

PART II: TOUCH

Susie Orbach

That's my squeeze machine . . . some people call it my hug machine. . . . it exerts a firm but comfortable pressure on the body, from the shoulder to the knees.

As she lies in her machine . . . she feels that the machine opens a door into an otherwise closed emotional world and allows her, almost teaches her, to feel empathy for others.

(Oliver Sacks, *An Anthropologist from Mars* pp. 263, 264)

Psychoanalysis's Discomfort with Touch

Sometimes psychoanalysis comes to the ordinary common sense embarrassingly late. Tell someone not in the field that touch is crucial to human psychological and physical development and you'd get a contemptuous look and yet we within the non-body, and particularly within the psychoanalytic, will get singularly jittery and uneasy when touch comes to therapy. This can be the case even for those therapists who were trained in body therapies but whose current interests have led them to psychoanalysis. Indeed so uneasy are we about this, that we are either fuzzy and don't think about it or we have a set of rules around no touching as though that could resolve the issue. If we fall into the latter category, patients who touch us can become designated as rule-breakers and their wish to touch us or be touched by us can be interpreted callously as though their or our impulse were dreadfully wrong, pathological, boundary violating. By categorizing them in this way, we avoid engaging with what touch might be about. We move away from psychoanalysis's dictum to welcome and explore the meaning of things. Rather we can become threatened and deny ourselves access to crucial aspects of individual idiom, desire and need.

With a few exceptions, we psychoanalytic clinicians leave the discourse and theorizing about touch to the body-orientated therapists and we keep quiet about those hugs, the touch on the shoulder, the hand that needs holding, the kiss that got planted on us. In so doing we short-circuit an attempt to think about when and why we should or shouldn't touch. What are our and our patients needs, desires, fears of and confusions re touch? Unlike other psychoanalytic activities touch is just off limits.

When something becomes off limits without being much thought about or rather thought about anew from time to time, we are in danger of fossilizing. Our field, our collective and individual practice diminishes. I am very

mindful that this is the Bowlby Memorial Lecture. For me it is very much in the pioneering spirit of John Bowlby if I say at this point that I myself am not sure exactly how I feel about touch. I believe that Bowlby himself was not exactly sure what he thought about early childhood attachment when he set out to see if he could understand for himself what was really going on in the early mother–baby relationship. Bowlby’s project demonstrated the absolute centrality of understanding real attachments in order to understand the human inner world. Attachment theory is the epidemiology of modern psychotherapy and has given us the working paradigm for all relational approaches to psychoanalysis. And, as Sir Richard Bowlby has often said at these memorial lectures, his father would be the first to admit that he had just begun the exploration of the significance of human attachment. It is now up to us to explore in as open manner as possible the vexed issue of touch within psychoanalysis.

Reading the psychoanalytic literature, it is interesting to see how this issue attempts to assert itself and then gets lost. There are review papers about every 20 years,¹ there are attempts to theorize touching therapy and psychoanalysis but they don’t really develop, or at least I don’t know about those developments, or they have the same problem I was discussing in Part I of this lecture, that they are about the body and touch as containing *the deepest truth* about the psyche or how purposeful touch in therapy – a hand on an abdomen, for example – can provide relief via tears or a slowing down in breathing rather than about the body and touch warranting attention in its own right. That said, I have every expectation that after our conference conversations we shall all have advanced our understanding of the role of touch in the therapeutic encounter. I know I will be further along than my personal ruminations can take me.

How Can We Think About Benign Touch

We therapists know how absolutely critical benign and loving touch is in both early development and in life in general. We enter our first love affair with life viscerally either vaginally or via a Caesarean, and through skin to skin, mouth to nipple, face on breast, enclosed by arms we start our journey. We enter human culture through a relationship in which we require touch and we need to touch others. Touch is the bio-psychic means by which we feel our bodies and the bodies of others. Touch initiates our subjective bodily sense.²

What psychoanalytic therapists don’t know is about benign, thoughtful touch in therapy. To be fair to us, we know a good deal about malign touch by therapists. We know about the disaster that is sexual aggression by therapists. We know about the kind of invasive and inaccurate interpreting which reaches in and with a searing touch fractures an individual’s fragile sense of self.

What we haven't focused on and haven't theorized are why we might touch, why we might not touch, what's going on inside us when we think about being touched or touching, what the interpersonal intrapsychic pressures may be that mean we feel impelled to do so. Nor, because we don't talk about it, have we approached what happens in the therapy relationship, within the transference when a benign touch is offered but experienced as disturbing. Or what a patient makes of a body language that clearly indicates that our invitation to explore everything does not really mean everything because touch is *verboden*. Nor do we even know what a person we work with might make of our physical closedness, our reticence or refusal to hug. Nor, because of the taboo on touch, do we discuss among ourselves what we can make of stepping forward into the patients' space as though to hug them before a long break, for example, and discovering we've done the wrong thing. We don't discuss it because we don't do it or rather we don't admit to doing it. Thus we have little data to discuss with one another in the psychoanalytic world about touch.

We have one highly discussed case in which Patrick Casement (1985) discloses changing his mind about holding the hand of his patient as she relives the trauma of her mother's letting her hand go when she was being operated on as a child. In *On Learning from the Patient* Casement tells us that he withdraws his offer to hold her hand, lest he fixate his patient rather than enable her to relive the trauma and come through it. In his earlier and recent discussions of this case (Casement 2002) and his decision not to touch, he is aware that he re-enacts, through his own withdrawal, the mother's withdrawal. He recognizes that he precipitates a breakdown through not touching and in his latest appraisal of the case he argues that acceding to her request to touch would have been easy. The hard part was *not* touching.

Although I find Casement's argument convincing for him, what it seems to leave out is the understanding of the desire for touch as being co-created between analyst and analysand. We have an account in which the patient is the person who registers on Casement, who is, as it were, almost an outsider, rather than that the analyst is someone who, by his previous actions with the patient, made possible or conveyed the possibility of the idea that holding was needed and that touch could happen. Without wanting to take away from Casement's thoughtfulness and evident concern for the patient, I am left with a sense (more so in his later rather than his first discussion) that Casement sees the patient as the only actor on the therapeutic stage and Casement's response then as being entirely reactive rather than the outcome of an intersubjective, interpersonal and idiosyncratic exchange.

Touch and Attachment

But a perhaps more challenging theoretical point for me relates to two areas. One is the continual dismissal by psychoanalysis of the materiality of the

body which might question whether this woman could have her body, a body which had been burnt, soothed entirely through words? The second is about another dismissal: the bypassing or disregard of the work on the bio-psychological significance of touch, both in development and in everyday life.

In 1947 René Spitz reported on hospitalism (Spitz 1960). He reported that those babies in the hospital ward given the same feeding and changing but who were closest to the nurses' station and who received a few more touches as the nurses passed by them more frequently, survived while those furthest away failed to thrive. This has been an important psychoanalytic finding that we have somehow stripped of its physicality as we have taken it with us into practice. We've interpreted Spitz's finding as to do with the centrality of relationship: the baby needs to be held in mind, the baby needs contact but, like so many of the things we were discussing, the touch part, the physical interaction, the body to body contact, has somehow become lost in the discussion during this post-World War II mentalist period of psychoanalysis. It is as though we have to learn again what was being written and observed and we have to draw on other fields because we've lost the eye to see what is in front of us in our neglect of this area.

Harlow's monkeys who craved touch and attached themselves to wire monkeys covered with terry-cloth but without a bottle in preference to wire monkeys with a bottle, was another conclusive bit of evidence about the critical function of physical feel and touch in attachment. But again these bits of evidence were not, *are* not evaluated by psychoanalysis for the clinical significance of touch but for the significance of attachment behaviour as though attachment were a purely mental construct. My experience with patients' attempts to create a body in some of the ways I discussed earlier is in essence a response to touch hunger. It is not just a tautology to rename material as such. Without going into the neurobiology of touch (Field 1990), it is surely irresponsible to ignore the findings of the Miami Touch Research Institute which shows that 'a hand on a shoulder' can reduce the heart and lower the blood pressure, or Vivette Glover's work on oxytocin, the bonding hormone which is increased through loving touch and which creates a sense of bio-psychological well-being (Glover *et al.* 2001). Touch can be healing and, although it is unfashionable to say so, psychoanalysis is also very much about healing and I wonder what kind of disservice we do by *not* touching.

Touch is a fundamental way in which we come into our subjective sense of our body. The psyche-somatic unity which Winnicott talks of as being crucial to the sense of an aliveness is less a magical process that either goes right or goes wrong and is more one we need and are beginning to understand. Touch is one of the ways, the physical vehicles (if I can be so mechanical about a sense) through which the maternal body manifests its connection to the potential other and the body other that is the baby.

Without physical touch, the baby cannot flourish. The kind of touch and touching the baby receives structures their subjective relation to her or his body and makes possible or problematic and all the states in between those two poles, the sense of aliveness of vitality and indwelling, to use another of Winnicott's notions (Winnicott 1971), that is either taken for granted or repetitively sought.

The preoccupation with the surface of the body, especially the surface as represented through graphic design or photography of either the still or moving variety and its capacity to destabilize the body sense or potential body sense of literally millions of girls and women, works its terrible mischief, in part, because an interior sense of vitality and aliveness has failed to be established. The missing piece is the reticence, the awkwardness, the interruption and by interruption I mean the cyclical interruption of the impulse to touch. Touch, once absent, tentative, gawky or inconsistent, fails at both a neural and a psychological level to animate the body for the individual. The touch we are able to give, the touch we respond to, the delight and appreciation of another's physicality, is part of what vivifies a body. Without it, we are in the territory of body as surface, body as symbol, body not as lived experience, but body as text on which we inscribe the desperateness of not having an alive body but only a facsimile body.

And it is psychoanalysis's participation, emphasis and elevation of the facsimile body, the body as text, the body as drive that must be tamed, that we are trying to rethink at this Bowlby Memorial Lecture. We have to be courageous enough to invite physicality into the consulting room in more than its symbolic forms. We can comprehend the historical injunctions against touch in a schema that sees the body as the fundamental source of drives and the ways in which sexual drives become converted into hysterias as attempts at drive regulation, but for the taboo on touch to be a passenger to contemporary psychoanalytic theory with its focus on affects, attachment, internal object relations, the struggle for connection and differentiation seems woefully unthought through.

The Architecture of the Analytic Session

One thing that I think our current preoccupation suggests is that the seating position of analyst and analysand, client and therapist, in which the therapist sits to the side of or behind the supine patient, is clearly up for reconsideration. The architecture of bodies in a room and bodies in relation or the difficulties that patients and therapists can experience with embodiment, would seem to militate against the therapist sitting behind the patient. The receiving ear – the main analytic instrument – is both a psychological and a physical receiver. We register and mimetically respond to resonance, timbre, tone, interruption, rapid speech, hesitancy, tears, speechlessness. But we register and respond as though in doing so we are actually responding to the

physicality of the person rather than as we are doing, responding to a representation or a truncated version of their issues around physicality, embodiment, corporeality. The metaphors we grab for in describing the couch as holding or containing are words denoting something physical, again as though physicality can be represented by sounds and speech. My clinical experience working face to face suggests that physicality, and the problematic around the patient's physicality, is insufficiently addressed as long as we remain in the realm of the symbolic. Symbols are useful for symbolizing but the body struggling to come alive, struggling to be held, may well need more than symbols. It needs to be engaged with, struggled with, feel welcomed, feel put upon, invaded, affronted, moved, turned on and turned off by a body in the room. Without a body to see, without a body experience in the room, we psychoanalytic types can reprise an elaborate confirmation of disembodiment and prohibition in which defensiveness and false or dead bodies reign supreme.

Of course, against this, you might argue that speech – words – like feelings is a physical activity. Words are not a mentalist practice. Language is the enunciation of our psyche-somatic nature. Words can reach us very deeply – and when we say deeply, we mean they can move us and, when we say they can move us, we mean we feel something shift and change and find a new place. However, despite the physicality of the words we use and the motion we associate with their power – sometimes words are insufficient.

When Touch Came to Therapy

Let's take a couple of cases where something else, where touch came to therapy to see if we can get further. Lest you think I am a touch propagandist or promoting touch in the consulting room, I'm not. I am as uneasy as the next person about raising the issue lest it be misconstrued. I am absolutely not saying let's all touch; let's abandon the taboo. *I am* saying that, in the context of touch and attachment, let's think about it and see where we get to. This is a question addressed to body psychotherapists as much as to those of us from psychoanalysis. Let's increase our understanding of why we feel moved to do so and why shy we don't. We don't need to act precipitously. That's not what I am arguing.

And, of course, touch is a personal idiom. Some of us are very prone to touch and be touched. Others of us get 'touchy' if we are. And I've pondered on this word. Why 'touchy' when we mean very sensitive, irritable, peevish, grouchy, cross, emotionally prickly? Why 'touchy' when we mean daring, risky, chancy? Does our language know more than we acknowledge as analytic clinicians about the deficits of not being adequately touched and the consequence then of becoming insufficiently emotionally resilient?

I want to give three brief vignettes. One is a case of a supervisee I've discussed before (Orbach 1995), of a woman of 50, Sara, suffering with vaginismus who requested a hug from her therapist. The therapist, a man, was surprised to discover that he was rather stunned by his response to her request. Her asking for a hug made him recognize his reluctance and catalysed for him something more than discomfort. It made him aware that, uncharacteristically, he was actually quite out of physical sympathy with her. For several sessions around the hug incident, he had experienced a putrid smell in the room like that of a rotting mango. In discussing how he might handle this powerful olfactory countertransference, he had found a way to see this smell as an expression of her ripeness for the sexual intercourse she longed for. But it is the hug that I wish to focus on now, because it seems to me such a very clear example of a relational communication, in which his wariness or discomfort about receiving or giving her a hug was made possible by her creativity in communicating to him via the countertransference just how ghastly she felt in her body, how turned off she was to entering into her own body, let alone letting another enter what felt so physically repulsive and unseemly to her.

The hug was absolutely pivotal. In the therapist struggling with his countertransference so that he could authentically receive the 'putrid' body, Sara was able to reverse the corporeal hatred that had stemmed from the touch neglect of her parents for whom physicality was only medicalized. Her vaginismus dissolved. *Her body, not her symptom, now came to therapy.* It was not a body only closed or a body only in pain or a body over ripe, but a body beginning to be accepted. A body on its way to vitality. A body which could receive.

Sara became very excited. She took this new potential body subjectivity and the fact of her not knowing her body in this emerging way as a serious project. She enthusiastically changed the way she dressed, began to decorate the surface because she wanted to adjust and portray the aliveness she newly felt within. Her experiments with style concretized her growing physical fluidity. More impressively still, she could mourn the body she never had, the missed undeveloped body of so many years, the missed body of adolescence and her twenties and thirties, and enter into the challenges of the middle-aged body, suddenly awoken.

The physical exchange was, I repeat, pivotal. This woman could not progress delimited by words. She needed a body to accept her body. She needed to hug and be hugged. She needed to feel the welcome, when she herself was more than hesitant about her own capacity to accept her new corporeality.

* * *

A woman I was seeing adopted her baby who came to her at 6 months and was rigid. The baby's legs were stuck straight out ahead of her, whether from

fright or trauma, I do not and did not know. The clinical point is that the disruption of the *impulse* to touch enraged this adopting mother. She was shocked to find herself wanting to hurt this baby, to shake it out of its rigid stance. She experienced her daughter's rigidity as both a belligerent affront and as an aggressive passivity. She could not always recognize this 6-month-old as a baby, as babies are soft. Her baby's physicality became inscrutable, challenging her with its immobility.

In the therapy, we had to find a way for her to overcome her impulse to hit. I myself wanted to soothe this mother's body. It was as though it was inflamed, and she had become infected by her baby's inability to tolerate touch. But I knew that I couldn't just touch her. That touch would have been too invasive, too much me as the one who could touch in a calming way and she as the one whose touch was only aggression.

One day she brought the baby to a session. She wanted to show me how awful it was for her. I saw what she meant but, of course, the rigidity did not carry the affronting feelings for me and I felt able to stroke the baby gently, which she received. In the course of the session, my patient began to be able to stroke the baby too. We found a synergistic, gentle rhythm which suited all three of us. I relinquished touching the baby and found that I had began stroking her arm as though my touch could be a balm to her inflammation. She gained some confidence in touch, first at one remove, and then directly. I had not expected to touch her, in fact, I had anticipated quite the opposite. In the event, it seemed the only thing to do. The therapeutic touch reduced her fear, projections and panic and, in the experience of being soothed, released oxytocin – the bonding hormone, which they had both required.

* * *

My third and final case is about a hug foisted on me which I did not want or anticipate at the end of a session. In my attempt to surrender to the patient's idiom and receive the hug I pondered what she made of it. I don't feel I am such a successful dissembler that she wouldn't pick up some initial discomfort from me but she didn't seem to for she moved forward towards me to hug me at the end of subsequent sessions. Although I didn't find her hug repulsive, it was definitely unwanted. I didn't feel it was right for me. I couldn't find a way to bring this up or make sense of it for a considerable time so I bore the hugging when it occurred and hoped I might understand this physical disjuncture. It is not that I haven't been hugged or indeed hugged before. I have. It is my response and its possible meanings that intrigued me.

Jane was involved in a rather cold and cruel relationship with an ex-junkie. It was as though there was a deadness at the heart of him and he couldn't tolerate the warmth that she brought to the relationship much as he craved it. There was a great deal of push-pull (Eichenbaum & Orbach 1983) in the

relationship and for her some ravaging severings which disturbed her. As she described her experience it seemed to me that dead was absolutely the right word for the chill at the centre of this man or rather the freeze that occurred when they got close.

Jane talked about her sexual life with him and let slip, and I say let slip, because I think she was uneasy about this, that their sex life now involved S&M practices. She saw herself as sexually very free which interested me given my sense of her body being so unplotted on the one hand and so full of self-disgust on the other. But I took what she said for what else could I do and I was intrigued by the turn in the sexual relationship and her discomfort with it. The unsolicited hug began to make sense to me. It was a misreading of the physical exchange between us: a possible parallel process to that which was occurring in the current sex with the boyfriend. It was a physical adjunct, a concretization of the difficulties she was having with the transgression of what felt right to her sexuality. She passed onto me a discomfort, a discomfort that had been passed on to her.

One final point. And this is an idea I can't quite get but am reaching for and, in the spirit of this being a working conference, I'd like to seed it as a potential thought. Touch, or abandoning the taboo on touch within psychoanalysis, seems to me a part of the movement to democratize therapeutic practice. We've moved away from the analyst or therapist as all knowing to the analyst or therapist being seen and understood as a co-participant in the therapeutic endeavour and specifically a co-creator of the transference-countertransference ambience and enactment (Mitchell & Aron 1999). We've come to understand the democratization of the therapy relationship through addressing the paradox of the asymmetries that exist within it. While still privileging the thoughts and feelings of the analysand, we have recognized the central importance of the therapist's thoughts and feelings too, particularly the ones that don't fit, the ones that perplex, the ones we have that seem, on the face of it, counter-therapeutic. In bringing our bodies into the room, we are going a step further in the democratizing of the process. Two bodies, two minds, two souls, two subjectivities.

Does touch, benign, thoughtful and tender extend this democracy? Does the touch hunger of the autistic engineer in the description by Oliver Sacks at the beginning of this lecture, tell us something that is right in front of our eyes? Namely that reversing touch hunger is a door to empathy for many? Can we find a way for it to or must we remain scared, so scared of its power that we can't contemplate it? And if we can't, what is our theoretical justification – not our rhetoric – that's easy, but our theoretical underpinning to reject it?

Thank you.

Notes

1. See, for example, *Psychoanalytic Inquiry* 20(1), On touch in the psychoanalytic situation (2000).
2. I am setting aside a discussion on the new work by Peter Halligan, Antonio Damasio, V.S. Ramachandran in neurobiology which is looking at the body from a different perspective and which, I think, will in time yield extremely interesting results for psychotherapists.

References

- Casement, P. (1985) *On Learning from the Patient*. London: Tavistock.
- Casement, P. (2002) *Learning from Our Mistakes*. Hove, East Sussex: Brunner Routledge.
- Eichenbaum, L. & Orbach, S. (1983) *What Do Women Want*. London: Michael Joseph.
- Field, T. (1990) *Infancy*. Cambridge, MA: Harvard University Press.
- Glover, V., Giatu, R. & Fisk, N.M. (2001) Maternal stress in pregnancy and its effect on the human foetus: an overview of research findings. *Stress* 14: 19-203.
- Mitchell, S.A. & Aron, L. (1999) *Relational Psychoanalysis: The Emergence of a Tradition*. Hillsdale, NJ: The Analytic Press.
- Orbach, S. (1995) Countertransference and the false body. In *Winnicott Studies No. 10*. London: Karnac Books.
- Sacks, O. (1995) *An Anthropologist from Mars*. London: Picador.
- Spitz, R. (1960) *The First Year of Life*. Madison, CT: International Universities Press.
- Winnicott, D.W. (1971) *Playing and Reality*. London: Tavistock.

CONSULTING ROOMS IN LONDON, E8
For one-to-one therapy or group therapy

Quiet, freshly decorated, inviting rooms in what was once a bookshop. Separate entrance and toilet facilities. Easy access by public transport (Zone 2), on-street parking. Reasonable rates. Availability: from September 2002, Saturdays as well as weekdays.

Contact: Jo Robertson on 020 7249 6871