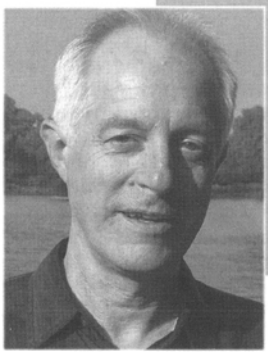
The therapeutic modality of touch and statutory regulation

Tom Warnecke



Perceptions of touch and tactile contact are permeated by associations with nurture, care and healing on the one hand, and with erotic pleasures, sexual taboos and abuse on the other. With the prospect of statutory regulation looming, do we need to review touch as a therapeutic intervention?

The practice of body psychotherapy is by no means synonymous with touch, nor requires touch, but theory and practice of touch certainly constitute significant aspects of the field. As a psychotherapeutic intervention, touch is employed to invite movement, to deepen or relax breathing, to soften or strengthen boundaries, and to release or help contain emotions. Touch is also an essential form of communication - we can speak and listen through our hands. An exploration of hand to hand contact between therapist and client for example will facilitate an engagement with both individual and relational psyche-soma dynamics. Hand contact may be warm, mechanical or withdrawn, evoke sensations and feelings or invite involuntary motor intentions and narratives to unfold.

Contactful touch, with a client's informed consent and within its appropriate ethical boundaries, may provide a person with new frames of reference for qualities of touch and its distortions such as invasive or depriving touch. But touch is also a mutual experience. The sensory-motor systems of two people become aware of each other and respond, interact and relate to one another (Warnecke 2003). Our open loop physiology of limbic and motor systems is designed to resonate, regulate,

predict and respond. Sensory cognition skills develop through mapping our sensory-motor experiences as they occur in resonant relationships with others. As a therapist, I utilise my sensory cognition and any subliminal sensory-motor processes evoked by touch as openings for verbal dialogue or as cues to engage, mirror or co-regulate relational tensions.

Touch and tactile contact contribute crucially to human existence and development. In Juhan's words, *'to touch the surface of the body is to stir the depths'* (1987: 43). Not surprisingly, these depths prove evocative and give rise to potent projections around the issue of touch. Such projections commonly thrive on emphasising single aspects of touch at the exclusion of others. Touch is viewed as gratification for example or indeed sexualised in the psychotherapeutic context. Therapists trained in somatic approaches are not immune to fears and idealisations of touch either. Some associate touch exclusively with 'mother touch' while others claim touch can be expected to turn on some mating instinct in the brain.

Touch has been a therapeutic modality for at least 2000 years and the taboo against sexual relations between healers and patients can be traced back to the writings of Hippocrates. Historically, practitioners of the healing professions have struggled to contain the powerful forces of erotic transference and countertransference. Eros, and the undeniable intensity of bodily experience in passionate desire and unrequited love, compelled Greek poets and philosophers to recognise psyche as the body's inner dimension. Eros awakens the body-mind to itself. It is hardly surprising that these powers enchanted and dominated theory and practice of psychotherapy throughout its history.

In the field of psychotherapy, we have learned to embrace this struggle as an unavoidable presenting dynamic in our professional practice. Mann summarised this position with his assertion that *'... rules of abstinence will stop neither erotic fantasy life nor the erotic nature of the unconscious'* (1999: 2). Perceptions of erotic transference and countertransference parallel perceptions of touch in a variety of ways. In the fears and discomfort they both provoke for instance or in the allure to abstain from the 'slippery slope' of their potentially explosive forces altogether. 'The most intense mingling of infantile and adult passions' (Mann, 1999: 1) characterises the erotic arena but provides an equally apt portrayal of non-erotic touch. And the temptations to revert to a defensive position when speaking about erotic transference will a familiar experience for body psychotherapists discussing touch as a therapeutic intervention.

Should we outlaw what is potentially dangerous? Let me take you back to Hippocrates. His systematic study of clinical practice does not only prohibit sexual relations between healers and patients but also established the notion of permissible

therapeutic interventions within appropriate boundaries. Soble's philosophical encyclopedia (2006) emphasizes that the explicit prohibition of practitioners' sexual gratification also constitutes an implicit permission and definition of nonsexual interpretations of actions that could be seen as sexual in other circumstances. Freud argued along similar lines in his 'Observations on transference' (1915/1958: 170-171): '*The Psycho-Analyst knows that he is working with highly explosive forces and that he needs to proceed with as much caution and conscientiousness as a chemist. But when have chemists ever been forbidden, because of the danger, from handling explosive substances, which are indispensable, on account of their effects?* '

Establishing our professional standards of good practice seems to become ever more relevant in 21st century western society. Modern society displays increasingly embarrassed attitudes towards nudity contrasted by the exaggerating and titillating eroticised images of the human body which dominate its consumerist culture. The 21st century has also seen a sharp ascendency of risk management, often at the expense of common sense but driven by the commercial interests of insurance companies, which introduced a rampant health and safety culture that borders on the hysterical. This is contrasted by a blatant absence of risk management in the financial services sector and in natural resource management which have become infamous for their reckless disregard of prudence and accountability. The political trend to prioritise commercial interests of business over the rights and interests of the individual citizen/consumer is deeply concerning for the field of psychotherapy. We need to ensure that best practice and future developments of psychotherapy are not stifled by a risk avoidance culture.

Risk avoidance has become an influential force in the healing professions. There is a danger of practitioners becoming frightened and avoiding interventions seen as 'risky' instead of carefully weighing up possible risk and potential benefits in a conscientious and ethical manner. From an ethics perspective, risk avoidance presents a quandary. Zur and Nordmarken (2009) argue that it would be unethical for therapists to avoid touching clients in psychotherapy in order to prevent complaints or legal action. Ethical evaluations of withholding treatment have been the subject of controversy since Hippocrates.

But the ascent of risk management also serves to expose fundamental flaws in established practice. Historically, the medical professions have made little effort to differentiate between professional and personal conduct or to develop good distinctions between the two arenas. The field of psychotherapy in contrast has devoted much attention to researching the practitioner's participative role in the therapeutic process and to utilise a practitioner's transference and personality for the benefit of

clients. These efforts have deepened appreciations of the crucial role of the therapist - client relationship and quality of the practitioner in determining outcomes but also advanced a better understanding of the risks associated with such therapist - client involvement. The 21st century offers new opportunities to contribute our understanding to other professional fields such as medicine and social work.

And how do we decide when to touch and when not to touch? Sensitivity to variables such as clients' presenting issues, their history, gender or cultural background and considerations of the relational dynamic in the therapeutic relationship will contribute to an ethically informed intervention involving touch. Shoshi Asheri describes a common scenario for relational body psychotherapists: *'The dilemma we are persistently grappling with is: when is it therapeutically valuable to meet the client's desire to be 'treated' by touch and when is it more valuable to challenge this desire and facilitate a process of necessary disappointment?'* [2008: 109]

Any engagement with touch has the potential for multiple and sometimes simultaneous dimensions of reality and meaning. A clinical decision not to touch may serve as a relational enactment for instance. I recall a therapeutic relationship where I, for no apparent reason, could not feel comfortable with my client's repeated request for hands-on 'body work'. I followed this inner cue and persisted with the use of cushions for all bodily contact work. For some two years, my client's angry expressions were matched by my own prevailing sense of withholding and depriving. Eventually, it became apparent that this person carried not only a history of emotional/tactile neglect but also experienced a series of abusive boundary violations.

The questions of when to touch and when not to touch cannot be solved just by rules and regulations alone. Self-monitoring and accountability are best achieved through sound clinical practice and review in supervision. On occasions, clients will sexualise physical contact regardless of context of touch or the intentions of a practitioner. Some individuals may carry conscious or unconscious histories of sexual abuse. Tactile interventions may provoke powerful responses or abreactions in a therapeutic relationship. As therapists, we also need to monitor which aspect of a person's inner world we may be touching at any particular moment, and which parts of ourselves become evoked in response.

Feeling comfortable with touch and tactile contact is paramount for client and therapist alike. Touch and tactile contact are applicable in a wide range of clinical contexts - from working with coma states on one end of the spectrum to potentially explosive explorations of borderline and psychosexual dynamics on the other. It is crucial that both participants in the therapeutic relationship agree to monitor and respond to any sense of discomfort arising. With some clients, the issue of touch may not arise in the therapeutic process at all. With others, cushions may offer a suitable alternative interface for contact work. But body psychotherapists will also have to develop theirs skills in

navigating a continuum of tactility to meet the wide spectrum of cultural attitudes towards touch.

The field of body psychotherapy will need to become more assertive and define its professional standards of good practice explicitly. At present, there are few explicit references to touch in the various ethical guidelines of body psychotherapy associations. More work needs to be done to differentiate and clarify ethical principles of therapeutic touch and tactile contact.

As a relational body psychotherapist, I do not feel defensive or apologetic about touch as a therapeutic intervention. Nor do I believe that there is any need to be defensive or apologetic. On the contrary, body psychotherapists have everything to gain from taking their extensive body of knowledge into the wider field to contribute to clinical discussion, review and further research on this subject. Body psychotherapy can assert its position as a distinct branch of psychotherapy with explicit theories of mind-body functioning and the complexities of reciprocal psyche and soma relationships. These include a range of theoretical constructs around touch that offer not only differentiated styles, intentions and qualities of touch but also identify modalities of touch such Biodynamic massage or Boadella's differentiation between 'air', 'earth' and 'water' touch interventions for example.

The field of psychotherapy cannot allow risk avoidance to override sound clinical judgement or risk management to determine good practice. We need to ensure that the boundaries of good clinical practice are not defined by lawyers and regulators at the expense of sound theory and practice and to the detriment of our clients. I suggest we need to develop explicit guidelines for the use of touch in psychotherapy as a matter of urgency.

Further Reading

Zur, O. and Nordmarken, N. (2009). To Touch Or Not To Touch: Exploring the Myth of Prohibition on Touch In Psychotherapy and Counseling. Accessed on 6 Sept 2009 from http://www.zurinstitute.com/touchintherapy.html.

Please contact the author for list of references

Tom Warnecke (UKCP, ECP, EABP) is a relational body psychotherapist, supervisor and trainer based in London. He is particular interested in the intricacies of psyche and soma dynamics in the therapeutic alliance and teaches relational body psychotherapy in Croatia. He has also worked in community mental health services and is the author of several papers (www.integralbody.co.uk), two on somatic and relational perspectives of BPD. He is a Vice Chair of UKCP.