Touch: The Forgotten Language

Hence, the first impulse of every creature must be a desire to establish contact with the outer world.
Wilhelm Reich

In verbal based psychotherapy, without physically touching the patient, there are many ways for both the patient and the therapist to be touched. An incomplete listing includes: transference, countertransference, resonance, somatic resonance, coupled, electro-magnetic resonance, projective identification, vegetative identification, primary identification, empathy, containment, reverie, investment, holding, somatic transference, field theory and mutual inductive identification.

In addition, when using touch in psychotherapy, there are a wide range of themes and considerations. There is touch as physical treatment (physical touch) and as personal experience for both patient and therapist (emotional touch). Being emotionally touched as a therapist is still a difficult theme to discuss and work with. Too often therapists are trained not to pay attention to their own experience of the physical contact and if they do it is often pathologized - something that needs to be worked within supervision. One reason for this difficulty, is the sexual issue but touching goes much beyond and deeper than sexuality. A more important element of touch is on the personal level, the character of the therapist. The therapist knows unconsciously that there is a personal involvement/risk, that some therapists choose not to take, a border they cannot cross. They know on a deep level that to touch is to be touched. The Kinsey Institute Traumatic Stress Research Consortium (KI-TSRC, 2020) found that 75% of trauma therapists reported some form of abuse or neglect in childhood, the most common being emotional abuse. They had significantly higher rates in three particular domains: emotional abuse, sexual abuse and emotional neglect. The study showed that 45% of trauma therapists suffered emotional neglect as compared to 27% of the general population. It's obvious that this is not a coincidence. It is of value for each therapist to ask themselves what attracts them to their own individual style of touch based therapy or why they avoid it.

This personalized element of physical touch has even begun to become a theme in the "purely" physical, manual therapies — massage, Rolfing, Osteopathy — whereby they are now concerning themselves with the "somatoemotional" response — "biopsychosocial model" in osteopathic philosophy — of patients and how to process these personalized states.

> …the osteopaths included in this study highlighted a lack of knowledge and skills to assess and address psychosocial risk factors. . . These findings indicate the need for osteopaths to acquire additional skills and knowledge in professional training programs to develop a more operational, holistic view in managing chronic pain sufferers. (Formica, 2008, p. 13)

They have yet to breach the topic of the biopsychosocial response in the therapist her/himself.

The fascial research of Schleip and Jäger have reported that there are specific touch receptors in human skin called C-tactile afferent fibers that underly "…emotional, hormonal (for example oxytocin) and affiliate responses to caress-like skin to skin contact between individuals" (Schleip and Jäger, 2012, p. 90). These give a social element to touch supporting the "social touch hypothesis" of Olausson. (Olausson, et al., 2008). They showed that light touch is important in

creating and maintaining social bonds "…alongside behavioral, hormonal, and autonomic responses during gentle touch between individuals" (Olausson, 2008, p.186) In fact, they indicated that the stimulation of C-tactile afferents may directly influence the ANS, the very basis of Reichian body oriented psychotherapy. This research supports the movement towards a gentler touch as developed in Functional Analysis many years ago. Unfortunately research on touch in humans has focused mostly on the sensory aspects of discriminative touch and not the social or emotional aspects, because these subjective reactions are harder to study (Olausson, et al., 2008, p.186-87). In psychotherapy, the subjective reactions of both patient and therapist is our main concern when touching. As a result, the border between therapeutic physical touch, social bonding touch, emotional touch and sexual touch is little understood and in the clinical setting can easily be confused.

> An interesting thing about touch is that the brain doesn't just tell us how something feels but how it ought to feel. That's why the caress of a lover feels wonderful, but the same touch by a stranger would feel creepy or horrible. It is also why it is so hard to tickle yourself. (Bryson, 2019, p. 14)

Since Harlow's groundbreaking studies of touch, or rather lack of touch, with infant monkeys in the 1950s it has been known that touch is essential to mammalian health both physically and emotionally. Yet, Freud's model that the oral segment was the first developmental stage held sway for almost 80 years. Reich (1983 & 1967) had suggested in the 1940s, that the ocular segment was more primary than the oral and research in the 1980s/1990s by the so-called "baby watchers" proved him to be correct (Beebe, 2006; Stern, 2003). It is now considered by some researchers that touch is the first relational experience of the infant.

A study done by the neurobiologist Linden (2015) showsed that children, born either deaf or blind, who received nourishing touch in the first years of life, grew emotionally and physically healthy. In comparison, children neither deaf nor blind, who were deprived of this nourishing touch suffered from emotional and psychiatric difficulties as well as physical problems into adulthood. Linden (2015) underscores that touch is not a choice, it is the first sense the foetus develops.

Another example showing how touch is essential for mammals, in 1980 Nerem, et al. studied dietary benefits in laboratory rabbits. They were startled when the results showed no difference between the control group who was feed a good diet and the experimental group whose diet was deficient. They repeated the study paying attention to how much the rabbits were touched, petted, stroked and played with by the lab technicians and discovered that touching was the variable that significantly decreased the negative effects of an unhealthy lifestyle.

The body-oriented psychotherapist Bergami describes why touch is so important.

> Physical touch is not optional. It is essential for human development, from there it all started. Human beings need contact and love and want to touch each other. A gentle, affectionate touch, a hug, a kiss, is inherently intrinsically and naturally therapeutic. Numerous researches have recorded the brain activity during the interaction between mother and child. They provided us with evidence that physical contact, the mother's affectionate physical exchange provides a sense of security, protection, pleasure. It develops synapses, neural circuits, production of receptors and neurotransmitters such as serotonin and dopamine, stimulates the release of endorphins and oxytocin. This wonderful natural tranquilizer is released for free into the bloodstream whenever we have a person in our arms, we caress a dog or a cat, we dance with our partner or we simply put our hand on a friend's shoulders.
>
> Physical contact has a direct relation to stress reduction, the main killer of recent decades. Hundreds of studies on physical contact have found evidence of significant effects: faster growth in premature babies, reduced pain, decreased symptoms of autoimmune diseases. It lowers glucose levels in children with diabetes, strengthens the immune system, stimulates the thymus gland, which regulates the production of white blood cells, lowers the heart rate and cortisol level, reduces anxiety. (Bergami, 2018)

The quality of the touch is also a factor. There is touch without intention — such as the handling of the rabbits during the study — and touch with intention as performed in body oriented psychotherapies. Touch without intention is performed for the benefit of the one doing the touching; it satisfies by the act itself. For example, the lab assistants wanted to clean the rabbits cages. On the other hand, touching with intention is only /successful/satisfactory, if it has the desired effect on the other; the calming of a baby, releasing of tension in the muscle.

It has been known for some time that all sensory input is interpretive. Kandel (2012) states for example, the eye is not a camera. We select what to see. We have no direct contact with reality. Because of the discovery of *interpretive* interoception on the micro level within fascia, it has become clearer that what we intend to transmit as therapists with our touch, is not necessarily what is received, The osteopath Myers calls this "illusionary interoception" on the part of the patient. He or she interprets our touch.

Body-oriented therapists use touch with intention: to treat the patient and the problem. But there is a problem about treating the problem. Returning to the issue of transmission and reception, a therapist can touch different patients in the same manner, but each patient will experience their version of the quality of that touch. I always find it fascinating when using our Points&Positions touch technique how different patients respond differently to the same touch I do: same pressure, rhythm, location. And also, how a patient will respond differently to the same touch as the therapy progresses. This is due to the plasticity of connective tissue whereby under the right conditions, the tissue will spontaneously reorganize itself back to its prestressed state and my touch will be "interpreted" differently.

It is interesting that the manual/physical oriented therapists bring up the very same issues we face in body oriented psychotherapy. In discussing interoception with Myers, Schleip (2019) emphasized that interoception is not direct input from the body to the nervous systems but interpretive. Social context, lived experiences and expectations (historical content in psychotherapy) influence interoception; what a psychotherapist would understand as the "filtering" done by the character structures' defenses. He argues, because of this, these are not "real body" sensations being processed. Additionally, input from the interoceptive receptors travels not directly to the somato/motor cortex whereby it would be registered as physical sensation, but rather to the insular, which is always involved with emotional evaluation — basically an evaluative process of approach/avoidance. As a result, the insular "fishes" for what it needs. "We create our own movie. We construct reality" (Schleip, 2019) what Myers called "interoceptive illusions" (Myers, 2019).

This is difficult ground to cover. From a functional point of view, all sensory input is as real as anything else. My position is that if the patient is experiencing my touch as aspecific emotion, then it is "real" enough, which is in line with Reich's position that, "Everyone is right in some way. But how? …Certainly not in the way they say." (Reich, 1967, p. 48) As an example, a patient of mine was talking about a sexual abuse she suffered when she was 8 years old. She was describing the situation to me and then she suddenly looked intently at me and said: "I don't know if I was abused, but I feel abused." And this is what we worked on: her interpreted, subjective experience of abuse, and not the "reality" of a possible historical past event and the man involved. She was right in her own way, even if the actual event might never have happened. It is all true to the patient whether it happened or not. The same is true for anticipatory pain. Patients report panful responses to a touch,

yet when they direct me in my touching of them, the “pain” disappears even when I begin touching them in the same manner as before. I have not yet done a real physical work, yet the “pain” is gone.

As a result of the condition of the CT we are touching, one patient could feel the same touch as reassuring or caring, another as seductive and a third as invasive. This explains the phenomenon of anisotropy: different patients responding to the same external stimuli in different ways. Neurology has shown that 100% of sensory input is interpretive with no direct contact with the external environment and research has shown that on the micro tissue level we are interpreting our sensations emotionally, not just experiencing them. As a result, all touch is unique because the personal emotional resistances and blockages that a patient developed over the years, are individualized, filtering physical interventions, reducing even further their clear contact with the external world. All touch is self referential. As an example, when I gently lifted a patients head and began to softly touch it, the patient opened her eyes and said; “My father never held my head like that.” She immediately was in the so-called past, what had *not* happened and became sad. She was not in the present with the need to be touched like that and satisfied by the pleasure, support and reassurance of my touch on her head. My touch was individually filtered by her past experiences.

In Body Psychotherapy, the personal relationship is stressed and so the information exchange between two people takes on another context. I repeat: to touch another is to be touched. And due to the condition of the connective tissue and the energies passing through them, what is transmitted through touch is not necessarily what is received by the patient!

Another example is when I was treating a patient who had had 12 years of psychoanalysis. Although psychoanalysis has changed since the time of this session, it still focusses on a transferential orientation towards therapy and therapists; the therapist takes on the role of what the other, the father/mother, had done to the patient in the past. In this case, my patient had a nationally known, moralistic, dominating father. With the patient lying on his back on a mat, I was touching his abdomen and as I gently increased my pressure to move deeper towards the psoas muscle, he opened his eyes, looked at me and said: “It feels like you are putting a knife in my belly.” I withdrew my hand, and told him to stay in eye contact with me, take my hand in his, and slowly make the same movement with my hand that I had done. He began doing it and when I asked how it felt now, he said: “I feel like *I* am putting a knife in my own belly!”

There are a number of interesting themes in this interaction, but the most important one for this discussion is that my physical touch was irrelevant to him. What I was intending to transmit had nothing to do with my actions or his experience of himself in the so-called “real” world. His experience of my touch sent him back to his dominant, dangerous, invasive father and he needed to protect himself from that, not me. My touch was filtered, interpreted in the physical realm by his history and by the contracted, dehydrated state of his connective tissue. Supported by recent fascial studies and in neurological findings, Reich’s position that there is no past, memories are alive in the body in the present moment has been proven; what is now called embodiment, somatic recall or soft tissue memory. All of this is possible because of CT’s role in energetics: its health and dysfunction. Because of this, the patient’s “illusions” are real and are coming from their own “real bodies” yet they are distorted. In therapy, this must be expected and respected.

What is so fascinating in the body-oriented psychotherapy process is, when the patient has a different experience of the same historical event they have been working on in therapy when nothing has changed about their history. The event is exactly the same, there is no new input, but

they feel differently about it and about themselves. They “see” it differently but no new information has been added to that story. What has changed is not the content, the story, but the context: the physical and character structure of the patient allowing them to have a different experience of that same event. This ability to re-formulate is the basis of how we can restructure a primary relationship years later with no new input and how the changes found in in-depth psychotherapy are achieved. The object remains the same. The story remains the same. It is the patient’s *experience* that changes. Similar descriptions are found in the phenomenological point of view. “The learner remains unchanged. It is his experience of the situation which changes.” (Syngg, 1941, p. 406)

Syngg’s quote refers to the psychic level. On the physical level these changes are a result of the reorganizing of connective tissue due to its plasticity that spontaneous happens if you know how to touch it. Putting the physical and psychic together, this is the psychoanalyst Adler’s (1933) model of how both body and character have become “congealed” and then “re-liquified”; fluid, flowing movements and emotions emerge. As Rolf wrote, structure is behavior and behavior is a function of our experience of ourselves. If the structure changes, the life experiences change, and then so too does the behavior.

Another way to represent the relationship of form and shape to behavior is to imagine two garden hoses lying on the ground. One has a large diameter, while the other is narrow. When the large hose is attached to the faucet and the water is turned on, the hose continues to lie on the ground with the water slowly flowing out. When the narrow hose is attached and the faucet is opened, even though the same amount of water and pressure is applied, the response is totally different: the hose moves rapidly in an excited snake-like fashion. The only thing that is different is the shape which then changes the behavior of the hose. The same emotion passing through a body will be experienced differently in different character structures, due to their different shape producing different internal experiences and external behaviors. Anger in the peripheral flaccidity (wide hose) of a hysteric's body has no similarity on the subjective *experiential* level with anger experienced in the contracted, tube-like schizoid's body. It is a matter of quality not quantity. The quality determines the experience and therefore what it means to the patient. It is the *context*, the character structure, not the *content*, the emotion/memory, that is important to focus on in psychotherapy. And this experience is largely determined by the structure and conditions of CT as memories, histories, emotions, movements and thoughts pass through it. Experience, subjectivity and any meaning to all of this is determined not by the quantity but by the context; the form, the shape, the character structure and character armor not the content, the history.

Working with a patient whose mother died when he was young we did no discussing, analyzing etc., only Points&Positions touch. He told me the history after the treatments. After 9 sessions he began to softly cry reporting later that he realized his stepmother loved him. He spontaneously, unconsciously and by himself, reorganized a primary object representation and felt loved. His stepmother didn’t change. He re-experienced the same object relationship in a new way through touch and connective tissue reorganization. (See: The Biological Foundations of the Schizoid Process, Part I)

In Functional Analysis we work through the medium of the connective tissue matrix throughout the body by our touch method. This matrix is a physical structure composed mainly of collagen fibers whereby all parts of the body are connected with every other part from the macro to the micro and vis-versa. This matrix provides an instantaneous, whole body, non-neural communication system

resulting in the phenomenon that there are no local problems and no local treatments. It is also the basis of the psychosomatic matrix.

This is possible because collagen molecules transport all the bodies energies: light, heat, electro-magnetism, sound, pressure. These energies are information/instructions to the body/mind. The condition of the this tissue is of essence. When stressed, the body will automatically increase connective tissue fibers in the area stressed. This is the tension, knots, hardness we feel when we touch these contracted areas. In this stressed state, the tissue becomes dehydrated and energetic transmission gets reduced and distorted. The body is receiving misinformation which accounts for how patients will respond differently — individually — to our touch. In Functional Analysis, with our gentle, non-invasive, bordered touch, we activate the tissue's natural "plasticity" allowing it to reorganize itself and return to a healthy, well functioning state. We do not manipulate the tissue to try to make a change. Much like in a homeopathic model, our touch acts as a "wake-up" call for the tissue to begin to restructure itself and return to a "remembered" healthy state, what psychotherapists call the "resources" of the patient.

Summary

Considering that we know touch is essential for healthy human development, healing and relationships why do we as psychotherapists limit ourselves? As mentioned, there certainly are potential problems in touching patients in the therapy settings. But do they outweigh the advantages? Many other professionals touch their patients or clients from hair dressers to chiropractors and onto medical doctors — often touching patients in various states of undress — whereby these same problems can arise.

As trained psychotherapists, we are the only profession that deals with these potential problems in our own trainings, i.e. we undergo therapy ourselves to at least identify any potential issues we might be bringing to the clinical setting to help us overcome problems with touching. We also have a supervision format where these issues can be handled professionally as they arise. No other profession that I know of that uses touch has these two safeguards. And psychotherapy has strict ethical codes concerning crossing personal borders with patients.

Besides the nurturing quality of touch in development and healing, touch also offers us and the patient another avenue to gather information, to help to understand the patient's process on a deeper level and be in a more elaborated relationship. Reich had been aware of this since the 1930s.

> "Postulations resulting from the connecting of facts immediately lead to further findings. If the character armor could be expressed through the muscular armor, and vice versa, then the unity of psychic and somatic functioning had been grasped in principle, and could be influenced in a practical way. From that time on, I was able to make practical use of this unity whenever necessary. If a character inhibition did not respond to psychic influencing, I resorted to the corresponding somatic attitude. Conversely, if I had difficulty in getting at a disturbing somatic attitude, I worked on its expression in the patient's character and was able to loosen it. I was now able to eliminate a typical friendly smile which obstructed the analytic work, either by describing the expression or by directly disturbing the muscular attitude, e.g., pulling up the chin. This was an enormous step forward. It took another six years to develop this technique into the vegetotherapy of today."

Done correctly the advantages of proper touch far out weights the potential problems that might arise.

will davis

A patient's feedback on being touched in Functional Analysis:

I feel expanded from your pressure. Massage and other body works give me the feeling of being "compressed" from the outside. This work "elevates" me from within. The touch is consistent -– it is always the same. It never varies.

This touch — it goes to the interior. Other physical techniques go to different parts of the body — the arms the legs, the back. This goes to the interior.

This touch is not a "Mother" touch -– but it always brings me to my childhood.

This technique has an element of aggression. It is an attenuated aggression. It puts me in contact with an experience of the aggression of the ancient man. An aggression we have inside our being. Our body knows how to respond to this. My person, me, as an individual, doesn't know how to respond to this aggression. My "archaic body" knows.

The body reacts because it has the experience of aggression, conflict and healing! Healing is not always the consequence of the aggression and conflict experience. Death was possible too.

Attenuated aggression yields a relaxation, a release. Together with this, there is an archaic sense of healing. After the aggression, comes a healing. An archaic, genetic sense of aggression stimulates the healing. This not something that comes from my head or thinking.

My feeling of expansion is a consequence of being aggressed. It is like a vaccine. I am recoursed to energize inside of myself –- to my archaic being. Aggression and healing normally are not seen as being together. I have a history of psychological aggression against me and as a result, a difficulty to relate to others.

What is being healed in me through the "other" type of aggression is the current problem about my historical aggression. For me as well as for most people, the common defense against aggression is to close because the individual does not have the experience of the healing. But the ancient/archaic body has the experience of the healing.

SEE ALSO: The Role of Connective Tissue in Development and Defense.

References

Adler, A. (1933) The Sense of Life. Fischer, Frankfurt am Main.

Bergami, E. (12/10/18) Conference " Redefining Health and Disease" Senigallia, Italy.

Bryson, B. (2019) The Body: A guide for occupants. Transworld Publishers, London.

Formica, A. Thomson, O.P., Esteves, J.E. (2018) 'I Just Don't Have The Tools' - Italian osteopaths' attitudes and beliefs about the management of patients with chronic pain: A Qualitative Study. International Journal of Osteopathic Medicine. Volume 27, March 2018, Pages 6-13.

Kandel, E. (2012). Age of insight: The quest to understand the unconscious in art, mind and brain from Vienna 19000 to the present. Random House. New York.

Linden, D. J. (2015) Touch: The Science of Hand, Heart and Mind. Viking Press. NY.

Olausson, H., Wessberg, J., Morrison, I., McGlone, F., Valboe, A. (2008) The neurophysiology of unmyelinated tatctile afferents. Neuroscience & Biobehavioral Reviews 34(2):185-91 DOI: 10.1016/j.neubiorev.2008.09.011

Nerem, R.M., Levesque, M.J., Cornhill, J.F. (1980) Social environment as a factor in diet-induced atherosclerosis. Science. June 27;208(4451):1475-6. doi: 10.1126/science.7384790. PMID: 7384790 DOI. 10.1126/science.7384790

Schleip, R. (2012) Interoception. Eds.Schlep, R. Findley, T.W., Chaitow, L., Huijing, P., Fascia: The Tensional network of the body. The science and clinical applications in manual therapy and movement therapy. Churchill Livingstone, Edinburgh. p. 89-94

Syngg, D. (1941). The need for a phenomenological system of psychology. Psychological Review. 48, (pp. 404-424)

TSRC. (2020) The Traumatic Stress Research Consortium, Kinsey Institute Indiana University. September 2020 Newsletter. https:// kinseyinsttitue.org/research/traumatic-stress.php. Accessed: 3/10/2020.