The Meanings of Touch in Psychoanalysis: A Time for Reassessment

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PSYCHOANALYSIS TRADITIONALLY HAS PLACED an almost total interdiction on physical touch between patient and analyst within the analytic arena. Yet touch, based on our largest sensory organ, the skin, provides a fundamental and elaborate form of communication. So important is tactile stimulation for development and maintenance of physiological and psychological regulation that recent research demonstrates that physiological and psychological regulations of persons of all ages are "righted" through physical holding and touch.

Physical touch within psychoanalysis has been hotly debated beginning with Freud and Ferenczi. Ferenczi (1953) felt that nurturing touch could facilitate the analysis by helping a patient to tolerate pain that was characterologically defended against. Freud felt that physical contact would almost certainly lead to sexual enactments. In the heat of this controversy, Ferenczi's patient (Clara Thompson) boasted to one of Freud's patients that she was allowed to kiss "Papa Ferenczi" anytime she wished. Freud strongly objected, admonishing Ferenczi that this sort of behavior would inevitably lead to a downward spiral to full sexual engagement. Unfortunately Freud's

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and E. Jones's subsequent silencing of Ferenczi, now well-documented (Rachman, 1989), forced the issue of touch to go underground.

While Freud's rule of abstinence and interdiction on touch has, thus, predominated in the psychoanalytic literature, there have been notable exceptions where physical touch is seen as not only appropriate, but as necessary when dealing with periods of deep regression (Balint, 1952, 1968; Winnicott, 1958, 1975), with psychotic anxieties and delusional transference (Margaret Little, 1990), and with deeply disturbed patients (see Mintz, 1969a, b, who describes the work of Fromm-Reichman and Searles). More recently, additional reports of the facilitative use of touch have emerged in our literature (Bacal, 1985, 1997; Pedder, 1986; Breckenridge, 1995; McLaughlin, 1995). Psychoanalysts of different persuasions in private (Hamilton, 1996) will frequently comment that physical contact in the way of handshakes, handholding, hugs, and squeezes on the arm occur and are experienced by both analysand and analyst as facilitative. The emergence of psychoanalytic alternatives to classical theory, including more detailed and comprehensive motivational models (see Lichtenberg, 1989), and a vast array of empirical studies on the neurobiological functions and psychological meanings of physical touch is enabling us to readdress the meanings and uses of touch within psychoanalysis. This issue of *Psychoanalytic Inquiry* is a notable first to focus so comprehensively on the issue of touch and its role in psychoanalysis, a tribute to the editors and a sign of a changing climate within psychoanalysis.

The coeditors have chosen Patrick J. Casement's 1982 paper in the *International Review of Psycho-Analysis* entitled "Some Pressures on the Analyst for Physical Contact During the Reliving of an Early Trauma" to serve as a launching pad for the reconsideration of touch and its meanings within the psychoanalytic situation. The paper is focused on the analysis of Mrs. B who had suffered early trauma and who in the analysis had intensely pressured the analyst to hold her hand during the reliving of the trauma. Subsequently this paper has been widely discussed, for it graphically raised a number of important issues that are most pertinent for psychoanalysis today involving the consideration of physical contact for facilitating or encumbering the process of reliving and working through trauma.

The purpose of this paper is: first, to review and assess the classical theoretical basis for the interdiction on touch in psychoanalysis; second, to provide a brief overview of the research on physical touch;

third, to review briefly relevant psychotherapy research and clinical reports of touch in the psychoanalytic literature; fourth, to readdress Casement's case study in light of the above; and fifth, to lay down some guidelines for the use of touch in the analytic setting.

The Historical and Theoretical Basis for the Prohibition of Touch

Mintz (1969b), in a remarkably cogent paper on the clinical usefulness of touch, delineated three historical factors that contributed to the taboo against touch within psychoanalysis. First, psychoanalysis emerged within a cultural context of Victorian sexual prudery. It was within this context that led Jones (Jones, 1955) to write, "Freud and his followers were regarded as . . . sexual perverts . . . a real danger to the community. Freud's theories were interpreted as direct incitements to surrendering self-restraint" (pp. 108–109). In strenuous efforts to establish a respectable science, Freud and his group wanted to avoid any further misunderstanding that could have been wrought if physical touch entered the scene. With Freud's emphases on sexuality and aggression, any physical contact could easily be construed as sexually seductive or aggressive, placing in jeopardy the whole psychoanalytic enterprise.

Second, the historical association of physical contact with the traditions of religion and magic provided additional incentive for Freud's adamant rejection of touch as part of his effort to bring human conflict within the orderly framework of the rational positivistic science of the day. Physical contact was easily viewed as jeopardizing the psychoanalytic curative goal of rational insight.

And third, following his disappointment in hypnosis, Freud initially applied pressure, a remnant of hypnotic technique, by placing his hands on the patient's forehead, instructing the patient that, in response to his pressure, the appropriate memories and associations would emerge. Subsequently, he abandoned hypnotic technique altogether and distanced himself from it, including the avoidance of touching patients "in any way, as well as any other procedures which might be reminiscent of hypnosis" (Freud, 1904, p. 250).

The theoretical rationale for barring physical touch in the analytic arena is anchored in the assumption that, in keeping with the pleasure principle, physical touch gratifies (allows for energy discharge of) the patient's infantile sexual longings and, thereby, fixates the

patient at an infantile level. Refusal to touch, or nongratification, forces infantile sexual wishes into articulatory awareness that ultimately facilitates their renunciation. To facilitate this task, the analyst must become, through abstinence and neutrality, a blank screen onto which the patient's childhood fantasies are displaced and projected. Within the classical conception of transference, the goal is to prevent or remove any possible contribution from the analyst to the patient's experience in order to illuminate the patient's intrapsychically generated projections and displacements. Touch, as with any expressive, noninterpretive response by the analyst, is easily viewed as "muddying the waters," in that its deviation from the abstinent, neutral, and blank screen analytic stance precludes the analysis of transference. Touch is understandably prohibited within this model, for it is seen as an intrusion of the analyst that interferes with the free associational process and the unfolding of the intrapsychically generated transference. Based on this model, Casement (1982) refused to hold the patient's hand out of a conviction that to do so would gratify the patient, in this instance the patient's longings for a good object (not infantile sexual wishes), and would interfere with the full reliving of the trauma, including the patient's aggression generated by the trauma.

The dual motivational model of sex and aggression within classical theory renders touch as either sexual or aggressive. Other types of touch and, therefore, other meanings are excluded from consideration. Moreover, it is assumed that, if sexual feelings are kindled in the patient, they will be infantile in origin, and gratification will be fixating. Touch becomes a sexual enactment that interferes with the analysis. Not only are "adult" sexual feelings excluded (Hirsch, 1994), but it is assumed that nonaggressive touch would gratify infantile sexual feelings and preclude a patient's and analyst's discussion and management of them.

A Contemporary Perspective

Two major paradigmatic shifts have occurred within psychoanalysis: the change from positivistic to relativistic science and the movement from an intrapsychic to an intersubjective, or relational, model. These two changes have profound implications for the consideration of "to touch or not to touch." The shift from positivistic to relativistic science has made it clear that even our very act of observation

affects that which is observed. The second paradigmatic shift, partially emergent out of the first, involves reconceptualizing the analytic relationship as an intersubjective (Stolorow, Brandchaft, and Atwood, 1987) or relational (Mitchell, 1988) field in which there is a mutual bidirectional interactive influence (Beebe, Jaffee, and Lachmann, 1994). Combining these two paradigmatic shifts, we recognize that any action or nonaction of the analyst variably affects the relational field and, therefore, the patient's experience of the analytic relationship.

In contrast to the classical, or displacement, model of transference in which transference is intrapsychically generated, within what I call the organization model of transference (Hoffman, 1983, 1991; Gill, 1984; Stolorow and Lachmann, 1984/85; Fosshage, 1994; Lichtenberg, Lachmann, and Fosshage, 1996), patient and analyst variably co-contribute to the patient's transferential experience. Transference "refer[s] to the primary organizing patterns or schemas with which the analysand constructs and assimilates his or her experience of the analytic relationship" (Fosshage, 1994, p. 271). In other words, the patient tends to organize the current perceptual events, to which both patient and analyst variably contribute, in keeping with the primary thematic emotional patterns established through lived experience. From the perspective of this model, neutrality, abstinence, and the blank screen are all *actions* of the analyst that contribute to the analysand's transferential experience. The stringent avoidance of touch that is traditionally called for in psychoanalysis obfuscates that this very avoidance is not "neutral" and can have many different and profound meanings for analysands. Recognizing that the analyst variably contributes to the analysand's transferential experience makes us far more aware of the subtle, complex verbal and nonverbal communications that take place in the analytic arena. In turn, it opens the door for us to consider a vast array of interventions, including touch, that may or may not be facilitative.

Research on Physical Touch

While there were a few studies along the way, particularly beginning in the 1940's, it was not until the mid-1970's when an explosion of interest and research in the functions of the skin and touch occurred. In the seminal work, *Touching*: *The Human Significance of the Skin*, Ashley Montagu (1986) brings together the now vast array of stud-

ies that pertain to understanding the role of our skin and physical touch in human development.

Our skin is the largest sensory organ of the body. The various elements comprising the skin "have a very large representation in the brain," and the "nerve fibers conducting tactile impulses are generally of larger size than those associated with the other senses" (Montagu, 1986, p. 14). As a sensory system, the skin, Montagu concludes, is the most important organ system of the body, because, unlike other senses, a human being cannot survive at all without the physical and behavioral functions performed by the skin. "Among all the senses, touch stands paramount" (Montagu, 1986, p. 17). The tactile system is the earliest sensory system to become functional (in the embryo) and may be the last to fade.

Research documents that tactile stimulation is necessary for the arousal and development of various physiological systems and is fundamentally required for healthy affectional relationships (Bowlby, 1952; Harlow, Harlow, and Hansen, 1963; Harlow, 1971; Montague, 1986; and many others). On their study of bonding, Klaus, Kennell and Klaus (1995) demonstrate that those infants (human and nonhuman) who are stroked by their mothers at the earliest stages of their postnatal life do much better physically, emotionally, and interpersonally, as compared to those who do not get this experience of touch (see also Field et al., 1986). Moreover, the type of tactile contact pivotally affects behavioral development (Montagu, 1986). Montagu concludes:

> The study of mammal, monkey, ape, and human behaviors clearly shows that touch is a *basic behavioral need,* much as breathing is a basic physical need, that the dependent infant is designed to grow and develop socially through contact, tactile behavior, and throughout life to maintain contact with others. . . .When the need for touch remains unsatisfied, abnormal behavior will result [p. 46].

Tactile communication forms an elaborate, powerful medium of communication among primates. Stern (1990) writes: "The ultimate magic of attachment is touch. And this magic enters through the skin" (p. 99). Tactile stimulation has profound effects both physiologically and behaviorally. The mother's and father's holding and cuddling of the child creates a sense of intimacy, love, safety, and well-being.

Children who have been inadequately held and touched suffer from an affect-hunger for such attention and, as adolescents and adults, experience difficulty in sexual development.

Miami's Touch Research Institute (TRI), a scientific center devoted to exploring the effects of touch on health, has conducted more that 50 studies on massage, demonstrating its "positive effects . . . on every malady TRI has studied thus far" (Colt, 1997). And even more pertinent for psychoanalysis, Colt writes, "A simple touch—a hand on a shoulder, an arm around a waist—can reduce the heart rate and lower blood pressure. (Even people in deep comas may show improved heart rates when their hands are held.) Touch also stimulates the brain to produce endorphins, the body's natural pain suppressors, which is why a mother's hug of a child who has skinned his knee can literally 'make it better'" (p. 60).

Published Reports of Touch in Psychoanalysis

On the basis of what we now know about the profoundly important role of tactile stimulation and communication and the sense of touch in neurophysiological, behavioral, and psychological development, it is not surprising, in spite of the traditional interdiction on touch in psychoanalysis, that psychoanalysts have reported occasions of considered use of touch to facilitate treatment.[1] Ferenczi, already cited, would permit behavioral enactments that at times included affectionate kisses (see Shapiro, 1992). He also used touch to facilitate bringing a patient back from a trance state to the here and now reality. Fromm-Reichmann (1950) writes, "At times it may be indicated . . . to shake hands with a patient, or, in the case of a very disturbed person, to touch him reassuringly" (p. 12). Searles (1965) indicates that "declining to provide physical contact" may be helpful, yet he mentions the undesirability of "being neurotically afraid of physical contact" (p. 701). Winnicott (1965), reported in his own writings and in those by his patient Margaret Little (1990), would hold his patient and the patient's hand in efforts to create a sufficient "holding" environment. Little (1966) described a patient who despaired

[1] A whole level of discourse involving the potentially healing impact of touch from bioenergetics to expressive psychotherapies is of relevance but goes beyond the scope of this paper. Subsequent to the completion of this paper, Hunter and Struve's (1998) new book was published that provides a comprehensive study of the use of touch in psychotherapy.

over his discovery that his “accidental” self-injuries were intentional and needed the analyst to touch his hand. In his last lecture, Kohut (1981) described offering his two fingers to a patient to hold when the patient was in a state of deep despair (also reported in Bacal, 1985). Pedder (1986) described a deeply regressed patient who needed physical touch.

While published reports typically address the use of touch with very disturbed or deeply regressed patients, Mintz (1969b) suggests that physical touch may also be useful with the “healthy neurotic” in periods of deep regression when the patient is temporarily unavailable for verbal communication. Balint (1952) still further expands the circumstances of the emergence and meaning of touch and describes patients’ desire for touch toward the end of treatment when the patients are better integrated to communicate affection, mutuality, and a deeper connection. Touch under these circumstances is not erotically stimulating but is a powerful form of communication that leads to a deeper intimacy and a “tranquil quiet sense of well-being” (p. 231).

Mintz (1969b) delineates four possible meanings of touch in the psychoanalytic situation: direct libidinal gratification, symbolic mothering, conveying a sense of being accepted, and conveying a sense of reality. While the first, she argues, is problematic in a therapeutic situation, the other three meanings and uses of touch can be quite facilitative of growth and the analytic process. Breckenridge (1995) describes a clinical situation in which allowing for physical contact conveyed a sense of acceptance and helped to modify a profoundly negative self-image. And recently, McLaughlin (1995) has written about physical and psychical touching with an ease and acceptance as he has shifted away from the classical position on touch. He writes: “Handshakes come and go with some patients, stay consistent with others for the duration. The cue comes from the patient” (p. 441). Rather than obstructing analytic work, he sees handshaking as “having provided a surer sense of knowing I was there and in what kind of contact, before our longer relating through the verbal–aural reaching could be relied upon. It had been helpful that the handshake had been continued thereafter as another way to check in times of doubt” (p. 441). McLaughlin notes his increasing comfort with holding the patient’s hand, including when a patient on the couch reaches back for his. A patient may be reaching for “support, consolation, or for my presence in the face of the patient’s not yet speak-

able yearnings" (p. 441). He finds that "this responsiveness facilitates, rather than hinders, the patient's consequent analytic seeking" (p. 442).

Touch undoubtedly occurs much more frequently in the psychoanalytic arena than has been reported. In my recent private poll of approximately 30 analysts, every one had hugged or been hugged by patients. Reports have been limited for fear of slanderous criticism regarding "poor boundaries," gratification rather than analysis, and sexual seduction. The prohibition against touch and its discreditation, augmented by our litigious society, can easily leave the analyst experiencing discomfort with physical contact even when it is initiated by the patient and feels nonsexual. Nevertheless, handshakes, a reassuring hand on the shoulder, a supportive squeeze of the arm, an affectionate hug at the door, all do take place. Our psychoanalytic theory of technique does not correspond with psychoanalysis as practiced and clearly needs to be updated to include the judicious use of touch as a form of communication.

Psychotherapy Research on Touch

Freud's interdiction on touch has variably affected most schools of psychotherapy except those that are body oriented (for example, Lowen's [1966] bioenergetic analysis). In spite of this, research has amply demonstated that many psychotherapists, including psychoanalytic therapists, touch patients in order to express support, reassurance, warmth, caring, protection, or for other therapeutically motivated reasons (Kardener, Fuller, and Mensh, 1973; Patterson, 1973; Holroyd and Brodsky, 1977; Gelb, 1982; Milakovich, 1992; Horton et al., 1995). Emphasis has been placed in the literature on the undeniably harmful effects of erotic contact between patients and therapists (Pope, 1990), yet cumulative clinical and research evidence demonstrates that not all physical contact between therapist and patient (beyond a formal handshake) is a "boundary crossing," as Gutheil and Gabbard (1993) suggest, that places the relationship on a "slippery slope" of erotic gratification. Surveys of therapists fail to support the assumption that appropriate touch in therapy leads to inappropriate erotic touch (Pope, 1990). Clearly, touch, as with many actions, can trigger sexual feelings, which, in turn, need to be discussed, understood, and managed (Mintz, 1969a, b; McLaughlin, 1995), like any other feelings.

Two empirical investigations of the meanings attributed to nonerotic touch in traditional psychotherapy directly assess the experiences of patients in ongoing psychotherapeutic treatment. While Gelb's (1982) study was limited with a small homogenous sample (10 female patients with male therapists), the study identified four factors associated with patients' positive and/or negative evaluations of touch in psychotherapy. These factors are: (1) clarity regarding touch, sexual feelings, and boundaries of therapy (including the patient's sense that the boundaries are clear and unambiguous); (2) patient control in initiating and sustaining physical contact; (3) congruence of touch with the level of intimacy in the relationship and with the patient's issues; and (4) patient perception that the physical contact is for his/her benefit, rather than the therapist's. These four factors arising out of patients' reactions are, by and large, congruent with those emphasized by psychoanalysts in the clinical literature.

Horton et al. (1995) tested and extended Gelb's study. Their sample involved 231 adult (20 years of age or older) patients who were or had been in psychotherapy for at least 2 months within the last 2 years and who had "experienced some sort of physical contact with their therapist (beyond accidental contact or a formal handshake)" (p. 446). The sample included male and female patients and therapists, and heterogeneous and homogeneous pairs. The data supported the hypotheses that Gelb's four factors correlated positively with the patient's evaluation of touch occurring in therapy. "Congruence of touch with the level of intimacy" accounted for the largest portion of the variance. The hypothesis, "whether potential sexual attraction is inversely correlated with positive evaluation of touch in therapy, was not supported" (p. 449). In the patients' descriptions of touch, two important themes emerged. Touch, reported by 69% of the sample, fostered a feeling of a stronger bond, closeness, and a sense that the therapist really cares, thereby facilitating increased trust and openness. And 47% of the sample indicated that touch communicated acceptance and enhanced their self-esteem. "Sexually abused patients were more likely to attribute a corrective or educative role to touch in therapy, and to report feeling 'touchable,' 'lovable' or generally better about themselves as a result of touch than were nonabused patients" (p. 452). Ten patients in this sample reported negative experiences with touch in their current therapy: six patients described that current therapist behavior signalled their therapist's discomfort with touch, and four patients indicated that touch was accepted but

was not meeting "an expressed need of theirs" (p. 452). Discomfort with touch in these cases was often alleviated by its open discussion. The authors conclude:

> The results support the judicious use of touch with patients who manifest a need to be touched, or who ask for comforting or supportive contact. They also support Ferenczi's (1953) position that, contrary to orthodox opinion, "gratifying" the patient does not necessarily interfere with the patient's motivation to work in therapy, but may alleviate shame and help the patient tolerate the pain enough to face and work through issues more quickly, or on a deeper level [p. 255].

Casement's Case

Patrick Casement's (1982) valuable clinical material raises the specific issue of whether holding the patient's hand at her request would be facilitative or not in her reliving and reworking a childhood trauma. Casement chose not to be available if his analysand were to reach out for his hand, for he saw this as a defensive maneuver that would side-step the full reliving of the traumatic experience. He understood the subsequent deteriorating spiral to be part of the "reliving" of the original trauma, essential to the working through process. To their credit Casement and his analysand were able to find a way to reestablish an understanding connection.

While it is always difficult to approach another analyst's case material, for we were not there, Casement has provided sufficient detail to facilitate our efforts to enter into the analyst's and analysand's subjective experiences in an attempt to follow their interactive process. In a close reading of the material, I find myself questioning if Mrs. B's desire for touch was a defense. I also question if the deteriorating spiral that took place was necessary and, moreover, if it was a "reliving" of the original trauma. While Mrs. B and Casement were finally able to create together a needed healing process, I believe the healing factors were different from those named by Casement.

As I address the clinical material, I will juxtapose Casement's understanding of the material and his underlying models with my own. Of course, the question is whether or not alternative understandings and interventions would have facilitated the analysis. The problem of assessment and contrasting use of alternative models,

however, cannot be underestimated, for the latter is always creating a different dyad and analytic field and, therefore, a different analysis. Hence, discussions of this nature, as is true for the case material itself, are principally illustrative and are used to enrich our repertoire of possible understandings and interventions. These difficulties notwithstanding, I will focus specifically on Casement's model of transference, extrapolated from his interpretations and understandings of the clinical material, and contrast it with an alternative model. These models of transference (see pp. 6–7), in my view, are crucial in shaping our understanding of the interactive process and a patient's desire for touch and in deciding to allow for touch or not.

The case material begins with Mrs. B having presented a dream in which she was "trying to feed a despairing child. The child was 10 months old" (p. 279). Her ten-month-old son, Casement writes, "is a lively child and she assumed that she too had been a normal happy child until the accident. This revelation prompted me to recall how Mrs. B had clung to an idealized view of her pre-accident childhood" (p. 279). While Casement does not tell us what led him to believe that hers was a defensively idealized view, he interprets, "Maybe she was beginning to wonder about the time before the accident. Perhaps not everything had been quite so happy as she had always needed to assume. She immediately held up her hand to signal me to stop" (p. 279). After a silence, he continued and she listened in silence.

The next day she came in "with a look of terror on her face" and could not lie down on the couch for the following five sessions. A major disruption had occurred. "She explained that when I had gone on talking, after she signalled me to stop, the couch had 'become' the operating table with me as the surgeon, who had gone on operating regardless, after her mother had fainted. She now couldn't lie down 'because the experience will go on.' Nothing could stop it then, she felt sure" (p. 280). She subsequently recalls for the first time her terror at the start of the operation when she experienced her mother's hand slipping away from hers as her mother fainted and disappeared. "She now thought she had been trying to re-find her mother's hands ever since. . . . She said she couldn't lie down on the couch again unless she knew she could, if necessary, hold my hand in order to get through the re-living of the operation experience. . . . If I refused she wasn't sure if she could continue with the analysis" (p. 280).

Casement interprets her request metaphorically, "She needed me to be 'in touch' with the intensity of her anxiety." Mrs. B quickly reasserts that she needs to know if she can hold his hand.

While Casement interprets the dream as literally referring to Mrs. B's despair before her trauma at 11 months, I wonder what is triggering the dream at this particular time? Why is a despairing 10-month-old child emerging at this time? Is it being triggered within the analytic relationship or an outside relationship? Or is she beginning to confront her own (not necessarily pre-accident) despair? Does her caretaker position in the dream represent a primary adaptation to the loss of a protective mother? Can Mrs. B also identify with the despairing child as an aspect of her? If so, what is the history of that despairing child?

Casement's interpretation, rather than inquiry, is crucially impactful. Mrs. B objects and signals him to stop. After a pause, Casement breaks the silence and pursues his interpretive line. The next day Mrs. B, with a look of terror on her face, explains how at that moment in the analysis she felt that she had been on the operating table and the surgeon/analyst had relentlessly proceeded after her mother had fainted.

Casement perceives Mrs. B to be struggling with two intrapsychic conflicts: defending against memories of the scalding and surgery traumas and of her pre-accident childhood despair. Casement's view that Mrs. B's experience of him emanates from projections and displacements of her past traumatic experience, specifically related to her mother and the surgeon, is framed with the displacement model of transference. Accordingly, Casement does not consider that his interpretive actions contributed to Mrs. B's experience of him as the relentlessly advancing surgeon.

What triggered Mrs. B's current terror? She explains that she experienced Casement, *when he continued to interpret beyond her signal for him to stop*, to be like the relentless surgeon proceeding in spite of the loss of her mother's protective hand. In my view, his actions replicated for her the traumatic emotional scenario involving her mother and the surgeon. Would she have experienced Casement as similar to the surgeon if he had inquired about her experience before interpreting and if he had not persisted in his interpretation after her signal for him to stop? It is unlikely, for the cues would not have been sufficiently similar to trigger that *thematic emotional ex-*

perience (see Lichtenberg et al. 1996, p. 138).[2] In contrast to his view that she was projecting and displacing onto the blank screen of the analyst, from the perspective of the organization model of transference, the analytic interaction is viewed as sufficiently similar to activate the memory network of the past trauma and its associated affects. *Mrs. B, therefore, is not just reliving the original trauma but is living through a trauma co-created with her analyst that is thematically identical with and shaped by the original trauma.*

Recognizing that the analysand and analyst variably co-create the analysand's transferential experience positions the analyst to be alert to, address, and acknowledge his contribution. For example, the analyst might 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." The analysand's feeling that her analyst hears and understands her experience bypasses defensiveness and fosters reflective consideration of her own contribution to her experience (in this case, her attribution of meanings to the set of events). The understanding of traumatic emotional experience and their triggers in a nontraumatic setting creates a new experience that gradually establishes a new memory network and organizing pattern.

With these two models of transference in mind, let us return to Casement's case material to examine how they affect the analyst's understanding and response to his analysand's request for physical contact. Mrs. B needs to know that she could hold the analyst's hand "in order to get through the re-living of the operation experience" (p. 280) (and, I would add, to get through the traumatic replication within the analysis). With hope engendered by Casement's initial willingness to consider it, she sends Casement a hand-delivered let-

[2] It is inevitable that a thematic emotional experience of this intensity will be triggered in the analytic relationship. The issue is not to avoid, in this instance, the surgeon theme from being triggered, but to be aware of and to acknowledge how our action triggered it. Because interpretation traditionally has been the singularly sanctified analytic intervention, its impact as an action has often been overlooked (Gill, 1994; Fosshage, 1995b), which could have contributed to Casement's not addressing it here. Moreover, when a traumatic emotional experience is easily triggered, the analyst will need to change his behavior sufficiently in order to co-create a new experience. If the analyst verbally understands, but keeps doing the same, he is making clear that *in action* he does not "get it" (Bacal, 1988; Fosshage, 1995b). If he does not "get it," the trauma will be replicated and remain unanalyzable.

ter containing a dream in which "the child was crawling towards a motionless figure with the excited expectation of reaching this figure" (p. 280). To her this dream offers reassurance that she is feeling hopeful. She, as the child in the dream, is actively reaching out and, to that extent, is unparalyzed by fear. She sent the letter to offer reassurance to Casement because she was afraid that he would collapse, like her mother, under the weight of the previous session. Casement's framing that Mrs. B is attempting to ward off the original trauma positions him to see her wish to hold his hand and "to control" the motionless figure in the dream as defensive.[3] Casement understandably decided against the possibility of handholding, for to do so would be colluding with the defense, bypassing her full "re-experiencing of the original trauma" (p. 280) in which the absence of her mother's hands had been a central feature. The complete "re-experiencing of the original trauma" in the analytic setting is viewed as necessary in order to force unconscious memories into consciousness. Casement's initial willingness to consider handholding, followed by his retraction, came close, in fact, to duplicating the original trauma of losing her mother's hand, what Casement subsequently considered as a facilitative enactment created by his openness (here, he does include one element of his contribution) and role responsiveness (Sandler, 1976).

An analysand's remembering and reexperiencing of a trauma, however, cannot be an exact replication. It must occur ultimately in a different way for it to be reparative; otherwise, the trauma would be simply replicated and reinforced. Casement also sees the need for a reparative experience of the "unresolved breach of trust" (p. 281). The question is what is reparative and how do we bring it about.

In my view, Mrs. B experienced Casement's initial unstoppable interpretive action as replicating a traumatic event. At first, she felt sure that nothing could stop him. She, then, in a self-restorative effort, expressed her need for the availability of her analyst's hand to

[3] It is remarkable, and yet not uncommon, that Casement interprets the first dream manifestly and literally as involving the dreamer's awareness of her pre-accident despair (10-month-old child). He then interprets in the second dream that the motionless figure is her desire to control him rather than a perception of him. This inconsistency, I believe, is the result of the dominance of the displacement model of transference that tends to preclude those "accurate" perceptions of the analyst, particularly those that are negative, in waking and dreaming mentation (see Fosshage, 1997).

reconnect with a trustworthy (unlike her experience of the surgeon/analyst) and protective (unlike her experience of her mother/analyst) analyst. Having lost her mother's hand and now the analyst's protective presence, it is not surprising that she feels the need for the availability of the analyst's hand in order to overcome the current (not the original) trauma by recreating a reassuring, protective connection with her analyst. She states that, as she recalls the terrifying memories, she may need to hold his hand if, in my view, she cannot sustain a sufficient sense of his protective presence (particularly fragile after his neglecting her signal to stop); she does not say that she needs to hold his hand *instead of* talking about the trauma. Moreover, her request for Casement's *availability*, and not handholding, suggests, to my ears, that she is not defending at that moment against articulating her thoughts and feelings. If she and her analyst are able to recreate a protective connection, she will be better able to recall and recount the terror of the past in efforts to master the original trauma. The replication of the traumatic experience in the analysis, creating terror and mistrust of the analyst, will prevent a reflective reworking and possibly even a full remembering of the past trauma. For these reasons, I believe that it would have been a facilitative response to be *available* for handholding as the patient had requested.[4]

Whereas Casement saw the motionless figure in Mrs. B's dream as her wish and attempt to control him, I saw the dream as depicting her waking experience of him as motionless. She expressed her need for his availibility. His consideration of handholding fostered hope, and she is reaching for it, a potentially powerful restorative, mastery experience (a movement from passive to active).

Casement's view that Mrs. B is defensively attempting to have a "pretend mother" is based primarily on his seeing his analysand as solely involved with the reliving of the original trauma and not involved with a current, co-created replication. Rather than a "pretend mother," I see Mrs. B as attempting to recreate with her analyst a sense of protection and safety to overcome the current trauma that, in turn, will provide the necessary safety for the recollection and reliving of past traumatic memories. As the analyst is able to be dif-

[4] Silverman, Lachmann, and Milich (1982) also describe a patient who requested handholding, which was addressed through inquiry followed by interpretation.

ferent with the patient, she will be able to create the needed new experience and to master the trauma.

Mrs. B then reported having an image of the dream-child reaching the central figure, and as "she touched this it crumbled and collapsed" (p. 281). Casement viewed this as a projection of the mother onto him. In contrast, I suspect that Mrs. B sensed some pulling back on his part as he was musing about her wish to control him and concluded, and based on her childhood experience she would be prone to conclude, that he, too, had "crumbled and collapsed."

When Casement informed her of his unavailability for holding her hand, Mrs. B was stunned, experiencing his action as replicating the trauma with her mother in that he "too couldn't bear to remain in touch with what she was going through" (p. 281). A terrible deteriorating spiral ensued during which she had a series of dreams in which she felt "lost and unsafe amongst a strange people with whom she could not find a common language," "a baby being dropped and left to die," and "of being very small and being denied the only food she wanted. It was there but a tall person would not let her have it." She finally "stared accusingly at me and said, 'You *are* my mother and you are *not* holding me'" (pp. 281–282).

Casement viewed this as a full reliving of the original trauma with him. While, retrospectively, Casement identifies the consideration and withdrawal of handholding to be an enactment created by a role responsiveness and his initial willingness to be open to touch, he does not entertain the possibility that he interacted with the patient in such a way as to substantially contribute to her painful experience of him. In contrast, I see her experience as a co-creation of a replica of the original trauma, triggered by his unyielding interpretive action.

Casement views Mrs. B's request to be a defensive attempt to get him to be a "better mother" in order "to buy off her anger" (p. 281). In my view, his actions triggered an intense rage related to a feeling, she vociferously expressed, of not being heard and of not being "held." She, with increasing frustration, rage, and desparation, tried to get him "to hold" her in the way she needed during the current trauma and during her recollection of the original trauma.

After a most painful and dangerous period, Casement finds a way to reconnect interpretively with Mrs. B. He shared his subjective experience more fully (see p. 283). Feeling that he is emotionally

reaching out to her, she responds, "'For the first time I can believe you, that you *are* in touch with what I have been feeling'" (p. 283). Mrs. B becomes silent. Importantly, this time Casement is respectful and does not disrupt the last 10 minutes of the session. Casement commented that "she had been able to find her internal mother that she had lost touch with, as distinct from the 'pretend' mother she had been wanting me to become" (p. 283). In my view, she had been able to recapture a sense of safety and protectiveness that she had had with her mother when she felt understood and safe with her analyst again.

In Mrs. B's last reported dream, why had the car gotten out of control? I believe that this was the consequence of Casement's unyielding interpretive stance in response to the first reported dream, striking terror in her. In addition, Casement's view that his analysand's transferential experience was intrapsychically generated and, thus, his refusal to be available for touch, exacerbated the rupture and created a very painful and dangerous deteriorating spiral. His remaining firm, and we agree about this, had prevented her from an even more disastrous head-on collision. I believe that his sharing his experience, involving an understanding of her experience, enabled the patient to reconnect and to reach out "to safety" (p. 283). If the analyst had seen and acknowledged his contribution and was actively able to consider reparative, as well as defensive, meanings of handholding, I suspect that the needed healing experience of a related surgeon, a surgeon who could hear her, and a protective mother, a mother who could stay in there (which in the last analysis Casement did), could have occurred with less sustained terror and risk.

Touch and Clinical Work

Psychoanalysis, in keeping with our Western culture, has almost solely relied on verbal communication. Only recently have we been including the vast array of nonverbal communications. Ashley Montagu (1986) sums it up: "The languages of the senses, in which all of us can be socialized, are capable of enlarging our appreciation and of deepening our understanding of each other and the world in which we live. Chief among these languages is touching. The communications we transmit through touch constitute the most powerful means of establishing human relationships, the foundation of experience" (p. xv). Touch, like other senses, can trigger important memories of past events and communications. Moreover, research and

experience make clear that physical contact or touch is vitally important for survival and a sense of well-being.

In dealing in-depth with human beings, we cannot afford to exclude such a powerful form of connection and communication as touch. Thus, in psychoanalysis it is time to move beyond the traditional pejorative view, anchored in classical theory, that the wish for or occurrence of touch is an "acting in" of an infantile wish or defense. On the basis of research and clinical experience, we now know that for many patients, whether deeply disturbed or not, different kinds of touch, including "giving" as well as "receiving," can be facilitative of therapeutic moments and analytic work. That is why, despite the interdiction and our fears, and despite our cultural climate today with its proneness for cries of sexual harassment and litigation, we psychoanalysts have found ourselves responding on occasions with physical touch.

We all differ as to our comfort level with touch and each of us, as analyst, needs to remain authentic in the analytic encounter. Our comfort or discomfort with an analysand's request for hand-shaking, hand-holding, or a hug, as with all countertransference (broadly defined as our experience of the patient [see Fosshage, 1995a]), can be most telling about the patient and what is occurring in the relationship or it can reflect something about us. On those occasions when we are uncomfortable and feel that the discomfort is primarily "ours," an open acknowledgement of our discomfort, rather than pathologizing the patient's desire for physical contact, will facilitate the analytic interaction.

Yet touch, as with any analytic response, can be problematic. Desires for touch can be generated for protective purposes, and the more important task is to understand what is creating the anxiety. Psychotherapy research and clinical experience make clear that touch, as with any intervention, must be in keeping with the desires and needs of the patient and with the level of intimacy in the relationship. Occurring within a dyad, the analyst must feel comfortable and authentic with touch in order to create a facilitative interaction. The mix of genders and ages within the dyad undoubtedly affects comfort levels and meanings. Touch, as initiated by analyst or patient, can have very different (positive or negative) meanings for both members of the dyad. Physical contact can feel sensual or stir sexual feelings (Lichtenberg, 1989; Lichtenberg, Lachmann, and Fosshage, 1992, 1996)—so can a look, an intonation, a verbal remark. When sexual

feelings enter the analytic arena, they, like all feelings, need to be understood, accepted, and modulated. Occurrences of touch, like all interactions, need to be closely tracked and often discussed for understanding their meanings and for assessing whether they are facilitating or encumbering the therapeutic endeavor.

As for myself, I find myself liking and rather comfortable with touch. In the analytic arena, I find that handshakes with men and women create a sense of mutual respect and engagement. Sometimes they become ritualized; often, they do not. I find myself easily touching the shoulder of a patient, man or woman, as they are walking out the door. Hugs at the door occur occassionally with men and women. Because of the nature of these hugs, they are rarely experienced as erotic. If so, we work with those feelings. And some patients I never touch except at the end of treatment with a handshake. Like McLaughlin, I feel that I can usually (not always) sense the individual differences and can anticipate when touch will be facilitative or not. I try to make sure that hugs are initiated by the patient, because hugs can easily be experienced as an intrusion and as my agenda. I will always discuss a hug, for it typically has more import and meaning. In contrast, a handshake, at times clasping both of my hands on my analysand's hand, or a squeeze on the shoulder, I will initiate at times to communicate my presence and full support of my analysand. At times, the physical contact is discussed, at times not. Analysands have often commented on how important and healing the touch has been.

While touch has occurred during sessions, I have personally found it rare, for I have experienced touch as potentially interfering with analysands' articulations of their experience. For preverbal trauma, however, touch may be required for establishing an empathic connection. Touch has occurred during sessions in which there are periods of intense depersonalization and disorientation, and on these occasions, touch, combined with simultaneous articulation of experiences, has helped to bolster a holding environment.

Touch is a powerful form of communication. We cannot afford to eliminate a profoundly important mode of communication from our healing profession. As with any form of communication, verbal and nonverbal, we can use it advantageously or not for facilitating understanding, communication, and the analysis. As we recognize the communicative power of physical touch and expand our view of the possible meanings of touch beyond that of an infantile wish or a

defense formulation, we will be able to understand better our analysands' requests for touch or spontaneous gestures involving touch. It will afford the analyst greater comfort and, regardless of whether the analyst chooses to touch or not, he or she will be better able to work with the meanings of touch in a more flexible and constructive manner.

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