychotherapy: Ethical and clinical guidelines. *Psychotherapy: Theory, Research, Practice, Training, 35*(2), 269-280.
- Elkins, G., Marcus, J., Rajab, M. H., & Durgam, S. (2005). Complementary and alternative therapy use by psychotherapy clients. *Psychotherapy, 42*(2), 232-235.
- Erikson, E. H. (1950). *Childhood and society*. New York, NY: W. W. Norton & Co.
- Field, N. (1989). Listening with the body: An exploration in the countertransference. *British Journal of Psychotherapy, 5*(4), 512-522.
- Field, T. M. (1998a). Massage therapy effects. *American Psychologist, 53*(12), 1270-1281.
- Field, T. M. (1998b). Touch therapy effects on development. *International Journal of Behavioral Development, 22*(4), 779-797.
- Fosshage, J. L. (2000). The meanings of touch in psychoanalysis: A time for reassessment. *Psychoanalytic Inquiry, 20*, 21-43.
- Geib, P. (1998). The experience of non-erotic physical contact in traditional psychotherapy. In E. W. L. Smith, P. R. Clance, & S. Imes (Eds.), *Touch in psychotherapy: Theory, research, and practice* (pp. 109-126). New York: Guilford Press.
- Goodman, M., & Teicher, A. (1988). To touch or not to touch. *Psychotherapy, 25*(4), 492-500.
- Greene, A. U. (2001). Conscious mind-conscious body. *Journal of Analytical Psychology, 46*, 565-590.
- Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *American Journal of Psychiatry, 150*(2), 188-196.
- Harlow, H. F. (1959). Love in infant monkeys. *Scientific American, 200*(6), 68-74.
- Hetherington, A. (1998). The use and abuse of touch in therapy and counselling. *Counselling Psychology Quarterly, 11*(4), 361-364.
- Holroyd, J. C., & Brodsky, A. M. (1977). Psychologists' attitudes and practices regarding erotic and nonerotic physical contact with patients. *American Psychologist, 32*(10), 843-849.
- Horton, J. A., Clance, P. R., Sterk-Elifson, C., & Emshoff, J. (1995). Touch in psychotherapy: A survey of patient's experiences. *Psychotherapy, 32*(3), 443-457.
- Jourard, S. M., & Friedman, R. (1970). Experimenter-subject 'distance' and self-disclosure. *Journal of Personality and Social Psychology, 15*(3), 278-282.
- Kelsey, M. T. (1973). *Healing and Christianity in ancient thought and modern times*. New York: Harper and Row.
- Kertay, L., & Reviere, S. L. (1993). The use of touch in psychotherapy: Theoretical and ethical considerations. *Psychotherapy: Theory, Research, Practice, Training, 30*(1), 32-40.
- Kupfermann, K., & Smaldino, C. (1987). The vitalizing and the revitalizing experience of reliability: The place of touch in psychotherapy. *Clinical Social Work Journal, 15*(3), 223-235.
- Leijssen, M. (2006). Validation of the body in psychotherapy. *Journal of Humanistic Psychology, 46*(2), 126-146.
- Liss, J. (Ed.). (1977). *Why touch?* Port Washington, NY: Ashley Books.
- Lowen, A. (1971). *Language of the body*. New York: Macmillan General Reference.
- Mandelbaum, D. (1998). The impact of physical touch on professional development. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), *Touch in psychotherapy: Theory, research, and practice* (pp. 211-219). New York: Guilford Press.
- McNeil-Haber, F. M. (2004). Ethical considerations in the use of non-erotic touch in psychotherapy with children. *Ethics & Behavior, 14*(2), 123-140.
- Milakovich, J. (1998). Differences between therapists who touch and those who don't. In E. W. L. Smith, P. R. Clance, & S. Imes (Eds.), *Touch in psychotherapy: Theory, research, and practice* (pp. 74-91). New York: Guilford Press.
- Montagu, A. (1971). *Touching: The human significance of the skin*. Oxford, England: Columbia U. Press.
- National Association of Social Workers. (2006). *Code of ethics of the National Association of Social Workers*. Washington, D.C.: Author.
- Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology, 6*(3). Retrieved August 9, 2007.
- Ogden, P., Minton, K. & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York: W. W. Norton & Company.
- Orbach, S. (2003a). The John Bowlby memorial lecture 2003: Part I: There is no such thing as a body. *British Journal of Psychotherapy, 20*(1), 3-15.
- Orbach, S. (2003b). The John Bowlby memorial lecture 2003: Part II: Touch. *British Journal of Psychotherapy, 20*(1), 17-26.
- Petrucelli, J. (2007). When a body meets a body: The impact of the therapist's body on eating-disordered patients. In F. S. Anderson (Ed.), *Bodies in treatment: The unspoken dimension*. (pp. 237-253). New York, NY: The Analytic Press/Taylor & Francis Group.
- Pope, K. S., Sonne, J. L. & Greene, B. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients*. Washington, DC: American Psychological Association.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: W. W Norton & Co.
- Schore, A. (2003). *Affect dysregulation & disorders of the self*. New York: W. W. Norton & Company.
- Siegel, D. J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, "mindsight," and neural integration. *Infant Mental Health Journal, 22*(1), 67-94.
- Smith, E. W. L. (1998a). A taxonomy and ethics of touch in psychotherapy. In Smith, E. W. L., P. R. Clance, & S. Imes (Eds.), *Touch in psychotherapy: Theory, research, and practice* (pp. 36-55). New York: Guilford Press.
- Smith, E. W. L. (1998b). Traditions of touch in psychotherapy. In Smith, E. W. L., P. R. Clance, & S. Imes (Eds.), *Touch in psychotherapy: Theory, research, and practice* (pp. 3-15). New York: Guilford Press.
- Spitz, R. (1945). Hospitalism: An inquiry into the genesis of psychiatric conditions of childhood. *The Psychoanalytic Study of the Child, 1*, 53-74.

- Stake, J. E., & Oliver, J. (1991). Sexual contact and touching between therapist and client: A survey of psychologists' attitudes and behavior. *Professional Psychology: Research and Practice, 22*(4), 297-307.
- Stenzel, C. L., & Rupert, P. A. (2004). Psychologists' use of touch in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 41*(3), 332-345.
- Strozier, A. L., Krizek, C., & Sale, K. (2003). Touch: Its use in psychotherapy. *Journal of Social Work Practice, 17*(1), 49.
- Torraco, P. (1998). Jean's legacy: On the use of physical touch in long-term psychotherapy. In E. W. L. Smith, P. R. Clance, & S. Imes (Eds.), *Touch in psychotherapy: Theory, research, and practice* (pp. 220-237). New York: Guilford Press.
- Totton, N. (2003). *Body psychotherapy: An introduction*. Philadelphia: Open University Press.
- Tune, D. (2001). Is touch a valid therapeutic intervention? Early returns from a qualitative study of therapists' views. *Counselling & Psychotherapy Research, 1*(3), 167-171.
- Turp, M. (2000). Touch, enjoyment and health: In adult life. *The European Journal of Psychotherapy, Counseling and Health, 3*(1), 61-76.
- van der Kolk, Bessel. (1994). The body keeps the score: Memory and evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry, 1*(5), 253-265.
- Ventling, C. D. (2002). Psychotherapy of patients with incurable disorders: An untaught subject. In C. D. Ventling (Ed.), *Body psychotherapy in progressive and chronic disorders* (pp. 1-13). New York: Karger.
- Winnicott, D. W. (1963). Dependence in infant care, in child care, and in the psycho-analytic setting. *International Journal of Psycho-Analysis, 44*(3), 339-344.

Biography

Anastasia McRae, M.Div, MSW, LSW is a clinical social worker, and a massage therapist. As a clinical social worker, she works with families in a school setting in Chicago, IL. This research was completed as a Masters thesis in partial fulfillment of Ms. McRae's Master of Social Work at Smith College School for Social Work. The first part of the research was published here in Volume 7, Issue 2, 2008. She may be reached at amcrae1@gmail.com.

The USA Body Psychotherapy Journal The Official Publication of the USABP

Editor

JACQUELINE A. CARLETON, PH.D.

Assistant Editor

SASHA DMOCHOWSKI

Production Manager

ROBYN BURNS, M.A.

Peer Review Board

SUSAN APOSHYAN, M.A.

DAVID BROWN, PH.D.

RUELLA FRANK, PH.D.

MARY J. GIUFFRA, PH.D.

BARBARA GOODRICH-DUNN

ELLIOT GREENE, M.A.

LAWRENCE HEDGES, PH.D.

JOEL ISAACS, PH.D.

GREG JOHANSON, PH.D.

BLAIR JUSTICE, PH.D.

RITA JUSTICE, PH.D.

ALICE LADAS, Ed.D.

ALINE LAPIERRE, Psy.D.

LINDA MARKS, M.S.M.

JOHN MAY, PH.D.

PATRIZIA PALLARO, LCMFT, ADTR

MARJORIE RAND, PH.D.

LAUREL THOMPSON, M.P.S.

USABP BOARD OF DIRECTORS

VIRGINIA DENNEHY, PRESIDENT

PAUL BRIGGS, VICE PRESIDENT

LYNN TURNER, SECRETARY

JACQUELINE A. CARLETON, TREASURER

MARY J. GIUFFRA

GREG JOHANSON

ANN LADD

KATHY SCHEG

LAUREL THOMPSON

ADVERTISING INFORMATION

The USABP Journal accepts advertisements for books, conferences, training programs, etc. of possible interest to our members. Please contact usabp@usabp.org for more information.

CRITERIA FOR ACCEPTANCE

How does material in this manuscript inform the field and add to the body of knowledge? If it is a description of what we already know, is there some unique nugget or gem the reader can store away or hold onto? If it is a case study, is there a balance among the elements, i.e., back ground information, description of prescribed interventions and how they work, outcomes that add to our body of knowledge? If this is a reflective piece, does it tie together elements in the field to create a new perspective? Given that the field does not easily lend itself to controlled studies and statistics, if the manuscript submitted presents such, is the analysis forced or is it something other than it purports to be?

PURPOSE

This peer-reviewed journal seeks to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as an interdisciplinary exchange with related fields of clinical practice and inquiry.

To ensure the confidentiality of any individuals who may be mentioned in case material, names and identifying information have been changed. It must be understood, however, that although articles must meet academic publishing guidelines, the accuracy or premises of articles printed does not necessarily represent the official beliefs of the USABP or its Board of Directors.

The USA Body Psychotherapy Journal (ISSN 1530-960X) is published semi-annually by the United States Association for Body Psychotherapy. Copyright (c) 2008 United States Association for Body Psychotherapy. All rights reserved. No part of this journal may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording, or by any information storage and retrieval system, without written permission of the publisher.

SUBMISSION GUIDELINES AND SPECIFICATIONS

First consideration will be given to articles of original theory, qualitative and quantitative research, experiential data, case studies, as well as comparative analyses and literature reviews. Submission of an article to the *USA Body Psychotherapy Journal* represents certification on the part of the author that it has not been published or submitted for publication elsewhere.

Initial submission should be e-mailed to jacarletonphd@gmail.com as an attachment in Microsoft Word.

Manuscript should be double-spaced in 10pt. type, Times New Roman font, with at least a one inch margin on all four sides—please include page numbers, otherwise manuscript should be free of other formatting.

Title, full authorship, **abstract of about 100 words and 3-5 key words precede the text.**

Please include an endnote with author's degrees, training, mailing address, e-mail fax, acknowledgement of research support, etc.

Authors are responsible for preparing clearly written manuscripts free of errors in spelling, grammar, or punctuation. We recognize that the majority of contributors are not professional writers, nor do they function in a publish or perish mode. Furthermore, we are aware that the work of our profession is sometimes pragmatic, associative, intuitive, and difficult to structure. However, a professional journal such as we envision normally accepts only pieces that are fully edited. Therefore, we may occasionally suggest that writers find a reviewer to edit their work before it can be accepted. We will suggest names of possible editors if requested.

References: References within the text should include author's surname, publication date and page number.

Full attribution should be included in bibliography at end. *For books:* surname, first name, book title, place, publisher, date of publication. *For periodicals:* Surname, first name, title of article in quotes, name of publication, year, volume, and page numbers. Or, consult the latest edition of the Publication Manual of the American Psychological Association.

LETTERS TO THE EDITOR

The editors are eager to receive letters, particularly communications commenting on and debating works already published in the journal, but also suggestions and requests for additional features or departments. They may be sent to the email address below. A selection of those received will be published in the next volume of the journal.

CORRESPONDANCE ADDRESS

Jacqueline A. Carleton, Ph.D.

Editor

USA Body Psychotherapy Journal

115 East 92nd. Street #2A

New York, NY 10128

212.987.4969

jacarletonphd@gmail.com