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A RATIONALE FOR PHYSICAL TOUCHING IN PSYCHOTHERAPY

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Our patients in the 1990s are not really sicker than those of the 1890s. But the pace of our life is faster. Our moral and behavioral codes are looser. Our families sustain the individual less well. And we have much more freedom to act out. Vienna of 100 years ago was tight-lipped and straight-laced. The emotional illnesses today are more blatant. We are not treating nice neurotic patients.

It is much clearer now that the basic source of their anxiety is not Oedipal trauma, but the preverbal experiences they had as newborns and infants. For almost 2 years, each of us lived in such darkness before consciousness or memory existed. We had many frightening physical experiences during that time, but no ability to understand any of them. Most of these were objectively safe, but we could not know that. The nerve fibers of our cortex were not yet fully myelinated, and this part of our brain was not yet functional (Bar-Levav, 1988).

But nothing is lost in the universe. We survived, and within us survived traces of those early experiences. For the rest of our days, each of us lives with the same chance physiological response patterns that were associated with our survival. In adulthood we often react as if we were in danger, when in fact no danger exists. Similarly, old hurt and preverbal rage are easily stimulated in adulthood by mildly hurtful

or annoying experiences. Our body reacts in the present to signals from another age, long ago. The messages are wrong, but our body does not know it. Such "incorrect" responses are the cause of most adult difficulties and failures. These wrong messages are not sent by the cortex, the organ of understanding. They are issued instead by the subcortical brain, the one that controlled the autonomic nervous system at the very beginning and that sustains life thereafter.

Explanations to the cortex are therefore useless. It is not the source of the trouble and not in charge here. Patients understand, gain insight, and agree with our interpretations and reconstructions, but they do not change as a result. Even in "talking" therapies, the body and its physiological patterns must be altered. Not our thinking.

Until recently this appeared to be an impossible task. How can we ever know what happened before the patient had any memory and any consciousness? We cannot know it from what the patient says. But we can deduce it from what the patient is, and what he or she shows characterologically and characteristically. Our new knowledge of early infant development is also useful.

The basic human experience is universally the same. Individual differences exist only in the details. We know, for instance, why Spitz's babies died in England, even though they never told us. They were not mothered properly. They were carefully attended to, fed, and changed, but this was not enough. And how were they not mothered properly? They were not held and touched enough, and not well enough (Spitz, 1957). They literally wilted and died.

Everything that newborns and infants know about the universe they learn through their physical sensations. Orality is only one route. And not always the most important one. Our sense of safety comes from the softness, firmness, consistency, and steadiness of the mothering body. Most commonly this refers to the biological mother, but not necessarily.

If Mother is immature and anxious, the baby knows its world as jerky and jumpy, or as stifling and crushing. Such mothers typically hold their babies either too loosely lest they be crushed, or too tightly lest they slip and fall. Or Mother might cling to her baby to lessen her own anxiety. Either way, the young organism "knows" the world through such experiences. And this remains its "knowledge" for life, unless it is modified by good, long-term psychotherapy that addresses and changes such physiological expectations.

But how do we address and change such preverbal "knowledge"? Surely not by talking from our cortex to the patient's. It is done by repeatedly establishing exquisite contact with the distrustful and scared infant within the adult patient. We persist until the fragile inner baby

begins to feel safe in the therapeutic setting. Only then do patients drop their socially acceptable ways of being and of behaving. The affects and physical reactions of early preverbal experiences then bubble up and come to the surface.

This also happens in marriages, and this is what often destroys them. The expectations that result from the feelings that bubble up are not satisfiable in any reality. And such affects come up in real relationships with compassionate, consistent, and competent psychotherapists who earn the patients' trust over time. But only if a strict non-acting-out contract is in place. Such primitive and powerful affects remain in hiding unless the environment is experienced as totally safe. The emerging affects represent emotional experiences from the period of normal autism soon after birth, and, strictly speaking, they are therefore not transference.

Experiencing such affects early in life or many years later is obviously not the same: Only the adult patient is in a position to observe the panic, the deep hurt, and the extreme rage even while they are bubbling up. This is the critical difference. It makes resolution of the earliest autistic horrors possible. Sooner or later it becomes clear even to very disturbed patients that their enormously powerful storms of affect are not a function of the therapist or of the therapeutic setting. Here it's safe. All is well in reality.

Although propelled by powerful wishes to escape, to withdraw, or to lash out, none of these in fact occur as long as the non-acting-out contract holds. In the meantime the body's musculature, physiology, and subcortical brain are slowly "trained" to recognize that the information imbedded in them is wrong. Not having the powers of observation of the cortex, they are slow learners.

Patients must repeat such affective hurricanes many times before the wrong messages are no longer sent and received. The feelings finally change too. This is the essence of psychotherapy that heals depression. No wonder that such a process is tedious and takes a very long time. But real personality and character change is now an achievable goal. Living essentially without anxiety and depression is possible.

Physical touch, with the explicit permission of the patient each time anew, is the most reassuring intervention when the body undergoes such hurricanes. They are often experienced as literally life-threatening. Every patient naturally always wants to avoid them, or to escape from them as soon as possible. Verbal reassurance is not always enough.

A firm but gentle touch at the right moment allows a patient to endure such experiences of extreme panic and pain without bolting. It

intensifies the deep sobbing of hurt. It allows patients not to limit their powerful expressions of rage. These are always very frightening, and especially so for patients who have never had room to express any protest openly. Many people, including professionals, confuse the verbal expression of rage with acts of violence or aggression. They fear losing control. Patients sometimes need a hand, literally, not to curb such safe expressions of rage. Repressing affects cripples effectiveness in general.

The laying on of hands was always considered to be helpful in medicine. It is not hocus-pocus. It is not magic. The scared infant within the sick adult patient was always reassured by the touching hands of a physician. This often saved lives when no specific treatments existed.

Forbidding touch on the basis of the possibility of stimulating an erotic transference essentially reflects the fears in the therapist. Though it is often expressed as a generally accepted fact, such an assumption is also theoretically incorrect. The yearning of a patient for the therapist's love is not sexual. Such yearnings for affection are not even embarrassing when seen for what they really are: yearnings of the panicky infant to be mothered safely and perfectly.

We must make room for such yearnings and welcome their open and full expression. They are a necessary step on the road to self-mothering. Proceeding on this road often requires a gentle, obviously nonsexual, touch on the forearm or on the shoulder. More than any number of wise words, it speaks louder, more clearly, and more directly to the patient's confusion and fear.

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