I AM DELIGHTED THAT THE MATTER OF “TOUCH” is at last being properly debated in this issue of Psychoanalytic Inquiry and that my paper “Some Pressures on the Analyst for Physical Contact…” has been used as a take-off point for this discussion.

One thing that strikes me immediately is how interesting it is to find that an analyst in a paper, as with an analyst in a consulting room, can be used to represent positions that are allocated to him by those wishing to engage with particular positions. I am happy for this to be so, even though it means tolerating a fair degree of being misrepresented in the process, and I am therefore especially grateful for having this opportunity now to respond to that use of my paper.

Also, as with any analyzing that takes place in the absence of the patient (known as “wild analysis”), we can see how it can easily happen that assumptions begin to be made about an absent analyst/author, which, going unchecked, can lead to constructions that may end up rather wide of the mark. But, in this case, it does not matter, for two reasons: first, that I am fortunately in a position to respond (which is often not the case when debate takes place unknown to the person concerned) and, second, because this “use” of me as the analyst of Mrs. B may be providing important opportunities for debate with the positions represented. But, what may surprise some of the

Patrick J. Casement is Training and Supervising Analyst, British Psycho-Analytical Society; Author, On Learning, from the Patient (1985) and Further Learning from the Patient (1990), both published in Learning from the Patient (1990).

A Case for Some Use of Touch

Fosshage points out that “touch is a powerful form of communication,” and in some situation it may say more than any words can convey. I definitely agree that such occasions do occur when there may be no adequate substitute for communication by touch, and I think immediately of a patient of mine I shall call Jay, whom I was then seeing once a week.

Jay, a beautiful African girl, was 17 when she came to see me “for the last time.” Her life seemed to have completely fallen apart. Her father (with whom she had lived in Africa) was recently dead, and her African mother was not interested in her except to use her as a domestic help in her new home in England where she had now come to live. Jay felt completely unwanted and unloved, and it seemed to her that I was the only person who was at all interested in the fact that she was so clearly intelligent, with a yearning for further opportunities to learn and a burning wish to go on to University. Without that, she felt her life would remain unfulfilled and meaningless. She clearly had great potential, but her mother seemed to be totally uninterested in Jay's ambitions and was fiercely opposed to her doing work for her school, let alone whether Jay succeeded in her exams. It was always housework—not homework—that she was meant to be doing. So Jay felt that she was doomed to fail the exams that she would need if she were to be considered for further education.

I will not attempt to give a fuller description of Jay's plight, but the time had come when she felt no longer able to go on, not even with my help. She was now saying, despairingly, that all I could give her were empty words. So, she had come to say good-bye—before killing herself. Nothing I can write here could adequately convey the anguish that was in the room with me then, with this girl feeling so resolutely driven to her final act of desperation. In fact, I don't think I have ever been in
the presence of someone who was so determinedly suicidal. She clearly meant what she said, and this could really be the last time I might see her.

Throughout her outpouring, I sat on the edge of my chair wondering how I could reach this despairing girl. Then, as Jay got up to leave, she held out her hand to me, to say her final good-bye. Without hesitation, I took her hand in both of mine, and, looking straight into her eyes, I said to her: “This must not be the good-bye you came to say to me. I know it feels impossible to go on, but we must find a way for you to be able to go on. … I want to see you tomorrow. … I can see you at 12 o'clock. … Please come to see me then.” There was a further pause, and then I said: “Hold on.” And I slightly squeezed her hand, which I was still holding in both of mine.

Well, Jay did hold on. And a year later she gave me a poem that she had written some months after that crucial meeting. It was called “The Guttering Candle.” And a refrain in the poem was “Hold on.” So, I have not the slightest doubt that this moment of touch was an important communication: a very important communication—showing Jay that there really was at least one person who cared whether she lived or died. And she has continued to keep in touch with me ever since, usually once a year with a Christmas card, to let me know how things are going with her (and, of course, I always acknowledge having heard from her). It is now 25 years since I held her hand that once, and she has never forgotten it, and neither have I. (As with Ruderman's case of Martin [this issue] we find clear evidence of the lasting value of such an essential contact.)

Some sceptics might say there is evidence here that my “holding on” has resulted in Jay not being able to “let go.” I can understand why they might see it that way, but I would not agree with them. At least Jay has remained alive, and she did go to University where she did well. But what also remains is Jay's continuing gratitude that I was there for her when she most needed it—really there for her. And

It was my holding of her hand that got this across to her in ways that no words alone could have. So, if I had felt restrained by some rule or prescription against touching a patient, this patient might well not be alive today.

I have given this telling example to illustrate that I too am on the side of touching in certain circumstances. But, as Ruderman vividly illustrates: “It must be done on a case-by-case basis according to what is right for each individual.” And what determines whether it is right or not right cannot be found in any rule or prescription. As also outlined so clearly by Shane, Shane, and Gale, it is not a matter for “linear” decision: such a decision can only be arrived at “nonlinearly,” within the context of a particular patient and the particular therapist/analyst. This, therefore, is a matter I have long been convinced of. And I have continued to feel at ease, as most contributors in this issue have, with the possibility of touch with some patients in some circumstances.

There have been other important moments, too, not necessarily as urgent as with Jay, when I have again held a patient's hand in mine. For example, it might be when a patient is about to have a life-threatening operation, or leaving to attend a funeral; or it may be when a patient is feeling unmanageably abandoned by my impending absence for a holiday break: and I do not believe that it is necessarily right to leave a patient feeling inordinately alone at such times.

Another occasion when a token of touch may be appropriate can be at the end of an analysis, or therapy, when the patient says good-bye. Then, sometimes, a patient may reach out to put an arm around my shoulder. I do not resist this. But, what I do—I think always—is to sustain the handshake that precedes this, still holding the patient's hand that I have already shaken, while the patient's other arm makes a slight embrace. The sustained handshake here serves as a token boundary, which I continue to keep between the patient's body and mine, and I regard this “half embrace” as unique to the consulting room. So, it serves both purposes. The patient is not rejected, and at the same time, the analytic relationship has not dissolved into something else at this moment of leaving, which needs to be a going on rather than a holding on.

As with Holder's experience of patients outside of England, I too have found that some foreign patients bring the custom of their own culture to their work with me, such as a handshake at the end of a session. I naturally accept this, feeling entirely at ease with it, but usually I find that a patient moves on from this daily ritual to something that may happen at the end of a week or at the end of an analytic term. It is, of course, likely that I may convey, nonverbally, that there are other ways of ending a session. But I don't think that this is for any reason of feeling uneasy about it. I believe that these adjustments happen anyway between people of different cultures. The important thing always, I believe, is that I accept a patient's way as “alright with me” and that I do not impose on a patient what may be my own more usual way, in contradiction to theirs. I see other things to be more important than getting hung up on issues like these.

I would similarly echo Breckenridge (this issue) when she says: “Not to touch, particularly not to touch prescriptively, also communicates; however, the communication is, I fear, about rigidity or even worse.” Like her, I can see no justification for a decision of this kind being made prescriptively, and my decision with Mrs. B was certainly not made simply according
to the classical rule of abstinence (see my later discussion of this). Nevertheless, despite my agreement about some touching being appropriate, even necessary, to deal with a particular situation, I (like Holder) “would, in general, come down on the side of ‘not to touch’ because touching within a psycho-analytical setting involves so many imponderables and introduces so many parameters.” And it does so happen that I have not yet held the hand of a patient in analysis during a session, but this has not been for any reason of principle, even though I think that could be more problematic during a session than is an occasional handshake or held hand at the end of certain sessions.

Now, how is it that I have come to be so seriously misread by some of the contributors to this issue? I must accept some responsibility for this. Looking back on my account of the clinical sequence under discussion, I can see that, even though I have tried always to be scrupulously honest in what I describe—things really did happen as I said they did—I must have contributed to these misreadings through what I have left out.1 For instance, I can see now that I must

------------

1 When I discuss the clinical sequence below, I will give more details of what I took for granted in my presentations (with the reader in mind) and some of what was omitted from the text in my attempt to keep the clinical sequence brief enough for presentation at the Helsinki Congress.
recognized as being quite different—and therefore needing to be dealt with differently. The case of Alan also indicates a valuable diagnostic pointer, with regard to the use of any parameter. As Eissler (1953) pointed out, if a parameter has been appropriate it will lead to its own resolution through interpretation; if, however, it has been inappropriately used, it will often lead to a repetition. When, therefore, some repeated use of a “parameter” shows up in the course of an analysis, whether initiated by the patient or by the analyst, I think that such a repetition (or expectation of a repeat) may often be indicating that the parameter has either served its purpose (as with Alan and the second kiss) or that it may have been inappropriate or unnecessary.

The “Use” of Mrs. B's Analyst by Some of the Contributors

We are, of course, all familiar with being used in the transference: how patients will use some peg of reality within the analytic relationship

upon which to hang whatever belongs more specifically to the patient's own history and experience or what the patient seeks to work through with the analyst. Also, we don't necessarily have to take this use personally, other than (I would hope) considering carefully what we might learn from it.

Well, I have been noting with particular interest how “the analyst of Mrs. B” has been used to represent certain positions with which some contributors have wished to engage. And it is important that the positions being attributed to that imagined analyst here are debated. For instance there are many points made that, if they had been true, should definitely be challenged: I would challenge them too. Here I will mention just some of them.

\textit{If the analyst really did withdraw the offer to hold his hand “solely [on] his [own] decision based upon his theoretical supposition” [Breckenridge] it would be hard to justify. In fact I would say it would be impossible to justify it.}

I would maintain, as also suggested by Pizer, that reaching a decision affecting the patient should never happen entirely outside of the analytic dyad. That is why supervision, or consultation, alone should not be allowed to “direct” the handling of a case. The analyst or therapist concerned should always look \textit{within} the ongoing work with the patient for confirmation, or the \textit{lack} of confirmation, of such advice from any outsider. And that should include any of the analyst's own thinking within the process of internal supervision: that too should be confirmed, or not, within the ongoing relationship with the patient. And it is only within the ongoing work with a patient that it can emerge what has been “right” and what has been wrong. But the answer to this ongoing investigation is not always to be found in the manifest content of what a patient may be saying. The wider context, and the unconscious communications from the patient, must also be taken into account (see below). \textit{Whenever trauma is reexperienced within an analysis, it is “cocreated” [Fosshage] with the analyst, as if the analyst here were disregarding this. I agree that the two-person interplay, between analyst and patient, should always be taken into account.}

\textit{I also completely agree with Fosshage that we should always “be aware of and … acknowledge how our action [has] triggered it.” I regularly look for the way in which I have triggered a patient's response(s) and work openly with it, with the patient. The analyst of Mrs. B here is used to represent those analysts who seem not to acknowledge their own part in the interaction with the patient, and they should certainly be challenged to be aware of the co-creation of what happens between themselves and the patient.}

McLaughlin states his position, as if in contrast to mine:

\textit{I work from the position that the patient's experience of my behaviors as traumatizing needs to be accepted as valid in its own right and not arbitrarily seen as a transferred reflection of past trauma. I accept my impact as iatrogenic, missteps of my own until subsequent exploration shows us otherwise…. From this position I cannot envision that we work toward or with the past in its pristine form.}

I completely agree with this. In fact, surely, there is no such thing as the past in its pristine form any more than there can be a phenomenon that is “just transference.” And I believe that we should be constantly monitoring the nature of our impact upon the patient and the effects of this upon the interactive process.

\textit{Fosshage points out that there are some analysts who still use the “displacement model,” seeing the analysand alone as enacting the transference as if it were only generated intrapsychically.}

I agree that there are serious problems with the displacement model, which is why I consistently use the “organizational model”—although I haven't called it that before. I maintain that the analyst should \textit{always} seek to understand from the patient's view what his own contributions have been that have triggered the patient's emotional experience and what the
particular meanings his actions have had for the analysand. This is what Fosshage is advocating, and this has been a central theme throughout my writing. So I completely agree with this. That is why I rely so much upon trial identification with the patient, in particular within the ongoing process of each session, to monitor this interaction throughout from the patient's point of view.

I am therefore pleased to see that Ruderman also advocates that we “take seriously the impact that our responses and behaviors can have for our patients.” Without this, we can surely get at odds with our patient and will, without doubt, create iatrogenically induced disturbance. And when this happens, I too believe that this should be acknowledged—as it was throughout this clinical sequence. None of my interpretive work with Mrs. B was done without this dimension being considered and acknowledged by me, but I see that Fosshage writes as if the analyst of Mrs. B had neither seen nor acknowledged his contribution.

Interestingly, Fosshage suggests that I might, at one point, have said: “I can understand when I did not respect your signal to stop and continued with my interpretation, how that could easily have felt like the advancing surgeon.” In fact, I said almost exactly that, except that I put it terms of the surgeon going on regardless (see later), but it is not possible to include each and every interpretation in a clinical account that has to be kept within definite limits.

Some discussants seem to see the analyst as coldly following the rule of abstinence, apparently regardless of the implications of this for the patient. And McLaughlin sees me as likewise committed to nongratification, which again is missing the point of what was guiding me throughout this sequence.

I too would regard that as heartless, and it should certainly be challenged. I would like to think that no one would do that. Similarly, the analyst is seen as holding a position of “technical certainty that the proscription of touching is the only valid stance for effective work” [McLaughlin, this issue].

That too should be challenged, and I would never wish to support that view. Again, it is interesting that I have been seen as apparently doing just that. Yet, I have consistently wished to question any analyst who is in “pursuit of his own theoretical bent” [McLaughlin], and maybe anyone who is building a case, as I believe Pizer is doing in her paper. And, as part of that, Pizer even imagines an interpretation when there had been an uninterrupted silence. She writes: “What leads me to assume that this awareness took the form of an interpretation to Mrs. B is that his [casement's] next statement reads: ‘Mrs. B then reported an image, which was a waking continuation of the written dream.” She seems to find it hard to believe that this important communication, of the analyst being seen as collapsing, had not been in some way prompted by me.

All of my writing has been an attempt to show the importance of following the patient—above all else. And the clinical presentation under discussion was especially intended to illustrate this too. My commitment throughout the case of Mrs. B was to follow (really follow) her overall communications, rather than being committed to any particular point of theory or technique. Sometimes, in following the patient, we might incidentally appear to be confirming a particular aspect of theory or technique, but in practice that should always be secondary.

The analyst is seen as finding it “best to keep to the certainty of rules that simplify the practice and justify the nature of its outcome” [McLaughlin, this issue].

In fact, like McLaughlin, I “prefer to risk what feels right, to gamble with consequences I do not know enough to prejudge, and to deal as openly as I can with the consequences of working in a two-part confluences” (see below). The analyst's framework is seen as “a distinctly authoritarian one-person psychology” and that “of a one-person experience of certainty” [Pizer, this issue].

I too would want to take issue with any analyst who works with such a framework or from such a position of certainty. In my opinion, we cannot ever ignore the experiential fact of working continually within a two-person relationship, which also requires a two-person psychology, if we are to follow at all adequately what is happening between a patient and an analyst, and why. This assumption about my framework results in seeing me as apparently collapsing or foreclosing the potential space, at the very moment when I was in fact keeping it open for what followed (see below).

The analyst is seen as rigidly rule-bound [Pizer, this issue].
Analytic work of any real value cannot, in my opinion, be done on a basis that is bound by rules. This is why I have taken
trouble to outline as carefully as I can how we need to follow patients, not only at the manifest level of what is said but within
a fuller context, also taking into account the unconscious meaning of the interactions taking place between analyst and
patient. But, when we do follow the patient at this deeper level, we sometimes arrive at a position that is far less comfortable
than anything we might personally have chosen (see below).

There are many other occasions when the analyst of Mrs. B is used to fit in with the points that various discussants are
wishing to make, and many of their points are well worth making—as a general indication of what is appropriate compared
with what is not appropriate for analysts to be doing. But I now hope to clarify, better than I seem to have done in my original
paper, the context within which all of this work was being carried out.

Further Reflections on the Clinical Sequence Under Discussion

It may help if I say, to begin with, that one of the main issues during the first 2 years or so of this long analysis was that
Mrs. B had been seriously traumatized at a time of continuing dependence. She had therefore developed the defense of “self-
holding,” whereby she sought to protect herself from ever again depending on another person—at least at any deep level of
dependence.

Foreshage is quite correct in wondering about the history of the despairing child. And he asks: “Does [the patient's]
caretaker position represent a primary adaptation to loss of a protective mother?” Yes, indeed.

So, it had been a feature throughout those first years of this analysis that Mrs. B would frequently seek to control me, a
control that I usually allowed her. Latterly, however, we had been negotiating the beginning of some separation from that
near total control of me as analyst. Occasionally, as when I did not accept her signal for me to

———

stop, I had stood my ground in the course of some interpretive work. Gradually, through such moments as these, Mrs. B had
begun to allow me a more separate existence and a mind of my own, that was not held totally within her control.

I believe that we had to find a way for this gradual differentiation between herself and me, as not merged and as not
totally controlled by her, in preparation for what was to come later. Winnicott speaks of this differentiation in his paper “Use
of an Object” (1971) as a necessary step toward a patient becoming able to “use” the analyst, who is thus found to have a
capacity to survive, which actually belongs to the object—that is, not merely “given” (in fantasy) by the patient. With some
patients, this discovery alone can lead to a fuller experience of being held, when that holding truly comes from an “Other”
who is no longer seen merely as an extension of the patient's own self-holding. So, this was an important background to the
sequence under discussion, but I know that it does not in itself justify my not stopping when the patient signalled me to stop.
Thus, in the course of this session, my not stopping clearly came to be experienced as my being too much like the surgeon
who had carried on regardless. This is precisely what Winnicott writes about when he says that, at a crucial moment, we will
find that we have failed a patient “in ways determined by [the patient's] past history” (Winnicott, 1965, pp. 258-259). Yet,
he says, “in the end we succeed by failing—failing the patient's way. This is a long distance from the simple theory of cure
by corrective experience” (Winnicott, 1965, p. 258).

This similarity to the surgeon was acknowledged by me throughout. But, in my account of this work, I now realize that I
was not spelling this out clearly enough for some readers to follow. It happens that it was so much a part of the daily rhythm
of this analysis, in which the patient and I had been following each and every interaction between herself and me (in
particular, my part in what she was

———

3 Winnicott's notion of use here is quite different from what I am calling the “use” of the analyst of Mrs. B, which I have referred to above. Simple use, as in using someone to represent a particular position being criticized, is quite different from what Winnicott was speaking of. He was referring to a patient's discovering the analyst to have a separate existence outside of the patient's omnipotence, whereby he/she is found not actually to need the patient's protection to survive. Only then can the patient discover that his/her most intense feelings are not, after all, lethal to the other as had previously been assumed.

reacting to), it was understood by now that I was always thinking of that—and so was she. We both knew that. And never, at
any time, was anything in this clinical sequence regarded as “just transference.” It was always explored in terms of what my
contribution(s) had been and how the patient was responding to these, both in the present and in terms of her past experience (as detailed in Chapter 5 of Casement 1990).

Also, the quality of the transference neurosis at this stage of the analysis was such that the past was nearly all the time present. So, there was never an occasion for moving away from the present—as it were—to the past. We were constantly having to follow which bit of the past was most immediately present in a session and in each part of a session. So, staying with what the patient was bringing was a matter of staying with whatever experience from the past was being relived in relation to me at any particular moment—in response to whatever had triggered this within the analytic relationship.

Another background issue, which had been there from the beginning of this analysis, but which had been coming increasingy to the fore in recent months, was Mrs. B's belief that no one would be able to survive the full impact of her feelings: of her neediness, her anger, and her despair. As part of her characteristic defense against this anticipated collapse of the other person and of me as her analyst, Mrs. B's defense had frequently stayed with relating the details of her traumatic past—as an account of her life story. For a long time, therefore, she had thus avoided relating to me except as to a hearer of her narrative.

One suggestion [Fosshage] was that Mrs. B would still, surely, have been able to “talk about” her traumatic experience, even had I been holding her hand, and she might even have been better able to talk about it under those circumstances. But a major step had begun to be made in this analysis in that Mrs. B had begun to relate to me more directly, with the feelings that belonged to those figures in her past—who had apparently not survived her neediness, rather than just “talk about” what had happened to her. In fact, at this time in the analysis she was definitely beginning to relate more intimately to me, as a person relating to her, rather than to me as someone there to hear her story. This change, however, was bringing her into the area of her greatest fears: that I might actually collapse under the weight of her neediness. In fact, this was not just her fear: it was her conviction that I would collapse.

So, we come to the sessions under discussion.

First, on the Friday my countertransference was far more comfortable than is being attributed to me—in relation to the possibility that my patient might hold my hand. True, I was definitely anxious that I might lose my patient, and that fear was certainly made worse because I knew that I could be questioned about how my work with Mrs. B had been progressing, since the clinical sequence described in the paper that I was shortly due to present to my Society. But, apart from that, I felt quite at ease with this possibility of her holding my hand.

There had already been some important analysts before me (members of my own Society) who had found the courage to challenge the classical position, such as Balint and Winnicott. So, why shouldn't I too find the courage to do what they had done? And, surely, nobody could seriously question my decision to let this patient hold my hand—or just have the possibility of holding my hand—in these circumstances. How could anyone challenge my judgment on that, I had thought, had I kept open the offer of my hand for her to hold—particularly with this patient's history of a mother whose hand had slipped out of hers at such a crucial moment? And, in any case, my clinical position had long been that of a protestor against any blind following of rules—I being by nature a bit of a rebel. So, why not agree to her holding my hand, under these circumstances? In fact, I felt quite untroubled by that “decision” made on the Friday.

I am here reminded of a point made by Ruderman who considers it important (as I do too) that the question of touch be considered from within one's own particular limits—“whether touching ‘fits’…” But my limits had to be extended by the Monday. On the Friday I certainly did not have the courage to go through this sequence without the patient having the possibility of holding my hand. My habitual preference for fending off something difficult, also for offering myself as a “better mother,” were still not well enough worked through in myself at that time. So, the safer course for me was the one I was offering to take on the Friday. But, I had to find a way far beyond that if I were not to let down my patient most seriously.

I am also reminded of Fosshage here, when says: “An analysand's remembering and reexperiencing of a trauma … cannot be an exact replication. It must occur ultimately in a different way for it to be reparative, or otherwise the trauma would be simply replicated and reinforced.” The difference that Mrs. B needed, which she was unconsciously indicating to me, was not merely that I should be available to her to hold my hand but that she needed to find someone who was able to be there for what she had been feeling at the time when her mother had failed to be there. That is where the real therapeutic difference lay: not in the simple difference of having someone to hold her hand! Also, it was not just that she needed an opportunity to remember, but a chance to find someone able to bear the impact of her feelings about what she was remembering.
However, what began to shake my almost complacent acceptance that my patient could hold my hand, if necessary, was what happened on the Sunday morning. Mrs. B had hand-delivered the text of a dream from the previous night, in which “the despairing child ... was crawling towards a motionless figure with the excited expectation of reaching this figure.”

Two things in particular worried me about this: first, that I was again being represented as “motionless.” This reminded me of the long time in this analysis during which I had been held in place by the patient's defensive need to control me. This now felt like a warning that she might be slipping back into that position in which I was barely allowed to function as analyst, as a person separate from herself. I could argue that she might have needed to return to that defensive position, and I would probably have been comfortable with that possibility were it not for the second pointer—in that Mrs. B had felt it necessary to bring this dream to me on the Sunday, rather than wait until her Monday session. That was even more worrying.

Mrs. B's not waiting to tell me her dream further prompted me to realize that she was almost certainly feeling that I might need to be reassured (and this was confirmed in the Monday session). It looked as if, in her mind, I might really not survive the weight of anxiety left with me on the Friday unless she helped me to survive—by telling me straight away that she was feeling able to go on. This rang...

---

4 This is where the patient needed to be able to experience her old self, apparently with old other (thought to have withdrawn like mother), beyond which she could discover a new other who could—after all—survive the intensity of her feelings about that withdrawal. In working through that new experience (with me as the surviving, and therefore new, other) Mrs. B could the begin to experience herself as new self with new other, as so usefully described by Shane, Shane, and Gale (this issue).

---

many warning bells for me. For this was in the area of Mrs. B's belief that she would undoubtedly become too much for me. But what might be too much for me? Holding her hand did not seem to be a problem to me. But her not waiting to tell me was indicating a problem in this for her. She seemed already to be wondering why I had agreed to let her hold my hand. She also seemed (unconsciously) to intuit that the safer course for me was in allowing for the possibility of her holding my hand. With my hand in hers, or the possibility of her holding my hand still in place, I could much more readily count on being able to return to the safer position of again just listening to her narrative, rather than being more fully there for her to use me as the object of her anxiety and rage.

My agreeing to Mrs. B holding my hand was truly out of a failure in my courage, not a failure to be abstinent, but a failure to stay with the drift of the patient's material, all of which had so consistently been pointing to her greatest fear. That had not been a fear of remembering (she had long been remembering) but the fear of being too much for her mother or for the “Other.”

Breckenridge, I think, senses some of this when she points out that the patient could see that I was afraid of something, and she is right. However, the real fear was not in the idea of Mrs. B holding my hand but in what I would have to face if I were to withdraw that offer of my hand. And so it proved to be. She goes on to say: “The weekend seems to have convinced him that he wasn't afraid.” No, it had convinced me that I was much more afraid of what lay ahead in the analysis, in the way it went, and I knew that I owed it to my patient to find sufficient courage for me not to remain governed by that fear—my own fear.

I had unconsciously registered that, in agreeing to something unusual, I was almost certainly seeking to bypass something else more difficult that was around the corner, and we could still have avoided that if I had not reread the hand-holding. But then, the idea of withdrawing the possibility of Mrs. B holding my hand seemed more than I could tolerate, despite this already being indicated through her seeing me as likely not to survive the pressures of the Friday session without her help. Even though I had always been advocating the importance of continuing to follow the patient's communications, including the patient's unconscious prompts, here it seemed I was being pointed to something that was more than I could contemplate alone, especially if that might mean having to withdraw my hand...

from her. I therefore sought an urgent consultation. I rang up Dr. Paula Heimann who was already familiar with my work with Mrs. B. She agreed to see me straight away—on the Sunday.

Dr. Heimann, knowing the case, was clear that I would be avoiding what seemed to be the worst thing in my patient's experience: the intensity of her feelings, assumed to be unmanageable. And it had already been evident that Mrs. B had formed this view of her intense feelings, as too much for the “Other,” in relation to her mother who had been unable to stay with her throughout the operation. If I were to keep open—unquestioned—the possibility of Mrs. B holding my hand, I too would almost certainly be experienced by her as either unwilling or unable to bear the impact upon me of her feelings that had originally been directed at the mother who had fainted—in Mrs. B's mind because of them. So, if I continued to behave...
as if I too had to avoid the impact of her distress, I would undoubtedly have confirmed her deep conviction that no one could bear to remain in touch with her neediness and her most intense feelings. Dr. Heimann was therefore of the opinion that my avoidance here would almost certainly then come to promote a similar avoidance in my patient and that this might develop into a continuing avoidance of any really intense dependence upon anyone. The issues therefore were of profound importance.

Although I could see what Dr. Heimann was saying, I left my consultation with her still feeling that I could not possibly withdraw my offer merely because this consultant was so sure that I should. (And the reaction of many discussants in this issue highlights how unthinkable that was to me at that time.) In fact, I had said to Dr. Heimann that I saw no way in which I could do such a thing. However, she had replied: “Of course you must not introduce this from outside your work with the patient. You can't do that just because I say so. The patient will lead you. She will show you the way.”

I felt fairly happy with that last point, which I had always believed in; but on this occasion I was actually wishing to believe that my patient would lead me differently from how Dr. Heimann was suggesting that she might. Then, to my horror, in the very next session Mrs. B began to see me as the figure she might reach but who was then seen as collapsing.

This, then, was not just the first unconscious prompt from my patient that the handholding was not being quite the helpful thing that, on the surface, it had seemed to be. Over the week-end, and in the first session after it, Mrs. B was already seeing me as confirming her long-held belief that no one would be able to survive the impact of her most intense feelings. I had to take this in, and it is central to what I regard as learning from the patient that we be prepared to learn even what we least want to know. And this was precisely the thing that I least wanted to be hearing from my patient at that moment!

What, then, about my countertransference during this sequence? On the Friday I had, it is true, been trying to explore (prematurely) what may have been in the time before the accident. I had been wanting to believe that we had already negotiated the worst of this patient's traumatic childhood, in her reexperiencing of the accident (described in Learning from the Patient, Chapter 5), not wanting to consider that there could be something worse still to come—worse also for me. At this moment, therefore, I was the one who was defensively taking flight to the past.

So, my countertransference was also picking up something about what else might lie ahead. And I now know that I had been defensively deflecting the patient, and myself, from whatever it might be that did still lie ahead, by my unconscious manoeuvre to keep the worst of that experience still outside of the session. Then, with the help of my patient's prompts, I could no longer avoid seeing the more crucial issue for her: that of her analyst being experienced as “collapsing.”

Now, what grew out of this sequence was quite extraordinary. Mrs. B knew nothing about my consultation with Dr. Heimann (though I did eventually tell her of this several years later), but Mrs. B and I later learned something further about the background to her experience of her burns. Her mother had subsequently told her that (for reasons that I do not wish to go into here) it would not have been safe for her to be transferred to the nearest hospital for treatment after she had been burned. (The only hospital she could have gotten to was known then to be in no fit state to care for a patient with such severe burns.) In fact, the doctor actually thought that the child would die if she were to be sent to that hospital, and there were reasons

5 Mrs. B, at this time in her analysis, also did not know the detail I shall give below. She only came to hear of it from her mother sometime later and partly as a result of what she had been through with me in the analysis.

why she could not be taken to any other. So, the doctor had said to Mrs. B's mother that the best chance of her child surviving would be if the mother could nurse her in the home. But that would mean barrier nursing her, that is, not holding her or touching her except with sterilized gloves and then only for the most minimal and essential feeding and cleaning of the child. Whatever she did, the mother must not pick up her baby—however much the baby cried to be picked up—for if the mother did pick up her baby, it might lead to her dying from infection. What a parallel! So, we can imagine the agonies that her mother must have gone through as she cared for her baby, while having to inhibit the natural impulse of a mother to hold her distressed baby to herself, to give her the hug that is meant to “make it all better.”

Strangely, and I had no inkling of this at the time, I too had to go through similar agonies in being there for my patient's distress, and readers of my description of this also seem to have sensed something of that agony, wishing so strongly that my patient could at least have had the reassurance of my hand to help her through that experience. And, at the time, what I was doing made no more sense to Mrs. B (consciously) that it has to those discussants who have so much disagreed with my
the point of most fully having to become an analyst to get through it.

had to follow throughout: by no means just following a rule of abstinence.

behind me helping me not to swerve from my following of my patient's unconscious communication. That was really what I

too could not have found the courage to go through this sequence in the analysis, without holding, had I not also had a doctor

was that she nurse her baby without doing that most natural thing a mother would want to do, under the circumstances. And I

baby's recovery from the burns, in the analysis. Also, her mother could not have managed this alone: she had a doctor behind her telling her how important it

in the analysis. Also, her mother could not have managed this alone: she had a doctor behind her telling her how important it

in the analysis. Also, her mother could not have managed this alone: she had a doctor behind her telling her how important it


mother to collapse, hence Mrs. B's alarm at the thought that her analyst too seemed to be collapsing. And, already over the

weekend, the analyst in her mind had seemed to be in need of her reassurance—for him to survive the impact of what had

been so present during the previous week and on the Friday in particular. That issue (of surviving the intensity of her

feelings) had thus emerged as central—I seeing only some of it at first, but fortunately seeing enough of it to sense that I have

to find the courage to go through it with Mrs. B, and not in anyway to bypass it, however alarming it was to me as well as to

my patient.

I certainly did need a new courage to grasp the nettle when I did and to be there in this way for Mrs. B throughout many

months of her feeling so sure that I had acted out of cowardice and her raging at me for what I had done. But this fresh

courage was of a quite different order to anything that I had previously needed in what I had so far encountered with this

patient or any other. And it was only by following my patient through each and every session that I could find a way. None of

this could have been negotiated by rule, even less by rule alone. Throughout, it had to be seen as a two-person issue and

interpersonal. On both points I am in full agreement with those who have been stressing the importance of that perspective.

Also, I could most certainly not have stood by my “decision” had it been made simply on the basis of a rule, nor indeed

had it been merely upon the advice of a consultant, however much I respected Dr. Heimann. But it had been in my patient's

own communications, in the immediate context and in the wider context of the analysis as a whole, that I was being so clearly

prompted to act as I did: prompted that is, at a level far more crucial than that of the surface communication, which has

seemed to have been so persuasive to some readers of this clinical account.

I do not now regret having chosen to follow my patient in the way that I did, though there were many occasions at the

time when I wondered if I had been mistaken. And frequently I wanted to believe that I could have been mistaken. That

would have allowed me, after all, to capitulate to the pressures from my patient as she consciously so wished that I would.

My patient too does not regret that I stayed with my decision to follow her prompts. It was not a matter of persuading her

to agree with me, as has been suggested. Mrs. B, at the very end of her analysis,

selected this sequence in particular as the time that had been most central and most crucial to her. It had finally given her a

chance to refind the mother who had helped to save her life: strangely refound through my not holding her. In her mind,

previous to this, her mother had always seemed to have been cruel to her, in not being there for her when she had been most

needed, particularly at the time of the accident and later with the surgeon. Her mother, she later discovered, had in fact

managed to be there in the barrier nursing despite the appearance of not being. And, it should be noted, the loss of the

mother's hand (at the time of the operation) was all the more traumatic for Mrs. B because it so replicated the absence of her

mother's hands throughout that period of barrier nursing, but we did not know this at the time.

I felt that there had been a most extraordinary parallel process around when I learned of the mother's contribution to her

baby's recovery from the burns, in not holding her, so uncannily replicated in my not holding of Mrs. B during this sequence in

the analysis. Also, her mother could not have managed this alone: she had a doctor behind her telling her how important it

was that she nurse her baby without doing that most natural thing a mother would want to do, under the circumstances. And I

too could not have found the courage to go through this sequence in the analysis, without holding, had I not also had a doctor

behind me helping me not to swerve from my following of my patient's unconscious communication. That was really what I

had to follow throughout: by no means just following a rule of abstinence.

So, this is what I mean by “learning from the patient:” really learning from the patient. In fact, I have come to believe

that this sequence is what brought me to the point of most fully having to become an analyst to get through it. And this was

by no means a matter of just following the rules that classical analysts have chosen to follow. That, in my opinion, is not what

being an analyst means. It means truly following the patient and daring to go where the patient unconsciously prompts us to
go. And it meant so much more than merely proving what some people might regard as a “rule.” My struggle was not how to stay true to some rule, but how to remain true to my

6 The late Dr. John Klauber, once President of the British Psycho-Analytical Society, often used to say to recently qualified analysts: “Do remember that it takes at least 10 years to become a psychoanalyst—after qualification.”

patient. These are very different issues. That is why I regard the outcome here as something far more than anything to do with rules. Any similarity with the position advocated by classical analysis was therefore merely fortuitous and entirely secondary.

This sequence, therefore, became the heart of my book Learning from the Patient, (Casement, 1990). It is not, as has been suggested, where I had slipped away from learning from this patient. But, as I have been trying to say, if we really do learn from our patients, we will sometimes find that we are faced with having to learn some things we would much prefer not to be learning, hearing, or needing to find out.

Before ending, I would like to respond to some of Pizer's questions to me.

First, she asks whether I might “consider listening to [her] experience, and learning something so ‘other’ than what [I] already know.” I would gladly learn from something other. But, ironically, Pizer and I are actually on the same side in this, even though (as part of her dialogue with “the analyst of Mrs. B” as she sees him) Pizer places me somewhere quite different from where I actually was.

Pizer sets us all a wonderful example in the careful examination of her countertransference, without which she would not have become free enough to handle the case of Clara with the sensitivity she ultimately showed. I regret not having included more of my own exploring of my countertransference in my original paper, as I am sure that some of the misunderstandings that have emerged in these discussions could then have been avoided. But I hope that some of this will be clearer now, and I also hope that even the misunderstandings may have been fruitful in the discussions that were prompted by them.

Like Pizer, I too had to recognize where my Achilles heel lay in the sequence under discussion; however, it was not in any fear or unease at the possibility of holding my patient's hand nor in the possibility of going against some rule of analytic technique. It lay, instead, in my readiness to back off from something much more difficult for myself (in what came later) in the name of being there as the “better mother.” That was what drew me into agreeing that my patient could hold my hand, because that would have been inwardly easier for me. That was my lapse, not a lapse in relation to either abstinence or gratification of the patient, as many have been assuming,

but a lapse in my following of the patient at a time when she most needed me not to fail her.

More directly, Pizer states: “We don't know that your really holding Mrs. B's hand would have indeed produced a greater mistake.” I can understand that, in the absence of a fuller description of the context (including the state of my countertransference), Pizer might feel that she cannot know that. But in the context that I have now described more fully and with what we now know that followed from this, I do know that it would have been a mistake—a grave mistake. This would not have been because of any breaking of rules, let alone because of any gratification of the patient, which was never an issue here. But, from the patient's perspective, and within the over-all context of the analysis up to this point, I would have been seen as defensively steering away from what Mrs. B was sure that I would not have been able to survive, as if I were agreeing with and confirming her worst fears.

Pizer likewise presumes to know of me that: “At that moment in time in your clinical sequence you would not have felt comfortable holding Mrs. B's hand. You would have betrayed yourself and your analytic integrity—and therefore your capacity to hold, analytically, your patient.” Unfortunately, she has this back to front. I would personally have felt far more comfortable holding Mrs. B's hand. In truth, any betrayal in this sequence would have been in my remaining afraid to confront with my patient what she had so deeply believed I would be afraid to face: the very thing she had for so long remained convinced that no one would be able to survive if directly confronted by it.

The gains from this time were not primarily in Mrs. B being faced so immediately with her own trauma but in her finding that her analyst had opted to face it with her—in himself as well as in her—and in particular the feelings that had been so intimately associated with it. She had thus become able, eventually, to discover that, even in her most intense neediness and despair, she could find herself in the presence of someone able to survive the most immediate experience of that. These same feelings, from which she had spent her lifetime since the accident protecting the “Other,” were discovered after all not to be “lethal” as she had always assumed them to be. Then, and only then, could Mrs. B begin to find her new self in relation to a new other—as described by Shane, Shane, and Gales.
Finally, in the face of so much speculation regarding what I apparently should have done or what some people think would have led to a better experience for my patient, it may help if I allow Mrs. B herself to have her own last word here. Feeling it only proper that I should seek my former patient's agreement to this further exposure of her story, I sent a copy of my draft manuscript to Mrs. B for her comment and permission. Her reply seems most apt and pertinent to this discussion, the last words of which were: “I am just so grateful that you did listen and that you had the guts to be the analyst you were to me.”

I hope that I have been able to clarify further the journey I found myself travelling with this most interesting and challenging patient and how my decision grew out of that careful following of her unconscious cues in the ways outlined above. But I can see that the result has gone so much against the grain of “common sense” alone that some people have previously not been able to recognize what it really was that guided me. I do hope that they can now see more of the overall context and, with the help of that, now see beyond some of the assumptions that have directed their discussions so far.

I have valued all of the contributions in this most timely exploration of the issues concerning touch. I am also extremely grateful to Ellen Ruderman, “the onlie begetter” of this Issue of *Psychoanalytic Inquiry* and to the Shanes for their fulsome support of her imaginative project. And, of course, I am greatly indebted to them collectively for providing me with this opportunity to respond to the discussions in this issue on touch and in some measure to clarify the journey that my patient and I were ultimately engaged in.

**References**


**Article Citation**