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Physical Touch in Psychoanalysis: A Closet Phenomenon?

Kati Breckenridge, Ph.D.

I ALWAYS THINK IT IS INTERESTING to know why someone would take the time and effort to write an article. For me, one reason was that I knew from my own clinical work that there was occasional physical touch between patient and analyst. I could not accept that the psychoanalytic literature was so devoid of any discussion about it, reasoning as I did that I could not be the only one. I knew that during a moment of joy or a moment of pain, a patient and I might have limited physical contact, like a hug, an arm around the shoulders, or a hand held when offered. I could not see the harm; to the contrary, I could see its analytic value. Yet, in researching the literature, I noticed the almost total absence of references to touch in analysis.

Why, I questioned, was it not discussed in the literature? It may be that one answer has to do with a traditional and unquestioned assumption that touch belongs outside what is proper psychoanalysis. However, aided by the current ferment in contemporary psychoanalysis, many analysts, myself included, do not accept the idea of so-called "proper psychoanalysis." To me, **Spezzano (1993)** captured something vital in reference to the nature of truth in psychoanalysis when he said:

Dr. Breckenridge is a psychoanalyst and psychologist in private practice in West Los Angeles. In January 2000 she became the new president of the Institute of Contemporary Psychoanalysis in Los Angeles, where she is a Supervising and Training Analyst.

> *In a relational, two-person model of inquiry, discovery, and truth there is always more to be said. The point, as a matter of fact, is to keep talking. Truth is not relative in the sense that it is anything anyone chooses to label as the truth. Nor is it proven at one moment in time and then written in stone for all time. Truth emerges out of our conversations and confrontations, remains the truth for a time because no one can talk about the matter at hand in a more useful and compelling way, and then becomes not true or an irrelevant truth because someone does find another way to talk about the same matter that now seems more useful and more compelling [pp. 5-6].*

In writing this paper I want to challenge the idea that physical touch does not belong in the analytic session or in the analytic literature.

My premise in this article is that physical contact between analyst and patient within the treatment is not something to be categorically avoided. Rather, it should be considered between patient and analyst in the session and discussed in the literature in the same way other interactions in the relationship are. (My discussion of touch in this paper relates to nonsexual, nonaggressive, physical contact within the ethical and legal guidelines of one's community.) To support my contention, I will present some clinical material of my own where limited physical touching has been a natural and integral part of the work. In doing so, I have considered the risk to me as an analyst. The position I am taking is not common, and some analysts may consider what I am doing unanalytic. However, I do not see things that way, and this paper is partially in response to that anticipated assessment.

Touch Historically

Early on, before psychoanalysis was established, Freud himself had used touch. Disappointed with the limitations of hypnotic technique, Freud began the procedure of placing his hands on the patient's forehead

when free associations were slow in coming. He would instruct the patient to let the memories come in response to the pressure from his hands. When he abandoned hypnosis, he abandoned touch. He described his method as including the avoidance of touching patients “in any way, as well as any other procedures which might be reminiscent

of hypnosis” (Freud, 1904 cited in **Mintz, 1969**, p. 367). Mintz suggests additional factors contributing to the early avoidance of touch in psychoanalysis: the onus of violating Victorian sexual prudery, which psychoanalysis, with its ideas of childhood sexuality, was already vulnerable to and the aim of the early psychoanalytic movement to establish itself as scientific, distinct from magic or religion.

The interdiction on touching was codified with the development of the rule of abstinence. Beginning in 1910 Freud wrote, “The patient should be kept in a state of abstinence or unrequited love…. The more affection you allow him the more readily you reach his complexes, but the less definite the result” (**Jones, 1955**, **p. 448**). Then in 1915, Freud further articulated his stance with what was to become known as the rule of abstinence:

> *The treatment must be carried out in abstinence. By this I do not mean physical abstinence alone, nor yet the deprivation of everything that the patient desires, for perhaps no sick patient could tolerate this. Instead, I shall state it as a fundamental principle that the patient's need and longings should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes [p. 165].*

Later, in 1919, Freud forcefully stated, “Analytic treatment should be carried through, as far as is possible, under privation—in a state of abstinence” (p. 162). The theoretical rationale for this position was that blocking the patient's instinctual drives from being discharged would force their transformation into verbal representations. From there, the now conscious repressed instinctual wishes could be worked through to achieve their renunciation and sublimation.

From a classical psychoanalytic perspective, not touching the patient made all kinds of sense, as did every avoidance of gratification. However, **Lindon (1994)** points out in his paper on gratification and provision that, despite the theoretical directive there has always been actual gratification in psychoanalysis—with Freud a frequent contributor. Freud would show patients his small statues, give them meals, send them postcards, lend books, give them gifts of oranges or photos of himself, and so on. On the one hand, gratification has always existed as a reality in psychoanalysis; on the other, as Lindon states, “Not quite a law of nature [the rule of abstinence] … is unconsciously

taken as a given in psychoanalysis” (p. 551). In my opinion, the rule of abstinence is the foundation for a generally unquestioned related assumption: that of the prohibition on physical contact in psychoanalysis.

Despite the rule of abstinence, there are, here and there, a few early, scattered references to touching. **Mintz (1969)** cites Fromm-Reichman and Searles as two analysis who allowed physical contact in their work with severely disturbed patients. In addition, Winnicott's holding of regressed patients is well known. For example, **Little (1990)** wrote about her analysis with Winnicott and the essential physical holding he provided during moments of serious regression. **Balint (1952)** also writes of the occasional necessity of touch:

> *My clinical experience was briefly this: At times when the analytic work has already progressed a long way, i.e., towards the end of a cure, my patients began—very timidly at first—to desire, to expect, even to demand certain simple gratifications, mainly, though not exclusively, from their analyst. On the surface these wishes appeared unimportant: to give a present to the analyst or—more frequently—to receive one from him; to be allowed to touch or stroke him or to be touched or stroked by him, etc.; and most frequently of all to be able to hold his hand or just one of his fingers. Two highly important characteristics of these wishes are easily seen. First: they can be*

satisfied only by another human being; any autoerotic satisfaction is simply impossible. Second: the level of gratification never goes beyond that of mild fore-pleasure. Correspondingly a really full satisfaction followed by an anticlimax can hardlyever be observed, only a more or less complete saturation. Thus, if satisfaction arrives at the right moment and with the right intensity, it leads to reactions which can be observed and recognized only with difficulty, as the level of pleasure amounts only to a tranquil quiet sense of well-being [p. 231].

Balint's focus, undeterred by the pall on provisions, was in helping his patients to and through regressive states for which he felt that physical contact was sometimes necessary. His conclusion that the effect of the touching he gave was primarily a "sense of well-being" matches my own observations.

Thirty years later, **Pedder (1986)**, another British Middle School analyst, working with a regressed patient who needed physical contact, tried to find a theoretical ground for supplying the touch he felt his patient needed. He turned both to Balint's writings and to Bowlby's attachment theory for that grounding. The two theorists provided a "new way of viewing such patients' needs in a framework other than that of classical libido theory" (p. 295). In Bowlby and Balint he found the support he needed. Although original and exploratory in his treatment work, in this paper's preface he takes the traditional position. There he distances himself from touching, saying that "the technique used has not become a standard part of my therapeutic repertoire, and I have not handled a case in a similar way since" (p. 296). However, he also maintains that analysis do sometimes have to face such demands and that, although they may be discussed informally, "they are seldom written about" (p. 296). I find Pedder's struggle to find a way to respond to his patient and not be constrained by tradition admirable. I also find his need to distance himself from nonconformist technique understandable, given that there is so little support publicly for exploration and discussion in this domain.

The limited number of articles in the psychoanalytic literature that even mention physical contact suggests that analysts are either not writing about what actually happens in their practices, or the rule of abstinence is still dominant. One article that does, at least, address the issue of touch is an intriguing paper by Patrick Casement. In it he presents a moving sequence with a patient, wherein his refusal to touch her, despite her pleas, is pivotal.

Touch in Casement's Case

Within classical libido theory a theoretical argument can be made for the restriction of physical contact. In that theory, giving the patient what he or she needs interferes with remembering; it allows discharge into the "motor sphere" (**Freud, 1912**, **p. 153**). But when the closed energy system of that theory is discarded, then how can we decide what provisions are good? No other theory provides such clear guidelines on provisional behavior. Despite this, analysts of all persuasions have apparently retained the assumption that physical contact is wrong or ill-advised. To my view, **Schafer (1983)** describes the situation we find: "Experience is a tricky factor to consider. I

think it was Sartre who said somewhere that experience usually consists of somebody's repeating the same errors over a long enough period to feel entitled to claim some absolute authority for doing things in that faulty way" (p. 287).

To make this point substantively, I will discuss the clinical case first published in *The International Review of Psychoanalysis* in **1982** by Patrick Casement and later reworked for a chapter in his book called, ironically, *On Learning from the Patient* (**1985**). Casement describes in detail a long, very difficult sequence with his patient, Mrs. B, in which the issue of abstinence—specifically about holding her hand—is pivotal. It is clear from Casement's moving description of the case that he was deeply affected by the difficult work with his patient. However, he states that he followed his patient's cues and learned from her. I

do not agree. Of the several exchanges described by Casement in this evocative case rendering that I could use to make my point, for the sake of space, I will focus on only one. That one, to me, is a clear illustration of his NOT listening to his patient.

In trying to work through her traumatic feelings, Mrs. B says she must have Casement available to hold her hand if she needs it. Although he considers it briefly, he retreats to his standard abstinent position, theoretically justifying it to himself. He believed that it would be wrong for him to try to be a "better mother" and, further, that if he were to hold her hand, she would be avoiding the original trauma. Both decisions were unilateral and theoretically tinged. He (1985) says, "It would instead amount to a bypassing of this key factor of the trauma [the handholding], and could reinforce the patient's perception of this as something too terrible ever to be fully remembered or to be experienced" (p. 158). To my reading, this decision was fully his own and clearly not what Mrs. B said she needed. It escapes me how he can see this as "learning from his patient." It was solely his decision based upon his theoretical supposition that he should not try to be a better parent. I suggest that it was also based on the taboo against touching a patient. If he had truly stayed with the patient in what he called a "binocular vision," it seems to me that he would have had to continue to consider Mrs. B's request and its meanings.

I am not arguing that Casement necessarily should have held Mrs. B's hand. He may have been too personally uncomfortable to do so, but then, in my opinion, that would need to be stated as such, not

presented as a decision about what the patient needs. Over the weekend when Casement had told Mrs. B he would consider her request, she hand-delivered a dream she had just had, clearly trying to direct him to what she needed. He (**1985**) reports "The patient said she had had another dream of the despairing child, but this time there were signs of hope. 'The child was crawling towards a motionless figure, with the excited expectation of reaching this figure'" (p. 159). This seems to me a clear expression of the patient's intense needs for a positive response from Casement, but he tells her that she is trying to take a "short-cut" to feeling safer. "She wanted me to be the motionless figure, controlled by her and not allowed to move towards whom she could crawl—with the excited expectation that she would eventually be allowed to touch me" (p. 159). He then goes on to tell about a waking continuation of her dream-child sequence, which, to my reading, is a clear loss of hope in the face of his denigrating comment about her "short-cuts." It seems to me that she had caught the drift from that comment, and probably from his demeanor as well, that he was going to refuse her request. The waking continuation was that she saw the child reaching the central figure, "but as she touched this it had crumbled and collapsed" (p. 159). With all respect due to the advantage Casement has of having been there, I find I cannot agree with him on the meaning of this response. It appears to me to be a fragmentation in the face of something desperately needed and once more not there, a breaking of her hope, an awful repetition of the pivotal trauma. Casement, however, says,

> *With this cue as my lead I told her I had thought very carefully about this, and I had come to the conclusion that this tentative offer of my hand might have appeared to provide a way of her getting through the experience she was so terrified of; but I now realized it would instead become a side-stepping of that experience "as it had been" rather than a living through it [p. 159].*

The patient is stunned and asks him if he realized what he had just done, meaning that he had repeated the trauma. "Nothing I said could alter her assumption that I was afraid to let her touch me," he says (p. 159). To me, it seems that the patient was right, that Casement was afraid, and in fact, was repeating her trauma in a significant

way. He doesn't even seem to know that he is ducking, but his patient senses his fear. He admits: "Had I gone by the book, following the classical rule of no physical contact under any circumstance, I would certainly have been taking the safer course for me; but I would probably have been accurately perceived by the patient as afraid even to consider such contact" (p. 165). Because he briefly considered it (under pressure) in a Friday session and then thought about it over the weekend, it seems to have convinced him

that he wasn't afraid and that he wasn't retreating to following rules. However, his defense didn't convince Mrs. B then, and it doesn't convince me now. I wonder what would have been Casement's response to Mrs. B's desperation if she had required something other than touch from him: for example, another session, a weekend phone call, or a transitional object. Would he have so concretely denied her need as "side-stepping" what he thought she needed to relive? I propose that it was the specific request for touch that was so difficult for him.

A contributing factor to Casement's reneging may well have been the lack of professional support in the form of analytic discourse. Our not talking about touch, about our personal, clinical, and theoretical conflicts about it, has allowed the original, classical rule of abstinence to become calcified, as if it represented some inherent truth, rather than a guideline to be continually reexamined.

After considering and refusing Mrs. B's request, the sessions are filled with disruption, pain, and rage. Later, Casement congratulates himself for his independence of thought, saying, "I acted upon my intuition; and it is uncanny how this allowed the patient to re-enact with me the details of this further trauma, which she needed to be able to experience within the analytic relationship and to be genuinely angry about" (p. 166). To me, this is an appalling, inverted justification for his having failed her, evoking the very anger that he then proposes she needs to work through. He finds that which he has triggered and then declares that it was intrapsychically produced by the patient. During the devastating debacle that followed, Casement sees all of Mrs. B's responses to this rupture as "transference," but she will have none of it. She becomes "fully suicidal" "delusional" and has terribly disturbing dreams.

At length, Casement responds with obvious feeling, rather than in such an interpretive, way, and Mrs. B is able to get some footing in the relationship again. While I am in serious disagreement with a

number of Casement's points, I do see that he cared and that he stayed with Mrs. B as well as he could. I think she eventually saw this too and that it was this attempt at constant caring through it all, rather than his abstinent technique, that made her recovery possible.

I find limited touching a natural form of communication. Used within ethical, cultural, and common sense constraints, physical touch communicates with a subtlety and believability that words often cannot carry. Not to touch, particularly not to touch proscriptively, also communicates; however, the communication is, I fear, about unavailable rigidity, or even worse.

Three Touching Vignettes with Darlene

The following clinical vignettes from work with one of my analytic patients illustrates how touch is naturally involved in our interactions, but also how it is readily discussed, allowing the analysis to progress without major, unnecessary disruptions.

Number One

Darlene and I had been working together four times a week for several years. Near the end of a session she had become deeply regressed. I don't recall how or about what. She was curled up into a ball on the couch and I sat nearby. I thought that she probably wanted me to physically comfort her, but I knew from other discussions that this had been a deep and complicated link with her mother, as it is currently with her boyfriend of many years. I sat still, unsure, not wanting to intrude or preempt her, waiting to see how she would handle her feelings. She said in a voice that was primarily pleading, but with a touch of something else I could not identify, "Would you hold me?" I moved to her side and held her for a few moments, until she recovered, and then moved back to my chair. We talked a little about her fear, and the session was over.

In subsequent sessions I kept my eyes open, thinking about that funny sound in her voice. I thought it possible that she might be mad that she'd had to ask. Sure enough, after a lot of rationalizing and her making excuses for me, like, "I know that's not how you like to work," she was able to tell me how upset she was with me for my not "wanting" to hold her when she was in distress. Making historical

connections, she recalled vividly how her mother would alternately scratch her back, bringing her pleasure, or not touch her at all or speak to her for days at a time if she were upset with Darlene. She wanted to know why I hadn't understood she needed me to touch her before she had to ask. We discussed her ideas about what I might have felt, and then I told her what I had been thinking: “At some point I had thought she might want me to hold her, but I had also sensed something else that I didn't understand, and so I waited, not wanting to misstep.” The “something else” as it emerged now was her conviction that I wouldn't want to touch her. This insight seemed to resolve the issue for the moment.

Not long afterwards, Darlene had a dream: “The girl is sitting with her mother. She reaches to touch her mother and is rebuffed. She had seemed to be touching core-like calcificatins. She wants to touch her neck; the mother says no and pushes her away. There are harsh words and a feeling of punishment. The girl tries to lean on her mother's arm to reach her. She is told she shouldn't use a prop. The girl feels put off, not allowed to explore, crippled. They are angry with each other, but inextricably tied.” Darlene saw the dream as a rather straightforward rendition of what she had felt with me, as well as with her mother. She believed I have “core-like calcifications” and prefer not to be touched. I listened and helped her say what she believd. Internally, I wondered to myself about the extent to which her comments were valid for me. I also thought privately about the taboo on touching in psychoanalysis and considered the pros and cons of how I had dealt with her previous request to be held. The event receded, and we moved on to other pressing issues. I figured we would face touching as an issue again.

Soon after this sequence, when I had just returned from my vacation, Darlene told me she had gone to see another therapist for “birth trauma” work. I knew of her interests in this area from several workshops she had attended. I thought privately to myself that this was somehow different, primarily because it was one on one with another therapist, not a workshop. She was sure I would be hurt. I followed her thoughts about this carefully, asking in an open manner why she thought I'd be hurt. “You'll think I don't care, that you are in competition.” A circular conversation began in which she would reassure me, and I'd ask why she thought I needed reassurance. We'd do this circle again. Finally, I suggested that it might be that she

worried that I would be hurt if I knew whatever critical thoughts she had had about me that had made her seek out another therapist to touch her. (The essence of the birth trauma work involved her body.) I wondered whether it might have seemed easier to her to see someone else, rather than feel disappointed or angry with me for my limits or limitations on touching. She said this was right, but then began to get angry, saying she felt my comments meant she wasn't supposed to go see this other therapist. I questioned how she had concluded that from what I'd said. The line of my questioning successfully conveyed to her that I didn't feel the need to restrict her. She burst into tears, saying something about how she always does this, that is, “makes a mess of things with people she needs.” Then, after a bit, “Now I don't know how to relate to you. If I'm not rebelling, manipulating, or complying, I'm lost.” We both sat with that thought, and soon the session ended, leaving us both with the feeling that this was a good awareness.

Touching was important here because it directed Darlene and me to her fears about relational conflict and the strategies she employs when she assumes she can't get what she needs. These fears contribute greatly to her problems with her boyfriend, making it difficult for her to calmly address with him her longings or her negative feelings. Finding that we could discuss this matter has provided for her a better underpinning. Further, the working through of this particular disjuncture, while not providing any major resolution, has added to the trust between us, trust that we can work things through together. It might be argued that we could have reached this level of trust without touching, and I can only agree that this may be true. However, I do not see that avoiding touch categorically would necessarily have led to a better result or have been more analytic.

Number Two

Darlene was her family's “darling”; she was petted, preened, and fussed over. Her mother cleaned and picked at Darlene's body regularly, but only so long as it pleased the mother. Darlene says she became

adept at cajoling and manipulating her mother to stay longer. She also describes how she would climb in bed with her mother when she had a nightmare and "spoon." However, she had to hold absolutely still or she would be thrown out. Their relationship was very

close physically, but it was too intense and tied exclusively to her mother's needs. Not surprisingly, Darlene became promiscous early on, and until recently, her intense sexual relationship with her boyfriend has been vital to her sense of security.

I recall these events as I try to grasp the significance that touching me may have for Darlene. In my practice, nonsexual touching is not uncommon, but I always try to understand its meanings. In Darlene's case a common configuration has had to do with her assumption that I don't want to touch her, that she is a burden I simply endure, as did her mother. Further, she is sure that I will be put out if she complains about my not touching her or not touching her soon enough or with the right enthusiasm. Being reached for enthusiastically creates for her a brief, believable feeling of connection. I am aware from her history that touching is unusually complicated for her. The following vignette illustrates some of these nuances.

In January Darlene and I were having a phone session, the local storms having washed out the mountain road to my home office. We had met the day before in my town office. She began by complaining that she was washing and cleaning her house when she should be doing her reports for work. "I always do this," she said, meaning that she always gets going on something around her house, instead of what she should be doing. I commented on her having a conflict. She continued on the same theme, and I impulsively said, "Life is rich" (that is, full of choices). Somewhere in the back of my mind I was aware of being somewhat sarcastic, but I pushed the awareness away, telling myself that my intention was to alleviate her punitive attitude about not getting everything done. We laughed and the topic changed to a phone call she had had with her boyfriend the night before, about how angry and hurt she was about it. Then she returned to the cleaning house theme. I can feel again some mild, diffuse annoyance, which I am not understanding, but this time what comes back to me is the session the day before in my office and a somewhat similar feeling at the end of that session. Also I remember my sense of feeling coerced to smile back at her near the end. Fishing for a connection, I say, "Do you think that there could be any other reason you might be cleaning now?" I am thinking, "Is she trying to right something, repair something, control something?" She doesn't know. I try again, suggesting that she might possibly still be angry with me for my not having been available last Saturday when she had called

me in distress, something we had discussed near the end of the session the day before. (The idea in my mind is that my current counter-transference might be reactive to something subtle or unconscious in her from the day before. This is a track that has been useful with her on occasion.) "No," she answered, but quickly continued that when she'd hugged me at the end of the session she hadn't liked that she had had to initiate it even though she'd needed it. We talked about what it meant to her yesterday for me not to reach for her. She responded that she'd imagined that I had only endured her touch. She then said, "You were sarcastic with me earlier," reminding me of the "life is rich" comment, which I then had to acknowledge to myself. I asked her if she had any idea why I might have been sarcastic with her. "No." Searching, I asked if yesterday there might have been any feelings she had had even before the hug, recalling the feeling of coercion I myself had had, and still wondering about a connection between yesterday's and today's sessions. I told her that when I picture the day before I have an image of a little girl smiling engagingly, trying hard to re-elicit contact with a neglecting or rejecting parent. She then recalled that she had looked at the clock in the session yesterday and had asked, "Is it time?" I had said, "Yes." She had simultaneously said, "No," noticing that there was a minute left. My answer meant to her that I had wanted to get rid of her. She said, "Either you were in a hurry or my talk about my boyfriend during the session wasn't feeding you enough." It unfolded further that I'd leaned forward earlier while there was still eight minutes left, meaning to her that I must have been sick of her. I said I could understand her reasoning, but that as far as I knew, I'd

leaned forward to see the time because we'd been so intensely engaged that I'd lost track of the time. She cried out, “You mean you weren't tired of me?” “No,” I said. She began to sob with relief and then to talk about how good it felt to be able to disentangle this interaction between us. She continued discussing both her mother and her boyfriend, how conflicts with them always become blaming matches followed by silent withdrawal.

We were then able to see a potential explanation for my sarcasm earlier: She had been angry with me, assuming I was sick of her, but she hadn't known it. She had only known she was compelled to clean her house, that she had been annoyed when she had had to stop to call me for our session. I might have been responding to a subtle

attack coming from her with a reading of her thoughts to be something like: “Therapy doesn't work. See, I'm always doing things I shouldn't and you're not helping me. I'm having to clean up the mess myself.”

The touching, that is, the hug, from the day before constitutes only a minor part of this vignette, but it was a pivotal carrier for many feelings, for example, Darlene's increasing anxiety about rejection, along with her simultaneously sincere and manipulative attempt at reconnection. She had probably been trying to engage me with her big smile at the end of the session the day before as well, because she had already unconsciously decided I wanted to be rid of her. Her reach for a hug was perhaps a further attempt to “right” things with me. Although the hug did not accomplish all that she had wanted, if I had refused her physical approach, it would surely have created a more intense rupture, reifing her unconscious feeling that I was categorically rejecting her as her mother used to do. While we probably could have worked through that rupture in the long run, I think it was worked through more easily in the way described and without unnecessary pain. Touch with her mother was allowed only when the mother felt like it, creating confusing anxiety for Darlene and contributing to a strong need to manipulate her relationships. By maintaining the connection between us, literally by touch, Darlene and I were able to sort out with relative ease the tangled interaction from the day before and the next day.

Number Three

Another interaction occurred a month later that again involved touching, but with a very different implicit meaning. On this occasion, because of my own commitments, I had arranged a slightly different session time with Darlene. That day I waited for half an hour and was on the verge of giving up when Darlene appeared, smiling as if nothing had happened. In fact, until I asked about her being late, she thought she was on time. She was appalled and was immediately on the alert: “You're obviously distant, probably irritated; I would be.” I, of course, was interested in her thoughts about my probable reaction and about her thoughts concerning the change of session time. She responded with several rather tortured configurations, complained of being uncomfortable with me, and then urgently wanted to know

how I was reacting. The session was nearly over, and I suggested that we should continue to talk about the subject at the next session since she seemed to have no understanding about why she had mixed up our appointment time and was so certain that I was upset about the confusion. The next morning she came in very agitated. “I'm angry, ready to run over every stupid driver. I'm very upset about what happened yesterday. Now everything is ruined. I knew I'd do this sooner or later.” She had decided that she was bad for being late, that I was certainly angry with her, and that I would inevitably with draw from her. She added that nothing I could say would convince her that I wasn't annoyed at being kept waiting yesterday and that it was her fault. She said her brain always got changes mixed up, beginning to get frightened that she had an organic brain disorder developing.

Slowly, I was able to calm her, asking how she could be so sure I was annoyed: “Well, I would be,” she said. “And, therefore, I would have to feel as you would?” I asked. Proceeding, she realized she would be annoyed only with certain people, people who show her no respect, not with all people, suggesting that it

was not inevitable that I be annoyed. Little by little, she was able to remember that she really hadn't wanted to make the change I had requested for that Monday, but that she hadn't been able to think of a good reason to say no. Further, it hadn't occurred to her to tell me about her reluctance and helplessness. “I guess I let my unconscious do it.” At this we both laughed. She was amazed at the pervasiveness of her unconscious accommodation and the trouble it caused her. She talked of several situations growing up with her mother and with others in current interactions when she complies, gives the person what she thinks he or she wants, and then feels she can no longer trust that person. “Life for me is all about manipulating to survive,” she said.

As we stood to say goodbye at the end of the session, she hugged me hard and with feeling, saying how happy she was. “Things haven't been destroyed after all!” she said. On the contrary, we understood each other better now and she was more aware than ever of her own internal workings. The hug expressed her relief, her joy, her spontaneous joining with me—literally—emphasizing what had just happened. I was struck by the different quality of this hug from the ones described earlier. Each hug had expressed a different mix of feelings, each emphasized flavors that had been spoken, or were subsequently

spoken, but did so in a way that punctuated what was happening. Sometimes I think that a touch, like a painting, is worth a thousand words.

The Touching Case of Alan

The following vignettes illustrate the flexible use of touching and not touching in an attempt to illustrate the contextual complexity of touch for both the patient and the analyst. To protect the patient's identity, several patients with related intense eroticized transferences have been mingled. However, the essence of the interactions is maintained.

Alan had been seeing me in analysis for several years. Bit by bit, the constant sexualizing of relationships had become apparent. Growing up, Alan's mother had been his only early source of attachment, but she had also been extreme in her disgust about male sexuality. Alan, although only a late adolescent when he began treatment with me, had already learned to sequester his interests in anything but being a “gentleman.” Not surprisingly, then, he had enormous interest in and anxiety about his interest in women. In addition to having serious questions about the normalcy of his sexual impulses, Alan felt himself generally to be a misfit. He had grown up in a home with a sadistic and unstable father and a questionably stable, but very antiseptic, mother. There were numerous situations in his home life that would easily classify as traumatic. Alan had developed an intellectualized style in order to cope with his confusing home life, but his style furthe alienated him socially, making him feel like a pariah.

In midadolescence Alan turned to prostitutes for affirmation of his worth; he could not make friends with girls in the normal ways. While the sexual experiences temporarily bolstered his self-esteem, they subsequently added to his feeling that there was something very wrong with him. In the following vignette Alan, now 23, had been describing to me, with great shame, one such visit. He was convinced I would reject him as the disgusting animal he felt himself to be. We discussed how his recurring visits to prostitutes were efforts at regulating his terror of imminent collapse, trying to restore some sense of worth, if only for a moment. He remarked, “They are always glad to see me. They make me feel I'm wanted.” Slowly, he began to tell

me his sexual thoughts about me. They would quickly shift from being more physically affectionate to being more sexually sadistic, bloody, and remorseless as his reading of me or his anticipations shifted from accepting to rejecting. As the sessions went by, with my steady attempt at understanding his graphic sexual thoughts, he began to feel “able to swim in this lake” (a familiar symbol between us for the heretofore danger of any sexualization of our relationship) and find it “cool and pleasant, not oily and lurking.”

Finally, there was a beautiful sequence, a crescendo: It began with several “disgusting,” sexual references, and then he said, “When I used your toilet, I felt I should ajax it.” I commented once again on how repulsive he must feel he is to me. “If only,” he said, “it didn't have to get so sexual…. Okay, I think, will this one repulse you…. Taking me as a whole, could you possibly find me attractive? I just don't have any belief that says that…. Where are your feelings of repulsion towards me?” Suddenly he leaned up on his elbow, turned, looked at me, and with a strangled voice said, “Maybe you don't have any!” He began to cry, saying he felt at the same time an agonized scream and a scream of joy inside himself, like he was rolling around on the grass or standing in the rain. It was a moment of birth, the birth of a new belief: “I never felt a part of anything, anywhere; maybe I could here with you.” He continued talking about the sunshine he feels when he sees prostitutes who are friendly to him. “But it's an illusion, I know.” Then, he said, “You wouldn't let me touch your body, would you?” but he said it in a voice that conveyed that he knew the answer and was okay with it. He was bringing the only experience he had had of deep connectedness, that of physical union, together with our relationship. There was more to this important exchange and weeks more of integration, but an epiphany had occurred, leaving us both deeply touched.

A second vignette a year later involved actual touch between us. It demonstrates Alan's growth, if only that he could touch me without as much certainty of my revulsion. During the year between these two examples, Alan and I had continued to discuss his sexual feelings. My understanding and lack of criticalness about his sexuality, indeed, at times my enjoyment of his adventures, was very important to him. The increased trust led to two events between us that were significant. At one point he had a lovely fantasy of us together: Speaking of a time a few years ago when I had had some surgery, he

said, “If you had it now, I wouldn't be so devastated by the separation. I can see myself just staying in your hospital room. People would come and go, but I'd just stay.” I said that I could sense that he assumed I'd be fine with that. There was no hint of sexualization in his tone; rather, it was like that of a young child who feels his right to be with his mother without question.

That day as he was leaving, feeling very warm toward me, he kissed my cheek. It was quite natural, and I didn't ponder it particularly until the next day when he did the same thing. For this kiss there had been no special context, and I was alert, wondering what it meant. The next day he was filled with fantasies of self-denigrating sexual acts. As we discussed this shift, it emerged that he had felt the first kiss to be spontaneous, but that, nonetheless, it had scared him. He was afraid I might have resented it or I might be worried he'd do something sexual to me. Feeling rejected in his imagination, he then became angry with me and decided, although not consciously at the time, to see if I'd allow it again, “to see how much he could get away with.” He had so automatically felt rejected by me, and himself to be repugnant, that his sexual fantasies seemed to him to emerge from out of nowhere. This experience contributed to his feeling that, indeed, he must be a loathsome, sexual misfit. In our understanding the fantasy of the hospital room and the kiss sequence that followed, we began to see even more clearly his deep need to feel attached to me and, also, his deep, hair-trigger anticipation of the rejection of that need.

My comfortable acceptance of Alan's first kiss just as it was intended—an expression of warm affection—was eventually helpful to consolidating Alan's sense of himself as touchable, not the total misfit he imagined himself to be. I cannot imagine what would have been gained had I stiffened or moved away when he made his spontaneous gesture. The second kiss gave us ample opportunity to analyze his internal experience. Against the backdrop of the casual first kiss, it was easy for us both to see the wholesale contribution of his fearful anticipations.

In Conclusion

Using clinical examples I have tried to demonstrate that thoughtful, socially appropriate touching is no more inherently problematic than

any other type of relational interaction in psychoanalysis. I have argued that dialogues about physical contact with patients, traditionally restricted by the rule of abstinence, should be joined to the list of topic regularly discussed among analysts. I have attempted in this paper to continue that dialogue, interrupted so long ago.

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