Current Perspectives on Hakomi Training and Therapy Issues

by Cedar Barstow and Greg Johanson

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TRANSFERENCE IN HAKOMI

While it wasn't obvious to many of the early trainers of experiential here and now methods in the '60s, it is now quite clear that the same dynamics go on within training groups as within individual or family therapy settings. Training group members will project or transfer unto the leader(s) and each other all kinds of memories from significant others such as parents, siblings, extended family members, neighbors, coaches, teachers, etc. Other systems of thought would add that we simply come into the world with certain issues to work through, and that we use whatever relationships we are involved with to do so. On a theoretical level, in Hakomi we have actually taken transference much more seriously than others trained exclusively in more traditional analytical schools. For instance, we have never engaged in debates over whether it would ruin the transference, and therefore the energy to carry a session, if we shook hands when a client came in the door, acknowledged them in the parking lot when we both drove up at the same time, or were self-revealing, honest and genuine. That kind of debate implies transference is a fragile flower indeed. We have always been clear that a person will habitually and automatically organize their experience according to core beliefs on multifaceted memory processes, no matter what we do. If someone shy and withdrawn comes into our office or group and we are outgoing and friendly, they will feel fearful of the interpersonal intensity coming their way. That is transference. If we are reserved, silent, and allow a lot of space, the person will feel more at ease. That's transference. Either reaction can be tracked, contacted, and woven into the therapeutic process. It is grandiose to think we would have any real power or influence over someone being other than who they are.

BOUNDARIES

In both our therapy and training groups, however, we need to strive for greater methodological congruence with our theory. This would happen if we got clearer about the interpersonal implications or our work. Boundaries for one thing. We need to keep it clear that both students and clients are paying the trainers *and* assistants to provide a container, womb, context, transitional space, or whatever we call it, within which it is safe for them to explore and give birth to new ways of being in the world.

BEING FRIENDLY VS. BEING A FRIEND

One implication of this is that although we promote a partnership as opposed to a hierarchical model of therapy in which therapist/trainers seek to empower persons through helping them contact the wisdom of their own experience, and although we follow the humanistic-existential trail of believing therapist/trainers should reveal and model "full human-beingness" as Trungpa puts it— we also know that there is a big difference and boundary between being friendly, caring and self-revealing, and being a friend. The implication of someone being a friend is that there is a *mutuality* in relation to both our needs. While as thera-

pist/trainers we have needs that must be respected, we can never assume or imply that clients and students need to take as their task ministering to our needs. Our professional contract is that we will meet our needs elsewhere and focus our energies on the client/student. We do not ask for mutuality. We avoid dual relationships, sexual and otherwise, that bring our own needs to the forefront. Honoring these boundaries is an important part of providing the safe space within which the other may grow.

INTRA AND INTER-PERSONAL PARALLEL PROCESSES

Another interpersonal implication of our work is that we know that important aspects of someone's core organizing beliefs come out of memories of interactions with significant others in their past. We know that an idea, image, thought, or understanding is never powerful enough to counter or antidote such interactions. It takes new experiences to match an old experience. We know that that new experience must happen within the therapeutic context. Although we are helping people study themselves intrapsychically, we know they must build new ways of organizing their world around new interpersonal experiences with us as significant others in the form of therapists/trainers/fellow group members. Hakomi has always been clear about this within a given therapy session.

What has not always been spelled out as clearly is that parallel to the intrapsychic work is an interpersonal process. When someone reorganizes around a core issue that involves, for instance, the new belief that someone can tolerate them bringing their anger to the relationship, we know it takes time to integrate that belief. Integration can begin within an early therapy session that accesses the issue, but we know that, depending on the depth and strength of the belief and the memories it is based in, it can take months to years for the person to be able to look back and realize that the old belief no longer holds the sway over them it once did. During this time transference takes the form of the person experimenting with us as a new significant other in their lives. Unconsciously, the client/student will check us out. "Can this person really tolerate my anger?" This parallel process is normally quite subtle and beginning therapists often reveal in supervision that they miss it. They are working intrapsychically with the client. They are talking with the person about how he or she is experimenting with the new belief in their everyday world. It all seems quite conscious and above board. When the person then appears somewhat unreasonably testy or provoking, the therapist is confused and misses that the client is trying to evoke some situation in which they can test out bringing their anger to *this new significant other* in their life. If the therapist simple ends up confronting and challenging the client's unreasonableness, or dealing with it intrapsychically without acknowledging the interpersonal context, a therapeutic disaster results in which the person's early characterological belief is confirmed rather than transformed.

REPARENTING

Another thing we need to be clear about as therapist/trainers then is that people need us to be available to project their stuff on, and work through new possibilities with, both interpersonally and intrapsychically. It is analogous to a reparenting process. It goes on both within the therapeutic or training context and without. We can never assume mutuality outside the formal healing contexts. The boundaries extend to continuing contacts. New memories with significant others must be added to the client/student's data base, and they are pursuing them consciously and unconsciously at all times. So, we can never make a simple shift from being someone's projected parent, uncle, or scout leader to being a friend. As John Patton suggests, whatever our chronological age is as therapist/trainers, emotionally and spiritually we need to be available to others as "middle aged."

In relation to a child, a "middle aged" significant other provides both stable acceptance and boundaries. While it is never in question that the child is loved unconditionally, the "older," mature member of the relationship (whether chronological age is in fact reversed) offers the child boundaries to explore that teach it the limits it has to deal with in the world.

GROUP FEEDBACK

This same valuable function happens in group therapy settings as well as in our trainings which allow for group process times. The child, as Piaget says, grows through a dual process of accommodating and assimilating. To assimilate is to take in new input and make it fit with our preexisting beliefs, whether it is a good fit or not. To accom-

modate is to enlarge or change our present beliefs so that they take in a wider range of new information. For a group to encourage assimilation of childish, omnipotent fantasies ("I *always* should be chosen and be first in line") is disastrous. A group that has the safety and trust to "speak the truth in love" can be a wonderful instrument for helping people accommodate to greater realities without calling into question their fundamental worth. Also, it is an affirmation of faith to offer direct, honest feedback. It assumes and implies that persons "have what it takes". They are not fragile victims, but creative, responsible beings. To withhold truthful mirrors is to withhold a caring gift, just as not confronting alcoholics with the consequences of their behavior is to withhold a loving, albeit sometimes difficult act. It is never helpful to reinforce someone's illusion about the world.

MAINTAINING DUEL STATE OF CONSCIOUSNESS

A final implication of this discussion is that in both trainings and therapy settings we need to make sure that working with the child retains the qualities of a dual state of consciousness. The process should not be allowed to collapse into the childlike state alone. The adult must be kept on board as persons allow themselves to regress into the inner child. Talking exclusively to the child without the participation of the adult's reflective ego can lead to an unbalanced state of false expectations. Al and Diane Pesso's work with psychomotor structures is exemplary in this regard. Even when a person regresses into the womb, the Pesso's keep the adult talking to the child and monitoring what is going on. They also keep strict boundaries around group members who take over the voices of negative parents, ideals parents, etc. Whoever takes over a voice or enrolls to support someone in some way clearly derolls when the session is over. The point, of course, is that we don't want to promote the fiction of ideal parents being available in the outer world to minister to every need of the inner child, but to assist the person in claiming and integrating the masculine and feminine, parental, friendly and sane energies within in themselves through which they can minister to their own inner child. Since group members and leaders become much more compassionate and sensitive to a person's process and try to support it, this sometimes gets confusing. In the end we are not building an ideal world for a person that takes away suffering. We are simply helping them jump out of dysfunctional systems in which they give themselves unnecessary suffering. We never take away memories or defenses. We simply open the possibility of a person adding new memories and new ways of being to their repertoire. We are expanding horizons or encouraging communion with a greater spectrum of reality.

G.J.

SHADOW EXPECTATIONS

I am curious and concerned about some issues which seem to develop in Training groups around teaching and learning the Hakomi Method.

It seems as if there is an implied promise and expectation that by embodying the Hakomi principles the atmosphere will be completely safe; no one will get hurt; everyone can get their needs met; and we can stop creating more suffering for each other. We will be able to learn to treat each other the way we wanted to be treated as children. Everything can be different now.

It makes sense to me how this expectation develops. The Hakomi Method, in its principals, techniques and theory offers revolutionary good news: non-violence is powerful and effective; organicity works; compassionate acceptance is healing. The inner child, so conditioned to being hurt, misunderstood, alone, de-valued takes in experiences of love and understanding previously considered impossible. In Hakomi therapy and Trainings, things *are* different. We *can* be different in the world by discovering and changing our habitual responses. It's *not* hopeless.

It also makes sense to me how the shadow side of this glorious new perspective develops. At the very heart of Hakomi's intrapersonal work, the magical stranger meets the inner child, and says, "no, wait, this isn't the way it has to be. There are other possibilities. I can offer you an experience of satisfaction, being respected, understanding"... Its an extraordinary moment. The child has long ago decided how things are, and developed strategies for protecting its soul and avoiding pain. And the adult continues to live by these strategies in *this* kind of world. One actual conscious experience of being truly understood and accepted must shift a belief from impossible to possible. The belief must shift because one must maintain inner and outer coherence. What a wondrous idea — by studying

experience, one can gain choice over responses. By understanding the context in which the child map maker created core beliefs and strategies, the adult can find freedom from the prisons experienced in the past. This is a positive and transformational model which implies relief from pain, getting what you want, unconditional love and acceptance, special attention and empathy...

However, there are some special qualities to child consciousness — this level where most decisions and conclusions are made. One of these is a normal developmental self-centeredness. The child experiences him or herself as the center of the universe. This is expressed in a loving, generous way (for example, the child seeing itself as the central cause of mommy's unhappiness willingly gives up its freedom to make mommy happy); and in a natural, simplistic way (for example, the child wants *all* the toys, attention, cake). Another characteristic is simple, straightforward, two choice thinking. It's yes or no, mine or not mine, day or night, with little concept of maybe, or sometimes, or gray.

The child in Hakomi is offered the fundamental experiences important to the development of healthy potent full human-beingness — being safe, nourished, understood, loved, powerful. But, I have experienced in both therapy and trainings, the inner child becoming tyrannical — demanding attention, being self-righteous, selfishly disregarding others, sulking, throwing tantrums. I believe this tyrannical behavior happens because a core belief shifts first in the same consciousness from which it was made: self-centered, simplistic thinking. "I will *never* get what I need" shifts to "I will *always* get what I need". "I can't ever do what I want" to "I can always do what I want". "I'm not lovable because there's something wrong with me" to "Everyone will love me and there's nothing I need to change."

Met by someone and a context in which they are accepted, understood, loved — treated in the manner they have always longed for, clients and students naturally feel their longings as *rights*. They expect the child inside should now always be safe and happy. From self-centered, simplistic child-consciousness, it is difficult to understand that the magical stranger opens the door to what's possible, not what's constant truth. Experiencing hope and new possibilities, the child now relentlessly expects and demands safety and satisfaction in therapy, in the Hakomi Training.

I believe that another factor is involved in the development of this tyrannical shadow in Hakomi. Primary motivation for being a therapist or teacher/trainer is to help relieve suffering, to increase freedom of choice, to make the world a better place... Primary satisfaction in being a therapist or teacher/trainer is being there to provide a new possibility; modeling compassion, acceptance, understanding; opening the door to hope, heart, soul; being the messenger of the good news that the child is not bad or evil, or unlovable — just hurt and confused. It is a blessed role. With this kind of genuine satisfaction, it's very easy to get attached to being the magical stranger, ideal teacher who never hurts or judges, and is ever accepting and patient and to lose track of the reality of humanness which is about striving for what's ideal and not expecting or demanding to *be* it all the time.

Teachers, therapists, and students then all contribute to an atmosphere in therapy and trainings which I experience as marked by caution in relation to one another. Empathy for the pain which past insensitivity has caused is consciously developed in the training process. Conflict between wanting to tell the truth (i.e., I'm bored) and not wanting to cause pain or treat others in the ways that hurt them so much in the past causes lack of spontaneity, over-niceness, unwillingness to let an issue go unresolved, and perhaps over-attention to individual needs. It can be difficult to set limits and boundaries when teachers and therapists focus on creating conditions for freedom from limiting beliefs. Out of a heart-felt desire for things to be different — less painful and more loving (and this genuinely happens in Hakomi groups and sessions) — a tyranny of unrealistic expectations and demands may also result.

What's needed? A number of things, I believe, can help counteract the tendency to demand the ideal. I expect that none are new or outside the scope of the Hakomi Method, but it seems important to talk about them within this context.

First is to understand that although an extraordinarily powerful intrapsychic belief shift can take place within the space of a session, this shift requires a great deal of integration. The change happens in simplistic child consciousness and must, to become anything more than a tyrannical expectation of another betrayal (always is just as

dysfunctional in the world as never), be fine tuned with adult thinking capable of being affected by other's experience and able to respond to complex situations.

TIME TO SAVOR

Students, teachers, and clients need time to savor the new experience of what has been longed for (being understood, being at peace, being good enough, etc.). They need to know the details of how it feels inside, so that they can recognize it and bridge back to it. When it's really right, it doesn't take long to feel satisfied. "When the shoe fits, the foot is forgotten". New beliefs are very vulnerable. Habits of a lifetime will continue to prove themselves until there's enough consistent new experience to stabilize the new idea. Getting what you want has to happen a certain number of times before the new belief begins to become new habit or new expectation.

SUFFERING

Integration includes an acceptance of suffering as an unavoidable part of human experience. In a discussion Phil Del Prince put it this way, "You can't ever get what you really needed as a child because you aren't a child. You're a grown-up. And there is a suffering that we all bear. This experience of suffering is one of the things that belongs to our humanness. You *can*, however, share your suffering and have it understood and know some relief and comfort that wasn't available as a child". Suffering is normal and human and brings its own lessons about empathy, acceptance, not being a victim, and transcendence.

There is also grief that may accompany freedom from a limitation that a new belief brings. This is the grief of experiencing what was missed of the nourishment that was lost by believing it impossible. Freedom illuminates and is attended by painful, angry, and/or resentful awareness of loss. This grieving makes sense and has a different quality than the often hopeless anger and pain of a limiting belief. This grief just needs acknowledgment. It's part of the healing process.

GIFT IN THE WOUND

Pollyanna aside, another aspect of integration and avoiding the tyrannical child, is understanding the gift that comes with the wound. Character, personality, special abilities are born through suffering. There is a gift to be honored and reaped from the creativity, sensitivity, and precise development of each strategy that protects the soul from pain. The wound might come from the child being unpredictably yelled at and the gift might be the development of an exquisite sensitivity to energy and an ability to feel the energy in an interaction even before it is spoken. This sensitivity is a valuable tool and can serve well when it does not produce automatic shut down and override all other information. It can serve to protect when needed and to enhance the ability to communicate.

INTERPERSONAL FEEDBACK

My colleague David Patterson once said, "The best use of a group is feedback" and the best use of feedback is clarification about how one is in relation to others. Authentic feedback is of great value to the integration process. New beliefs are tempered and owned through feedback. A new experience of being lovable must transmute from "Now I'll be loved no matter what" to "I am lovable no matter what the response". A new belief about being understood is refined by a group member saying truthfully, "I'm bored." Painful as it is to hear "I'm bored" when being understood is a new and fragile experience, it helps the client/student/teacher learn *how* to best be understood. With a new core belief that they *can* be understood, that they *are* understandable, feedback about *how* to be understood can become a creative process of interfacing with, affecting and being affected by other people's worlds.

Clients/therapists/students learn discrimination through feedback. It is necessary to use adult wisdom to discriminate, for example, kinds of touch; or which people are safe to be really vulnerable with and how you know this; or when it's possible and appropriate to be taken care of. The atmosphere of safety and acceptance in a training or therapy session can make adjusting and refining new strategies much easier and quicker. However, there must be room for and appreciation of the *value* of feedback in Hakomi Training groups to offset the shadow expectation that one must not say what might be painful or insensitive. In fact telling the truth and authentic interpersonal interactions are necessary for new beliefs and strategies to become expansive choices.

MAKING IT WORK

A final piece of the integration process is learning to use the freedom, satisfaction and empowerment of new possibilities felt within out there in the world. As my friend Elizabeth Cogburn says, "if your insight or change doesn't grow corn, it's not worth anything". For clients/students/teachers there's a natural, organic need to try to make what's now possible inside, more possible outside in the family, friends, training group, earth community, world. Learning is truncated and the soul disempowered if it is not consistently put to use in a larger and active community framework. This requires complex, integrated adult *being* and *doing*. And this is one of the responsibilities that goes with more freedom. One of the joys, too.

In conclusion, it seems to me that intrapersonal therapy is superbly suited to the exploration and languaging of inner experience that leads to identifying, honoring, and changing core beliefs. There is also a shadow side to this process of creating experiences of longed for possibilities of fundamental love, acceptance, empowerment. This shadow is a tyranny of expectations and demands for an ideal and perfect world free of injustice and insensitivity.

In my experience what's needed to counteract tyranny is first, an increasingly full understanding of the shadow. Secondly, a rich understanding of the integration process which includes at least time to savor new experience, acknowledge suffering and grief, finding the gift in the wound, using interpersonal feedback, and making it work in the world. And third, an appreciation for the vital importance of *inter*personal work to balance, fill out, and individuate *intra*personal transformation.

C.B.

TRANSFERENCE AND COUNTERTRANSFERENCE IN THE HERE-AND-NOW THERAPIES

By David Feinstein, Ph.D.

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ABSTRACT: The various experiential, body-based, and other here-and-now therapies have been criticized for their insensitivity and naive handling of the dynamics related to transference and countertransference. How can approaches that emphasize the here-and-now recognize and work with larger patterns that only reveal themselves over time? This paper offers an overview to assist therapists who do not have classical training in attending to transference and countertransference phenomena. Moreover, it proposes that the here-and-now therapies, such as Hakomi, have specific advantages over psychoanalytically-oriented approaches for confirming or disconfirming observations regarding transference and for anchoring insights about transference phenomena not only into the client's conscious awareness but also into the client's perceptual framework and behavioral response set.

I vividly recall the first time I came to a gut-level appreciation of the way transference and countertransference operate. As a graduate student, I was being observed by my fellow trainees through a one-way mirror as I conducted an opening session with a man whom the intake team had described as belligerent and uncooperative. I charmed him. I showed so much empathy for his predicaments, so smoothly distanced myself from the counseling center's administrative policies, with which he was furious, and so sympathetically restated his frustrations, that his anger melted. After the session, I strutted back to the supervision group in the observing area, beaming with pride at my performance, particularly pleased about having outshone the infinitely more experienced intake team in enlisting this patient's cooperation.

The supervising psychologist made mincemeat of my hubris. On the patient's side, I was informed, it was a therapeutic blunder to smooth over difficult aspects of his interpersonal style rather than allow him to project onto the therapeutic arena his dysfunctional modes of perceiving and behaving (transference) so he might eventually come to recognize, understand, and consider modifying them. On my side, my need to dodge the patient's hostility and have him see me as a nice guy also sparked memorable discussion, and my fear of having someone think badly of me was glaringly underscored. I came to recognize that these unacknowledged needs and fears had shaped the session far more than any therapeutic considerations. That was countertransference.

In transference and countertransference, the past lives on as a symbolic representation which unconsciously displaces one's direct experience of the present.[1,2,3,4,5] A present experience is overlaid with a constellation of assumptions and emotions rooted in the past. As Freud

once commented, "The patient does not say that he remembers that he used to be defiant and critical to his parents' authority; instead he behaves in that way to the doctor."[6] While experiences from one's past are at the core of transference, the process is of course more complex than a simple mirror reflection of the past into the present. The memories and images are shaped by various intrapsychic forces, such as unresolved conflict or loss, as well as situational factors, such as the therapist's interpersonal style of even pitch of voice.

Sheldon Roth, a psychoanalyst, uses the well-known experiment where animals are deprived of necessary vitamins as an analogy for describing the manner by which transference operates: "These vitamin-starved animals, when offered an array of foods, gravitated toward those that alleviated their deficiency. In an analogous sense, what the patient primarily seeks in the transference relationship will be those frustrated elements of past life that have continued unfulfilled into the present."[7]

To one degree or another, transference and countertransference occur reciprocally, and incessantly, in all relationships. A distinguishing characteristic of the therapeutic relationship is that transference and countertransference can be brought into mindfulness and used as primary sources of information rather than reflexively accepted as irrevocable facts of the interpersonal underworld.

The various here-and-now therapies have been criticized for their insensitivity and naive handling of the dynamics related to transference and countertransference. If you stay in the moment, how do you recognize larger patterns that only reveal themselves over time? Ironically, one of the primary ways the more analytical therapies enter the realm of the here-and-now is by attending to transference and countertransference. By examining how the therapy is, moment by moment, recreating key themes in the client's life, themes that are larger than what might be recognized in any given moment are uncovered. Consider the following case, taken from a psychoanalytically-oriented introductory text:

> A reasonable and rather rational young woman begins therapy with a fair degree of optimism, energy, and enthusiasm despite the presenting complaint of social inhibition and occasional depression. I am at first seen as warm, straightforward, and receptive, as well as understanding and empathic. By six months into treatment the patient becomes depressed, increasingly experiencing me as cold, unavailable, and not understanding. When I am verbally active I remind her of her dictating, authoritarian, and often violent father; when I become quieter to combat this reaction, I then seem like her schizoid, distant, and apathetic mother.
>
> There seems to be no stance I can take and win, and it is exactly this that I communicate to the woman, suggesting that this was the plight she experienced in her home environment. She is struck by this empathic suggestion and can see herself more clearly as she sees the position she puts me into.
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> This helps her to understand, provides a road map to help structure her transference experience.[8]

Greg Johanson has pointed out that in Hakomi work, the curiosity that deepens the exploration is elicited "when core organizing beliefs are discovered which provide barriers to effective, satisfying living."[9] These core organizing beliefs, which I refer to as "personal myths,"[10,11] are often starkly revealed when transference occurs in the therapy. The transference that is acted out toward the therapist often reflects core organizing principles of the client's guiding mythology. The basic strategy in working through transference issues in psychotherapy involves facilitating a shift in the client from an acting out of the transference to becoming mindful of the transference. James Masterson describes a

case where before this shift had occurred, the client "was angry and attacked me for not being interested in him or taking over the sessions for him. When the therapeutic alliance had been formed and he could see me realistically as his therapist, it became clear to him that those feelings of disappointment and anger in the sessions were not due to me. Once this was established, he could begin to explore the sources of those feelings in his past."[12]

How does one facilitate the shift from an acting out of the transference to bringing about a mindfulness of the transference's role in the person's life? The classical approach involves the use of interpretation, an art whose requirements regarding observation, phrasing, and timing separate the experienced therapist from the unseasoned. Interpretation was once used to mean "making conscious something that was unconscious."[13] But, over time, the use of the term has gained precision. According to Gregory Hamilton, "an interpretation is a comment that indicates that a present feeling, attitude, or behaviour is a repetition of a former one.... When most effective, interpretations delineate parallels between the infantile life, the present-day life, and the transference."[14] He notes that the following interpretation, "You fear I will reject you if you are annoyed with me, just as you feared your mother would send you to your room for disrespectful behaviour" is more complete if the point is also made, "You are similarly afraid that your husband will leave you if you bring up your dissatisfaction with him."[15] Thus, the parallels among the client's early life, the transference as evidenced in the therapeutic relationship, and the client's current life, would all be addressed.

Transference, interpreting it, and "working it through," are at the heart of psychoanalytically-oriented psychotherapy. Problem-solving around the client's immediate life concerns is seen as secondary to the core changes in the personality structure that may result from working through the transference. When the therapist retains, to an extent, the position of a "blank screen," there is little else for clients to do but project their inner world onto the therapy situation, and this transference often becomes thick and palpable. As it fills the room, analyzing it is an art. For the transference to unfold, be analyzed, and reach resolution, time is required.

There is, in fact, usually a rather humbling gap between introducing a pivotal interpretation of the dynamics of the transference and seeing significant change in the client's behaviour. Recall the woman described earlier, where, when the therapist was verbally active, the client responded to him as if he were her violent father, and when the therapist became quieter, the client responded as if he were her schizoid mother. In making the interpretation, the therapist noted that the client was unconsciously but effectively placing the therapist in the same sort of bind that the client was in when growing up. While underscoring that such an interpretation can help the client understand her own behavior, the therapist adds a sobering prognosis: "We must be perfectly clear that many whys and wherefores, for many years, will be necessary before there is a significant diminution of this isolation and depression-producing transference."[16]

In fact, many dimensions of interpreting transference and countertransference are beyond the scope of this brief article. Sensitivity to the client's essential coping style, for instance, would dictate that for people diagnosed as borderline personalities the interpretation of the transference would take the form of confrontations about current behavior with less reference to past material than would be beneficial for people struggling with "normal" neurotic conflict. Similarly, an individual who might be diagnosed as having a narcissistic personality disorder is better helped by interpretations that focus on the person's grandiosity than on what shaped it. Another subtlety of the therapists's skill in interpreting transference involves an understanding of the psychological issues that attend the phase of childhood development being replayed.

An advantage of the here-and-now therapies is that they support a variety of potent techniques for anchoring transference insights not only into the client's conscious awareness, but also into the client's perceptual framework and behavioral response set. By working directly with systems that are usually outside of conscious awareness, such as underlying imagery and subtle bodily reactions to emotionally meaningful material, the client is able to more rapidly and more deeply integrate the insights that emerge

from successful analysis of the transference. Among the experiential techniques that might be particularly useful in deriving and utilizing insights about the transference are: psychodramatic reenactments of childhood experiences which may have been prototypes of the transference; Gestalt dialogues that allow transference phenomena that were observed in the therapy to be experientially explored in the context of other relationships and/or formative experiences; imagery work with transference phenomena; Hakomi "probes";[17] working with client's "subpersonalities";[18] Gendlin's approach of *focusing* on "felt sensations";[19] the experiencing of "psychomotor structures";[20] and bioenergetics analysis of the psychodynamic functions of posture and body armoring.[20] In any discussion of dissociative methods (age regressions, Gestalt splitting, etc.), it must be noted that when working with clients who have problems with dissociation, such as borderlines and schizophrenics, these techniques, if not completely contraindicated, should at least be used with great caution and sensitivity.

As with psychoanalytically-oriented therapies, all effective therapeutic work with transference begins with careful observation on the part of the therapist, including scrutiny of the therapist's own gut reactions. A clue that transference may be occurring involves the sudden eruption of emotion, in the client or in the therapist, that seems inappropriate in timing or intensity, to the context in which the feelings arise.[22] The data for formulating an interpretation about the transference, or an intervention to examine it, begins with the therapist's self-monitoring of personal responses to interactions with the client. This often leads, regardless of the therapist's orientation, to a hypothesis by the therapist about how what is occurring in the therapy may parallel what occurred in the client's past or what is occurring in other areas of the client's present life.

In the here-and-now therapies, there is an opportunity at that point to step out of the therapist-client focus and structure an experience that puts to a test the therapist's hypothesis that there are parallels between specific behaviors observed during the therapy and the client's childhood experiences. By psychodramatically recreating a situation from the client's past, for instance, the therapist's interpretation regarding the transference may begin to be vividly confirmed or disconfirmed. Notice how in the following vignette, excerpted from a session conducted by Ron Kurtz, a hypothesis is offered about the transference and is immediately confirmed experiencially.

> T: I notice that you re-word everything I say. I imagine as a child they didn't let you have your own reality....
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> C: (Gets immediately emotional.) No, they didn't. (In an emotional, slightly childlike voice).
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> T: (Switches to working with the child — a gentle, slow, caring voice.) Well, I can understand why that makes you so sad and angry.
>
> C: (A definite shift to looking like a crushed child.)
>
> T: So, you're feeling pretty bad, huh. You needed someone to really believe in you, didn't you.
>
> C: (Nods.)
>
> T: That's really important, isn't it?[23]

The client's characteristic though unconscious way of responding to the therapist is brought into consciousness with the therapist's comment that links to childhood experiences the client's need to reword the therapist's statements. The interpretation is confirmed as the therapist, with considerable finesse, subtly transforms the therapy into an age regression where the client comes to understand the transference with poignant immediacy.

As a therapist begins to unearth the transference, the progression of tasks can be summarized as: observe, hypothesis, confirm, integrate. *Observe* carefully your reactions to the client and the client's reactions to you. Be alert for

intense emotional reactions that seem somehow inappropriate, but also for the emotional undertow in even routine interactions, such as how the client greets you, relates to scheduling and fees, and how sessions are concluded. Any small blip on the radar screen of your inner surveillance system is worth noting. *Hypothesizing* involves thinking associatively (what does this observation remind me of?), analogically (if the client's way of behaving is a metaphor, what might it symbolize?), and empathically (if the client does to her/himself what s/he is doing to me, what might that signify?). You are also likely to find new hypotheses emerging as you describe a particular session in your case notes or read over what has occurred during a series of sessions. In these first two tasks, the therapist's role is essentially the same regardless of orientation, but the paths diverge in the manner by which analytically-oriented and experiencially-oriented therapists go about confirming their hypotheses and integrating the insights that are finally established about the transference.

Confirming or disconfirming hypotheses, along with formulating and reformulating them, can be thought of as the detective work that is the operating principle of all insight-oriented psychotherapy. The analytical approaches call for diligent observation as the therapist assiduously crafts a cogent interpretation. Here-and-now therapists can, as discussed above, draw upon lively techniques — such as age regressions, guided fantasies, and role plays — for confirming or disconfirming possible interpretations about the transference. The concept of the "Gestalt experiment" is a prototype for investigating observations of how therapist-client interactions are reflections of the client's inner life. What is occurring *inter*personally is used as a metaphor in structuring an experiment to examine what is occurring *intra*psychically. Faced with a client whose martyrdom elicits the therapist's anger, for instance, the experiment might involve having the client enact a dialogue between a self-punishing aspect of the self and a long-suffering aspect. The quality of expression in the dialogue will readily reveal the degree to which this particular formulation has currency in the client's psychic economy. The empirical data that can be immediately derived from such structured interventions provides clues that, patiently gathered over time, may reveal subtle relationships among the client's early life, psychological make-up, and the transference that is unfolding in the therapy setting.

Integration involves the anchoring of insights about the transference into the client's self-understanding, perceptions, and behaviors. In classical analysis, this begins with introducing an interpretation that has been carefully distilled through the processes of observing, hypothesizing, and confirming. In experiential work, the spontaneous energy of the present moment can be experientially linked to longstanding dysfunctional thought and behavioral patterns, and opportunities can be created to experiment with new modes of action and new ways of interpreting events. The woman who put the therapist in a bind that was parallel to her childhood dilemma of having had an authoritarian father and schizoid mother could be helped to integrate insights about the ongoing role of her early predicament through: a *probe* that causes her to become more mindful of the way she is organizing her relationship with the therapist to replicate her relationship with her parents;[24] a time regression where her adult self visits her childhood self and validates the reality she is experiencing; or developing inner support for a subpersonality that can be called upon to assist her when she suspects this core conflict has been activated. The here-and-now therapies have in the past two decades been overlaping with cognitive-behavioral approaches (role plays are called behavior rehearsals; guided fantasy techniques are utilized in cognitive retraining) in offering increasingly precise methods for engineering such integration.[25]

There is an important caution in using "experiential" techniques to work with transference issues. In a significant sense, the "here and now" way of analyzing the transference in psychoanalytically-oriented therapies — encouraging the transference to build and, face to face, confronting the client with straightforward, timely interpretations — is more direct than a "here and now" therapist's working with the transference by creating a metaphorical structure to view what is hot and heavy in the room. Sometimes, when the relationship between therapist and client becomes intense and confusing, there is a temptation on the therapist's part to take control and create, for

instance, a Gestalt enactment rather than to look the person in the eye and talk about what is going on. Like anything else, an "experiential" intervention can be used to create distance when the therapist is uncomfortable.

This brings us directly to the concept of countertransference. How do you know if your clue that transference is occurring — such as the sudden eruption of strong emotions that seem inappropriate in timing or intensity — is based upon your projections or the client's? The psychodynamic processes are essentially the same on either side of the coin, but our ability to maintain an "objectivity" on this single issue is one of the ways we justify our high fees. Among the clues that the projections might be on the therapist's side are when the therapist is feeling a distinct sense of helplessness, a need to control the sessions or direct the client's life, a fear of abandonment by the client, a need for constant reinforcement or approval from the client, or a desire to cross the boundaries of the professional relationship. It is a rather delicate matter of judgement and self-knowledge to determine when to bring these concerns into the therapy relationship through appropriate self-disclosure and when to deal with them privately. Many psychoanalysts see the core issue in training therapists as involving an understanding of the therapists's countertransference issues and how to deal with them. Again, a thorough discussion is beyond our scope here, but the issue deserves not only frequent consultation with your own observing ego but a continual alert to discuss countertransference concerns in supervision, therapy, or with a colleague.

In summary, the "here-and-now" therapist has access to potent interventions for exploring transference phenomena, and for experientially anchoring insights derived from that exploration into the client's ways of perceiving and behaving. Compared to therapists with a psychoanalytically-oriented background, however, most therapists whose primary orientation is in the "here-and-now" mode are not trained to emphasize the unfolding of transference and countertransference patterns. One purpose of this paper is to suggest that holding such a focus is not only advantageous to therapeutic outcome, but that "here-and-now" approaches offer distinctive strengths for immediately confirming or disconfirming observations about the transference and for utilizing those observations for rapid therapeutic gain.

Regardless of approach, however, the key to successfully working with transference and countertransference issues is to remain alert. Ron Kurtz tells the story of a worker who every morning crosses a border checkpoint on his bicycle.[26] A guard, suspecting that the worker is smuggling something, searches the worker every time he crosses, but finds nothing. The worker, of course, is smuggling bicycles. You may not be able in any single session to reliably identify the transference — the larger patterns the client is acting out in the therapy setting — but over time, as you remain alert for them, those patterns do begin to reveal themselves. There may be no way to know, based upon a single encounter at the border, that the client's scam is stealing bicycles, but over time, as you realize that the person is riding a different bicycle each morning, returning on foot each evening, and that the local supply of bicycles is dwindling, your curiosity might be aroused.

I've had some 20 years now to think about other ways I might have approached the session described at the beginning of this paper, which was so embarrassingly scrutinized by my supervision group. Perhaps, were I more aware of the transference and countertransference issues, it might have unfolded something like this:

> Client: (Arriving 10 minutes late, smoking in a building with clearly posted no-smoking signs, begins loudly and angrily) I can't believe it! After telling those two damn social workers at that stupid intake session that I expect to be seen by a psychiatrist, I get you! You look like you're still in college! My ulcers are a *real* physical problem and I want a *real* doctor!
>
> Me: Sounds like the evidence is mounting for you, today and on your first visit, that you're not going to get the treatment you came here to get?

Client: Damn right! You think *you* can prevent me from getting more ulcers? Hah!

Me: Let me make a guess about your ulcers. You rush in here ten minutes late, disregarding the smoking regulations, and, although you have no real information about me, yelling at me because you've already decided I won't be able to help you. Now let's just suppose that there are parallels between the way you treat a professional whose only job is to help you and the way you treat your stomach, an organ that is closely connected with your emotions. If your stomach gets nearly as up-tight and constricted as I felt when you stormed into my office, we may already be finding some keys to preventing future ulcers....

While in the original session my interventions were limited mostly to placating and conciliatory statements, here, in my rendition of "Behind the One-Way Supervision Mirror II," I am not yielding so much to my countertransference-based desire to be liked. I am responding more from my center. As a result, I am more able to recognize the client's self-contradictions, and I can risk enough confrontation to get him to begin to examine what he is projecting, transferring, onto the treatment situation. Of course, I realize, we don't always have two decades to center ourselves and formulate our interventions in tough clinical situations, but it does help to have a part of yourself always on the lookout for transactions between you and the client that have a whiff of smuggled bicycles.

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HELPING THROUGH TOUCH: THE EMBODIMENT OF CARING

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Suzanne M. Peloquin, M A., O.T.R., is an assistant professor of occupational therapy in the School of Allied Health Sciences at the University of Texas Medical Branch in Galveston, Texas. This article first appeared in the *Journal of Religion and Health*, Vol. 8., No. 4, Winter 1989, pp. 299-322 and is used with the permission of Human Sciences Press as well as the author. It is a well referenced article that beings together a wealth of information on the use of touch in therapy.

ABSTRACT: There is a power to touch, and a magic. Some call it mystery. The purpose of this paper is to reflect on the various meanings and uses of touch, particularly within the context of relationship and helping. There will be no attempt to formulate a protocol for touch or to lay claim to a definitive meaning for touch. Reflection about touch may instead clarify some of its meanings and dynamics while encouraging care providers to embrace the experience of helping-through-touch. This paper supports a considered use of empathic touch because of its power and its ability to embody care.

Martin Buber shares a personal story that is highly relevant to any discussion of touch:

> When I was eleven years of age, spending the summer on my grandparent's estate, I used, as often as I could do it unobserved, to steal into the stable and gently stroke the neck of my darling, a broad dapple-grey horse. It was not a casual delight but a great, certainly friendly, but also deeply stirring happening.... When I stroked the mighty mane . . . and felt the life beneath my hand . . . something that was not I . . . placed itself elementally in the relation of Thou with me.... But once ... it struck me about the stroking, what fun it gave me, and suddenly I became conscious of my hand. The game went on as before but something had changed, it was no longer the same thing.(1)

Buber reflects: "A few years later, when I thought back to the incident, I no longer supposed that the animal had noticed my defection. But at the time I considered myself judged."(2) Self-conscious reflection about his pleasure in touching the horse abruptly dispelled the magic that Buber had experienced in touch. One ought not, in reflecting about touch, dispel its magic.

The purpose of this paper is to reflect on the various meanings and uses of touch, particularly within the context of helping. There will be no attempt to reduce the act of "touching another" to a procedure, to formulate a protocol for touch, or to lay claim to an ultimate or definitive meaning to touch. There will be no attempt, then, to dispel its magic. Instead, this paper aims to support a considered use of touching the other in the helping process precisely because of its magic. There is a power to touch. The touch encounter can be a stirring and inspiriting event. Reflection about touch may clarify some of its dynamics while encouraging an embrace of the lived experience of helping through-touch.

The metaphorical language of touch

One indicator of the powerfully human significance of touch is its function in language. "Touch" refers to tactile sensation while also associating with human emotion. Montagu claims that "touch is not experienced as a single physical modality, as sensation, but affectively, as emotion."(3) If length of entry in the dictionary communicates the importance of a word's function, then the fourteen full columns on "touch" in the Oxford English Dictionary affirm the significance ascribed to touch. Montagu describes the definition of touch:

> The operative word is feeling. Although touch is not itself an emotion, its sensory elements induce those neural, glandular, muscular and mental changes which in combination we call an emotion.... When we speak of being touched, especially by some act of beauty or sympathy, it is the state of being emotionally moved that we wish to describe. And when we describe someone as being; "touched to the quick," it is another kind of emotion we have in mind. The verb "to touch" comes to mean to be sensitive to human feeling. To be "touchy" means to be oversensitive.(4)

Wyschogrod perceives in touch-language a link between touch, empathy, and sympathy:

> When "I am touched by Y's kindness," I mean that Y has compelled me to let down my guard, has drawn close so that I cannot remain indifferent to him. To remain untouched by another is to refuse to engage in a feeling-act which brings to light the other's plight, to refuse to empathize with the other. The active deployment of tactility is expressed in such colloquialisms as "I feel for you," by which we mean my body substitutes for yours, I take on your pain.(5)

Huss sees multiple references to touch in vocabulary as indicators of a sustained need for meaningful tactual input throughout life.(6) Even a cursory consideration yields numerous touch references signifying connectedness with human emotion. We try to "touch base," and to "stay in touch," but we often "lose touch" or "get out of touch" with others. We are moved by "touching situations." We "reach out" or "lend a hand," and we are warmed when someone reciprocates and "handles us well." We can "boost" or "uplift" one another. In turn, we can be "tickled by someone" and pleased to "get a good stroke." We resent being "manipulated," or "brushed off." We are "chafed" by "abrasive" people who "rub the wrong way." We resent being "pawed" or "manhandled" or being otherwise treated in a "tactless" manner by those others who are "heavy-handed" and "thick-skinned." Touch-affect associations in the English language are many. Jourard finds this ironical since actual touching in Western culture is hemmed in by strict social taboos.'(7) Taboos imply the power in touch—a power evident in both language and literature.

Images of touch in literature

If touch is taboo, constraints on touch may associate with a power clearly imaged in literature. Weber sees touch as the denouncement in *The Death of Ivan Ilyich*.(8) Struggling with pain on his lonely deathbed, Ivan is touched by the gesture of his son; the transformation brings Ivan a final peace:

> Just then his son crept quietly into the room and went up to his bed. The dying man was still screaming desperately and flailing his arms. One hand fell on the boy's head. The boy grasped it, pressed it to his lips, and began to cry. At that very moment Ivan Ilyich fell through and saw a light, and it was revealed to him that his life had not been what it should have but that he could still rectify the situation."(9)

Ivan then regards his family for the first time with empathy; he seeks their forgiveness. He dies in peace, transformed by a caring gesture on his deathbed - by the power of touch.

The natural urge man has to reach out and touch another during emotional times is clearly imaged in *One Flew Over the Cuckoo's Nest*. The Chief, a chronic schizophrenic patient who is psychotic, electively mute, and American Indian, approaches wellness as his contacts increase with the boisterous, spontaneous, and freely-touching patient named McMurphy. One night the Chief speaks for the first time in years; he speaks to McMurphy lying in the next bed. After the conversation the Chief thinks:

> I ought to touch him to see if he's still alive.... That's a lie. I know he's still alive. That ain't the reason I want to touch him. I want to touch him because he's a man. That's a lie too. There's other men around. I could touch them. I want to touch him because I'm one of these queers! But that's a lie too. That's one fear hiding behind another. If I was one of these queers, I'd want to do other things with him. I just want to touch him because he's who he is.(10)

The passage speaks to a commingled yearning, reluctance, fear, and taboo associated with touching. In *I Never Promised You a Rose Garden*, the fear of power perhaps grounding taboo is even more clearly articulated. Dr. Freid touches her schizophrenic sixteen-year-old patient on the arm:

> The doctor touched her arm, "You set the price yourself...." Deborah pulled her arm from the doctor's hand because of some obscure fear of touching. She was right, for the place where the hand had paused on her arm began to smoke and the flesh under the sweater sleeve seared and bubbled with the burning. "I'm sorry," the doctor said, seeing Deborah's face so pale. "I didn't mean to touch you before you were ready."(11)

From that moment on, Deborah calls Dr. Fried "Dr. Furii," a name that means Fire-Touch in the language of Yr, her fantasy-world.(12) The power of touch is great and frightening because it can be felt as pain. Imaged here is one of the powerful tensions associated with touch; although the effects are powerful, the meaning of touch is not universal. Not everyone feels touch positively. Touch can harm as well as help.

Literature from the traditions of religion and medicine communicates not just a helping power but a transcending, healing power. A representative example from the literature of each tradition recalls the laying on of hands commonly associated with the practice of religion and medicine. Describing an Egyptian case in which the doctor touches the wound, Maino says "we should read deeper meaning into the gesture of touching the wound. It recurs so often ... that it suggests an intrinsic value.... Physical contact is reassuring; when a doctor touches the patient, both parties have the feeling that something is being done."(13) In the *Interpreter's Dictionary of the Bible* the entry on "touch" clarifies its biblical meaning as different from handling or feeling, and as much more than the brush of casual contact. Touch implies instead a tendency to hold and even cling.(14) One passage describing Jesus' healing touch is Matthew 8:14-15, the healing of Peter's mother-in-law:

> And when Jesus entered Peter's house, he saw his mother-in-law lying sick with a fever; he touched her, and the fever left her, and she rose and served him.(15)

Contemporary literature, while not perpetuating the tradition of a higher power, or framing the laying on of hands in a religious or medical context, nonetheless reflects contemporary belief in the profound power of touch.

A closer look at various characterizations of touch may clarify its continued identification with power. Various meanings ascribed to touch associate the functions of tactile experiences with human growth, development, and health, and establish the relevance of touch to personal well-being. These meanings ground the potential that touch has for helping.

The meanings of touch

Burton and Heller offer a philosophical grounding for touch: "Touch is the fundament of being-in-the-world, for it is the vehicle *par excellence* by which the person locates himself in space-time."(16) Touch reminds Gadow "that objectivity is not even skin deep....subjectivity exists at the surface of the body."(17) Touch implies a subjective self, embodied; touch affirms the self. Wyschogrod agrees; she maintains that "tactility is the sense which enables us to attain the feeling of a unified self."(18) She further believes that "the body through which objects arise for [her] is not any body at all but [her] body."(19) There is an "I" implicit in touch. The person, touching, affirms a basic reality: "Touch never lets me forget that I am my body."(20) Montagu describes the body as "the 'I' that each man is."(21) Both the hand and the skin of the body factor importantly in the experience of touch. The skin, says Montagu, is "the self's organ of embrace and contact."(22) And the hand, according to Wolfe, "both a tool of learning about the outside world and [as] an organ of spatial sensibility can be considered the fundamental vehicle of the structure of thought."(23) Touch, then, transcends being an activity or a gesture; touch is an essential function of selves who are being, learning, embodied, and therefore feeling-in-the-world. It is not surprising that touch is so widely used in

language and so poignantly imaged in literature. Touch is a manifestation of ourselves.

Touch fulfills several functions of the self. Through touch one communicates, tests the reality of the world, affirms connectedness and comfort with others, and manifests the self as a person. It might be helpful first to overview briefly each of these functions. As a more in-depth discussion of helping-through-touch unfolds, each function can then be more fully elucidated.

Many writers affirm the communicative value of touch. Hall calls touch the "silent language."(24) Geldard believes that "the simplest and most straightforward of all messages ... should be delivered cutaneously.(25) Lomranz characterizes touch as man's initial form of communication.(26) To Knable touch is primitive but very basic nonverbal communication.(27) When man is unable to express himself on a conceptual verbal level, McCorkle believes that he attempts to reestablish contact by more primitive methods such as touch.(28) Frank regards tactual sensitivity as primary; in interpersonal relations tactile language communicates more fully than vocal language.(29) One dynamic function of touch, then, is that it enables the self to communicate.

Another function of touch is its facilitation of reality testing. Through touch one grasps the reality and meaning of ones world. Wyschogrod says that touch enables one to "distinguish alterity and to recognize in the body schema the foundation of oriented space."(30) Touch is a mode of object manipulation.(31) Jonas claims that in touch one can pass over from suffering to acting: "mere touch-impression changes into the act of feeling."(32) Wyschogrod defines the process as active manipulation, an intercourse with things.(33)

Montagu elaborates on the process: "What we perceive through the other senses as reality we actually take to be nothing more than a good hypothesis, subject to the confirmation of touch."(34) Touch confirms a reality that the self may doubt.

Touch can also affirm connectedness and comfort with others, enabling the self to feel a person. Touch triggers awareness. Jourard says that "when part of your body is touched, you can't ignore that part of your body."(35) He uses the metaphor of being "turned on" to describe the sensation. The turning on can help the person maintain contact. Touching the self of another, say Gadow, can prevent that other's retreat back into self.(36) Touch elicits a personal response. Jourard calls touch "an action which bridges the gulf many people develop between themselves and others."(37) Touch reduces distance between people.(38) Physical contact is a mode of knowing the person in the Biblical sense; it requires permission to be touched.(39) To Frank, touch is a transactional process that involves "reciprocal, circular reactions, like a feed back [sic], with the participating persons tuned or prepared for such circular, reciprocal communication."(40) Tactile experience is reciprocal in that what a person touches also touches him.(41) Between persons, touch enables the sharing of feelings and of self.(42) Touch is intimate behavior (43) and intimate sense.(44) There is always a risk in touch that one person's subjectivity will flow into another's.(45) Despite the risk, there seems to be, in man, a biological need for touch, for this human contact and comfort of cutaneous stimulation, that persists throughout a lifetime.(46)

Morris movingly describes the roots of human intimacy anchored in early childhood experiences; he then describes the various forms of touch-related intimacies that continue over the life-span.(47) He writes: "To study human social intimacy is . . . to observe the restraint of cautious, inhibited contact, as the conflicting demands of closeness and privacy, of dependence and independence, do battle inside our brains."(48) He claims that despite the battle, the urge to touch one another remains. Adults satisfy the urge by formalizing it. One takes uninhibited modes of infant intimacy, and by fragmenting and stylizing them transforms them into socially acceptable forms.

Morris uses back-patting as an example - a gesture humans share with primate relatives. In infancy one gets patted within the context of the mother's embrace. Later on the contact is made with the

hand and arm alone, the beginning of a process of formalization. Another change also occurs. While the infant receives patting mainly on the back, an older child is patted almost anywhere: on the back, shoulder, arm, hand, cheek, top or back of the head, buttocks, thighs, knees, or legs. The message of infancy which was, "All is well . . . I will cling to you like this if necessary, but at the moment it is not, so relax . . ." changes to, "All is very well," or, "You have done well." Other changes occur as the pat moves from the adult-pat-child to the adult-pat-adult context. Patting on the hand, cheek, knee, thigh, or buttocks assumes a sexual flavor. Patting on the head communicates condescension. Patting on the back, shoulder, and arm remains unhampered.

Adults use primary patting on the back to signify condolence or congratulation. They use gentle patting to communicate comfort or concern when another is in need. Trivial acts of human intimacy most often stem from powerful and basic early bodily contact of extreme intimacy.(49) Morris similarly traces the evolution and formalization of hand waving, hand shaking, hand holding, and arm-around-the-shoulder gestures back to their highly intimate roots.

Writing within the context of Western culture, Morris notes that the need that adults have to make body contact is rarely fully expressed, often owing to the fear of sending sexual messages.(50) Formalization seems to be one response to taboos that is shaped by cultural differences. Frank writes extensively about culture's patterning of tactile experiences.(51) Cultures differ in the kind, amount, and duration of experiences provided in infancy. Cultures also define social inviolabilities; they place constraints on particular forms of touching and approaching.(52) The individual within a particular culture learns to "transform these parental prohibitions into self-administered inhibitions."(53) Cultural inhibitions can often be articulated. Among Americans, for example, Hall identifies four distinct distances or zones for human interaction: intimate (1.5 feet), personal (1.5-4 feet), social (12 feet), and public (12 feet or more).(54) There are contact cultures and non-contact cultures.(55) To illustrate this point, Jourard watched pairs of people engaged in conversation in coffee shops in Puerto Rico, London, Paris, and Florida, recording the number of times that one person touched another during a one-hour sitting. The scores were Puerto Rico: 180, Paris: 110, London: 0, and Florida: 2.(56) North Americans are clearly nontactual. Many other cultures expect individuals to relinquish early tactile practices in favor of symbolic substitutes at different periods of life.(57) Mintz deplores the practice, feeling that "taboo implies a prohibition which is maintained on the basis of tradition rather than rationality.''(58) Regardless of its intent, the climate created by any culture shapes the development of attitudes about touch, and defends against the abuse of touch.

In spite of the formalizations required within a culture, each infant develops unique associations with and individualized responses to touch. Attempts to help-through-touch must acknowledge a variety of individual differences within the range of acceptable cultural responses. Much has been written about early childhood development and about those biological underpinnings for tactile experiences that shape personality development and health.(59) Since it is impossible to provide an adequate statement of this development here, focus will rest instead on two broad developmental concepts germane to the issue of helping-through-touch. The first is Montagu's statement about the effects of early tactile experiences:

> Since tactile communication is essentially an interactional process, from the first contact with the hands of the person who has delivered the baby to the contact with the mother's body, any significant failure in the experiences of such contacts may lead to a profound failure or disorder to later interactional relationships . . . as well as in a variety of other behavioral disorders.(60)

Positive experiences associate with a healthy individual. Montagu proposes a normative indicator: ". . . to a very significant extent, a measure of the individual's development as a healthy human being is the extent to which he or she is freely able to embrace another and enjoy the embraces of others . . to get, in a very real sense, into touch with others."(61)

The second developmental concept is that within the boundaries of one's cultural context, and along

a continuum of possible touch encounters shaped by gender differences, individual differences, and life experiences with touch, there emerges an individual response. There will be a range of tactile expressions, of comfort with and response to touch, and of meanings associated with touch. Those needing help and those helping may differ markedly along these parameters. Shaping touch to meet needs will require sustained awareness that needs and responses are subjective. The attempt will require an engagement of self, an awareness of the other, and a willingness to allow the subjective need of the other to shape the character of helping.

The nature of relationship and helping

To understand better the dynamics of including touch in the helping process, it seems best to consider the nature of helping and the broader context of relationship within which helping occurs. Jourard finds dialogue a prerequisite to helping. In dialogue there is "mutual unveiling, where each seeks to be experienced and confirmed by the other as the one he is for himself."(62) Such dialogue, he says, is apt to occur when each believes the other is trustworthy and of good will. Helping, to Jourard, constitutes commitment as opposed to technique.(63) Any particular technique should reflect the commitment to dialogue.

Purtilo argues that relationships do not simply happen. She invokes caring in a helping relationship as "a kind of energy that one is willing to expend on another because one can remember, or vividly imagine, what it feels like not to be cared for."(64) Purtilo believes that helping occurs within the broad relational context called friendship.(65) If it can be said that a self helps by becoming a person to another, then Buber's formula is powerful: ". . . a person makes his appearance by entering into relationship with other persons."(66) Buber characterizes relationship as mutual:

> The elementary impressions and emotional stirrings that waken in the spirit of the "natural man" proceed from incidents - experience of a being confronting him - and from situations - life with a being confronting him - that are relational in character.(67)

Buber summarizes the situation: ". . . he who takes his stand in relation shares in a reality.(68) The concept of relationship, briefly considered here, includes dialogue, unveiling, mutuality, caring, friendship, and shared reality. Relationship seems an event into which the introduction of touch would seem natural.

Need the concept of helping alter the sense of relationship presented here? To what extent does helping extend the invitation to touch? These questions are best answered with a closer look at the process of healing. When filtered through the sense of relationship described here, particular views about helping will suggest a form and quality of interpersonal interaction that will permeate its content.

Purtilo first identifies attitudes integral to helping. She feels that the instinct to help must accompany a deep belief in the ability to help.(69) Together these ground the helping process. Next, one ought to assume the basic psychological posture of sensitivity, defined as "attitude of receptiveness."(70) The attitude is born of respect: respect for unique otherness.(71) A he]per's attitude, Purtilo says, must have labored through a moment of terror, that moment in which a recognition of what cannot be done for the other gives birth to a profound respect. (72) Because unique, the other always holds a sense of mystery. No helper can presume to understand fully. There is respect for what cannot be known, what cannot be understood. This profound respect, fused with an equal belief in the potential for helping, shapes a view of the person being helped as that of a vital collaborator.(73) Jourard encourages helpers to recognize the person, the fellow seeker, the collaborator in the helping enterprise.(74) Embracing this attitude constitutes taking the precise risk that Gadow describes that "one person's subjectivity will flow into anothers."(75) Taking the risk also means breaking what Collins calls "encapsulation," or the protective self-covering/ shield of values and concepts that he person can use to remain secure and intact.(76) The breaking of this capsule yields an empathic response; it also gives a "sense of awe, wonder and grace toward the human predicament."(77) Helping becomes an interpersonal process, because each person, as

interpercollaborator, stands to receive this unique gift of awe, grace, and wonder.

Helper optimism that is needed often comes with confidence in therapeutic skills. Purtilo identifies interpersonal relations and communication as primary, but identifies technical competence in one's particular helping field as equally important.(78) Technical competence hones the specific and well-defined professional tools that distinguish therapeutic from social helping.(79) When holding tools, a helper needs to recognize their power; they can suggest helper "omnipercipience," omniscience, and "omnicompetence."(80) The moment, however, that one clings to the view of helper omnipotence, one trades an interpersonal helping process for a subject-object procedure. The subject of the other is lost. The mutual exchange of gifts is lost. The relational component essential to collaborative helping is forfeited. One reduces the concept of help to that of acting upon.(81)

Helping, filtered through the view of relationship described here, needs to be collaborative. Commitment to collaboration will then direct interpersonal helping behaviors. A helper will commit him- or herself to personal awareness as a way of ensuring empathy and respect. Collins says of therapy:

> If we dare do therapy with people we had better be aware of our own internal process, drives, needs, and styles of relating to others. Unless we have dealt with our own issues, we may be tempted to focus on our own unmet needs [for power and control].(82)

One always brings a self, both giving and needing, to the helping process. Exclusive gratification of unmet personal needs would rob the helping relationship of its mutuality. A helper needs to reach out beyond self to communicate "I'm with you."(83) That movement away from self and toward another is called empathy, the merging process in which an I can approach a Thou.(84) In empathy, Collins says, one "stays in touch with the personhood of the other."(85) Wyschogrod describes empathy as a "feeling-act" that opens unique modes of access to other persons.(86) Empathy presumes another like oneself.(87) Wyschogrod writes:

> Thus, when I see weeping, an act of a physical body, I also perceive sadness within the unity of a single apprehension. This sadness is included in my grasp of the other's gestures.... It is a single feeling in two different bodies.(88)

The feeling-act of empathy forces the helper into a two-way rather than one-way vulnerability.(89) Purtilo feels that genuine help comes from sharing vulnerability - the process of human suffering.(90) Empathy is a feeling-act, in other words, a touching-act. Through empathy one is metaphorically touched while touching another. The empathic encounter seems a suitable context for real touch.

The kinds of touch

Wyschogrod reminds us that "not all tactile contact resembles empathy."(91) Describing nursing interventions, Goodykoontz distinguishes between procedural touch used in the discharge of certain duties and nonprocedural touch used when nurses spontaneously touch patients.(92) LeMay makes a similar distinction:

> Instrumental touch is deliberate physical contact needed to perform a specific task, for example, dressing a wound. Expressive touch is a relatively spontaneous and affective contact which is not necessarily an essential component of a physical task.(93)

Gadow contrasts instrumental touch with empathic touch:

> . . . empathic touch affirms rather than ignores the subjective significance of the body for the patient. Its purpose is not palpation or manipulation but expression - an expression of the caregiver's participation in the patient's experience.(94)

She describes instrumental touch as part of technological touch "in which nothing is expressed from one person to another, patients are not reduced to objects, but neither is their subjectivity engaged." (95) Another form of touch is philanthropic, one in which Gadow says "touch represents a gift from one who is whole to one

who is not."(96) Philanthropic touch precludes empathy because it prohibits the mutuality upon which empathy is based.

Weber proposes three models of touch paralleling three meanings of touch. Touch can mean "to be in contact with"; "to reach out and communicate"; or "to lay the hand or hands on."(97) From these three definitions Weber extrapolates three models of touch. The physical-sensory model relates to the first "contact" definition and resembles procedural and instrumental touch. The psychological-humanistic model "explores touch as a way of reaching and communicating with a self or inner person." (98) This model corresponds to the expressive and empathic meaning of touch. The field model sees touch as a laying-on-of-hands that harmonizes with Eastern philosophy and a holistic view of a world permeated with healing energy.(99) This last model proposes to include all expressive/affective aspects of the psychological-humanistic model while adding a healing dimension.

Since discussion here has concentrated on the helping process (as distinct from healing) and the empathic attitude that suffuses it, it seems appropriate to elaborate exclusively on empathic touch, or the psychological-humanistic model. The extent to which instrumental/technological touch (the physical-sensory model), or the laying-on-of-hands/healing touch (the field model), also called "therapeutic touch," might also function within the context of relationship and helping as defined here is a significant question reaching beyond the scope of this particular paper.(100)

The need for empathic touch

Jourard believes that "illness begins when a person's life begins to lose zest, a sense of future, meaning, and love."(101) Morris strongly agrees, affirming that illness also signals a need for increased physical intimacy, for touch:

> It is important, not only to be sick, but to be seen to be sick.... if the stress of life demands that we shall obtain increased comfort and intimacy from our closest companions, and forces us once again to sink into the warm embrace of the soft bedding of our "cots," then this is a valuable social mechanism and must not be sneered at."(102)

Morris calls this mechanism the "instant-baby" syndrome; people can get physically or emotionally ill, or have accidents when life stressors lower body defenses.(103) Those in need in this way receive intimate body contact with another human being.(104) What a tragedy, in light of this need for touch, if illness were to be treated in the following manner:

> Each patient lies in his own cubicle, and there is attached to him all kinds of wires, connected to his brain, his muscles, his viscera. Every time these wires, which are actually electronic pick-up, transmit signals to a computer indicating that the bladder is too full, a bowel stuffed, the patient hungry or in pain, before you could blink an eye, the computer sends signals to different kinds of apparatus which empty the bladder and bowel, fill the stomach, scratch the itch, massage the back, and so on. We could even mount each bed on a slowly moving belt; the patient gets in bed at one end, and four or six days later his bed reaches the exit and the patient is healed - we hope.... And what would patients be like?(105)

Such machines could not provide human warmth, love, and responsive care - the human touch.(106) Jourard suggests that people get sick when their lives become impersonal and they "feel like nobodies."(107) Closely communicative relationships can be "inspiriting" events during these times, events signaling that somebody cares, and events doing something to the body that enables it to throw off illness.(108) Jourard writes: "I think that body-contact has the function of confronting one's body being . . . I believe that the experience of being touched enlivens our bodies, and brings us back into them."(109)

Touch can also reduce stress associated with illness. Menninger offers a list of fourteen coping behaviors to handle stress, one of which is touching."(110) Montagu feels that "taking almost anyone's hand under conditions of stress is likely to exert a soothing effect, and by reducing anxiety give both the taken and the taker a feeling of

greater security."(111) Helping others during times of illness and stress represents a basic starting point when asking, "Whom shall I help through touch?"

The literature suggests, however, that helping-touch can be particularly effective with certain people in particular circumstances. Remembering that the effectiveness of touch lies in three primary areas of communication, reality orientation, and establishing a connection/comfort link between persons, it is not surprising that most for whom empathic-touch seems appropriate are needy in one or another of these three areas. Conversely, it can also be said that a helper will use empathic touch to communicate, to connect and comfort as a person, and to share the reality of his world.

Particular needs for touch

Those writing about touch articulate circumstances more specific than "illness" or "stress" in which touch can mediate help. Bowlby writes that in danger, incapacity, and sickness, adults' needs for touch increase.(112) Jourard feels that "one of the first things that ought to be done in any state mental hospital is to train a group of masseurs in the art of coping with terrified people who are being turned on.(113) Many feel that elderly patients are particularly in need of touch when depressed or in environments depriving them of social intimacies and personal care.(114) Berry identifies three groups of patients particularly sensitive to touch: (1) patients in stressful areas such as intensive care units; (2) patients suffering from pain, trauma, or a change in body image; and (3) elderly patients.(115) Huss feels that those experiencing an increase in stress of any kind tend to regress, they have an increased need for comfort, reassurance, and security that can be communicated through touch.(116) McCorkle sees the seriously ill as needing emotional support communicated through touch.(117) Physical touch, according to Dominian, provides special comfort and reassurance when the body suffers pain and trauma.(118) Barnett emphasizes the increased need for touch among hospitalized patients often depersonalized, sensorily deprived, or regressed owing to the experience.(119) Mintz finds touch appropriate for a patient with infantile needs.(120) Hollender describes the need/wish to be held among anxious, depressed, and schizophrenic patients.(121) Berry affirms the need for touch in those suffering a major change in their body image; touch reassures them that the disfigurements will not deprive them of human care.(122) Those who support touch for persons in need suggest an attitude toward touch consistent with that found in discussions of dialogue, friendship, mutuality, and shared reality. The attitude shapes touch into an empathic transaction.

Keeping touch empathic

Empathic touch springs from the sensitivity, respect, and awareness that ground empathy-in-relationship. Jourard describes the risk in the self-disclosure of touch: "People who reveal themselves in simple honesty are sometimes seen as childish, crazy, or naive."(123) Goodykoontz acknowledges the "risk involved in bringing a more human element to patients"; she nonetheless advocates taking the risk and using an ever-present human tool - the hand.(124) If the helper risks in self disclosing, so does his collaborator in touch. Awareness and sensitivity must extend to recognizing the meaning of touch for the other.

Weiss describes several qualitative dimensions that convey the meaning of touch: its duration, location, sensation, and intensity. She asks that one reflect on these dimensions when using tactile language.(125) She translates these qualitative dimensions into the message given to touch:

> You are a likeable physical and social being, whom I enjoy being close to frequently (frequency) and for long periods of time (duration). I like all of your body, not just some of it (location). I want you to feel good about yourself (sensation) because you are capable of experiencing a variety of feelings in an often powerful and intense way (action, intensity).(126)

Weiss's analysis of the message of touch may call to mind the earlier literary image in *I Never Promised You a Rose Garden.* To Deborah, the psychotic sixteen-year-old, the sensation of touch is painful; the intensity is too much. The doctor

immediately feels Deborah's response. She says, "I'm sorry.... I didn't mean to touch you before you were ready."(127) If touch is to be sensitive, its potential for painful response needs to be considered. Purtilo identifies touch, with its power and potential for pain, as a privilege granted professionals; in health care practice licensure protects against the charge of unconsented touching. (128) Because of individual meanings that it can have, Mercer asks that touch be *careful* and that the decision to touch be made on an individual basis.(129) Cashar and Dixson agree: "The therapeutic use of touch is basically a thoughtful use of touch."(130) Considered use of touch is important because there are individual.thresholds for intimacy similar to pain thresholds.(131) To Aguilera these individual differences warrant touching that is judicious and done with care.(132) With some patients for whom touch is threatening, or for whom privacy and space are strong needs, the empathic response might be to refrain from touch and to maintain distance.(133) Fisher merely proposes a common-sense caution against not imposing a greater level of intimacy than the recipient desires.(134)

Jourard nonetheless encourages a readiness to enter into touching.(135) He is reassuring. "You can know when you are offering the truth and reality of your experiencing to the person."(136) And if one is aware of and sensitive to the other as a vital collaborator, one can know his or her level of comfort or threat with touch as well. One can always ask the other. Personal dialogue can then shape the qualitative dimensions of empathic touch. After all, empathic touch considers that a unique, subjective other enters each new relationship. And while that other's circumstances may suggest the appropriateness of empathic touch, only the encounter can confirm it.

Much of keeping touch empathic relates, for the helper, to retaining a sense of self as person. A helper needs to acknowledge in himself or herself any presence of discomfort associated with touch, whether personal or professional. Jourard considers empathic touch an essential tool; a helper needs to struggle beyond his or her own "touching taboo" in order to be ready to touch.(137) He cautions against touching when uncomfortable with it, but simultaneously insists that a helper needs to grow in comfort with touch.(138)

Discomfort sometimes associates with the mutuality of touch; if one touches another, one gives the right to touch back.(139) Discomfort also reflects the Chief's worry in *One Flew Over the Cuckoo's Nest* about whether his urge to touch had sexual underpinnings. Certainly touch, understood as a powerful form of intercourse with another, can be misconstrued as sexual. The possibility of this misconstrual can threaten empathic touch.

Mintz finds "physical contact involving either the promise or the actuality of direct genital fulfillment invariably inappropriate" in the helping relationship.(140) This is so, she says, because "the essential nature of a helping relationship seems incompatible with the full mutuality of a healthy sexual relationship."(141) Jourard reminds helpers that "fortunately or unfortunately, to do so [climb into bed with a patient] is against the law" and against professional ethics.(142) He says, "It is probably wise we are restrained from *acting out* a sexual wish, but there is nothing to stop us from *saying* we would like to."(143) Corey and his co-authors phrase the dilemma well:

> Although we contend that erotic contact with clients is unethical, we do think that nonerotic contact is often appropriate and can have significant therapeutic value. It's important to stress this point, because there is a taboo against touching clients. Sometimes therapists hold back when they feel like touching their clients affectively and compassionately. They may feel that touching can be misinterpreted as exploitative; they may be afraid of their impulses or feelings toward clients; they may be afraid of intimacy; or they may believe that to physically express closeness is unprofessional.(144)

It seems that in a helping relationship keeping touch empathic means placing restrictions on the location, duration, and intensity of touch (its qualitative dimensions identified by Weiss) in order to minimize extensive sexual fear. Many helpers would never use empathic touch if they felt its essential communication included the

promise of sexual touch. Re-articulating the primary attitude of respect that grounds empathy seems important here. Profound respect for the uniqueness of the other issues from the profound realization of what one person cannot do for another. Respect precludes ascribing omnipotence to a helper because it compromises the helping relationship. Sexual touch in helping can be viewed in this context as a power-move beyond empathy, a step not to be taken as part of empathy. To keep touch empathic means to keep it in its respectful place. Keeping touch empathic means aligning it with the sensitivity, awareness, and respect inherent in the helping relationship.

Personal stories of powerful touch

Empathetic touch has been imaged powerfully in contemporary fictional literature. It has also been powerfully presented in the behavioral science literature. A number of personal stories painstakingly gleaned from descriptions of studies can help to recapture the sense of magic, the power and human significance of touch. The stories affirm the power of empathic touch to communicate with an "other," to orient one to the shared reality of a world, and to make comforting connections as and with a person. Each story speaks in its own way to the need for and power of touch.

Irene Smith, an assistant to Elisabeth Kubler-Ross in San Francisco, writes of several experiences she has had touching patients with AIDS. One experience follows:

> He was very close to dying and I sat down and asked Edward if he would like anything in the way of "touch" and he said he would; he didn't really know how he could move but he would like for me to massage his back. And so I told him not to worry, that I would find a way . . . and while I was stroking his back from underneath, I was running my other hand very gently across his chest.... All of a sudden he looked at me and said . . . this is the way you always hear that love feels, and you never get to experience it. These are true loving feelings and I'm experiencing them now.(145)

Joy Huss tells of her own hospitalization of one month during which time she felt anxiety and depersonalization:

> My salvation was one aide and the occupational therapist who were comfortable within the intimate and personal zones and whose hands conveyed a caring touch. They were the only two I perceived as caring for me as a total person and not just another problem occupying a bed.(146)

Dr. James Linden tells of his initial ambivalence in touching a patient that he thought needed some expression of affection during psychotherapy:

> I asked her, 'How would you feel if I held your hand now?' She was sitting about two feet away from me with her hands on her lap and her feet crossed. When I asked her this question she again turned her head away, closed her eyes and pulled her right hand back, all in one motion.... I sat still.... looking at her hand resting on her lap.... I slowly reached out my hand and put it on top of hers, lightly at first, then more firmly, then actually taking it in my hand and holding it.... Colleen began to weep for the first time since I had seen her.(147)

Linden writes that from this point on her therapy really began.(148)

Irene Burnside describes a small group project she tried with six elderly patients in a light mental facility. The youngest member of her group was 64, the eldest 86. All were diagnosed with chronic brain syndrome. Although her initial goals were to provide reality testing and increase stimuli for these patients, the following incident modified her plan:

> I went around the circle and shook hands, holding each person's hand tightly. ... I came to the last frail little lady. She was babbling....But then a shutter moved in this tiny woman. As I held her hand with its tissue-paper skin, she pulled my head down to her and kissed me tenderly on the cheek.... This was the best example of "touch hunger" I had seen in a long while.(149)

Burnside then increased her touching behaviors. She saw group members begin to touch one another. Though she admits her work lacks a scientific or sophisticated approach, she asks, "How much more in their 'here and now' could I be than by standing close, with both my hands on their hands, patiently trying to teach?''(150)

Jackie Knable used a case study approach to observe responses to nonprocedural hand-holding with fifteen critically ill adults.(151) Nurses selected two occasions within four hours when they believed hand-holding would be helpful to each patient. During one interaction the researcher saw the nurse terminate the hand-holding only to have the patient initiate it again. In response to the question, "Do you enjoy it when the nurse holds your hand?" one patient replied that "they don't do it very often."(152)

Sidney Jourard tells of one experience in psychotherapy:

> During one session, when the chit chat died out, there was a period of silence and the patient sat there, with a look of desperation of his face. I felt an impulse to take his hand and hold it. In a split second, I pondered about the "countertransference" implications of such an act and debated whether I should do such a thing. I did it. I took his hand and gave it a firm squeeze. He grimaced; and with much effort not to do so, he burst into deep, racking sobs. The dialogue proceeded from there.(153)

Marita De Thomaso tells of an encounter with an extremely lonely and distanced young patient named Sandra:

> One day she told me she had tried a new shampoo rinse and asked me if her hair looked softer. As I spontaneously reached out to touch it, she promptly withdrew. I waited a moment and said, "It *looks* soft; let me feel if it really is." Then she smiled, and I touched her hair....this seemingly trivial incident proved to be a turning point in our relationship and a step forward for Sandra.(154)

De Thomaso speaks here to the importance of not forcing touch on the lonely but allowing loneliness to be penetrated "from the inside."(155) Asking permission to touch can be part of a freeing dialogue.

Ashley Montagu describes the successes, through touch, of a physical therapist working with schizophrenics who had for years been inaccessible to other therapeutic approaches:

> In May, 1955, the successes with catatonic schizophrenics with Paul Roland, a physical therapist at Veterans Administration Mental Hospital, Chillicothe, Ohio, were reported in the press. Roland began by sitting with the patient and then after a time touching his arm. Before long Roland was able to give the patient a rubdown. Once that occurred rehabilitation proceeded rapidly.(156)

John Warkentin and Edward Taylor also describe the successful use of touch with a catatonic schizophrenic in a three-way relationship:

> In the seventh interview . . . Dr. A. took one of the patient's hands in a rather tender affectionate manner, and Dr. B. took the other. They stood silently through the interview, holding and caressing the patient's hands. The patient's manner was at first very fearful, then much less hostile, and almost grateful.(157)

The need for care in using the power of touch in working with schizophrenics is perhaps no better illustrated than by Dr. Arthur Seagull:

> The patient, Mrs. S., is a 23-year-old, fairly attractive, bright, well-kempt psychotic with suicidal and homicidal ideation.... At the initial interview I reinforced her delusions that she would make anyone who touched her sick by being ill that day, and having to leave the initial session. I touched her as I left and she became catatonic. She was hospitalized for five days.(158)

Lynne Goodykoontz used touch to communicate powerfully with the wife of a 78-year-old patient just pronounced dying of malignancy:

> I waited for a while, then went to the room. His wife reported what the doctors had said. Then she began to cry, saying she didn't

> know if she could stand to watch him die. I sat down beside her and put my arm around her. I could feel her tense muscles relax. We just sat together for a while . . . that is all she seemed to want. It seemed to me that we were talking a lot, but not out loud.(159)

This next story poignantly illustrates how patients can help one another sometimes even inadvertently, through touch. It happens at night in a nursing home:

> A patient calls endlessly for Tom, her husband who died many years ago. Reassurance quiets her for only a moment; as the nurse's hand moves away, the patient starts to call again.... Suddenly, as the night nurse prayed for sleep to comfort her, silence ascended Too suddenly? Another woman, unable to sleep had been pacing for hours. She wandered into the room from which the cries for Tom emanated. She lay down in bed next to the aching soul and the cries stopped. Both patients fell asleep.(160)

The studies go on, suggesting increased self-exploration associated with touch,(161) better patient-staff rapport and communication through touch,(162) rapid patient-nurse rapport established with touch,(163) therapies evaluated more positively when including touch.(164)

Whether reflecting the hazards or the benefits of touch, the literature speaks to its power. In her book *Health Professional/Patient Interaction* Purtilo includes an apt poem on touch by Shelby Clayson:

The Language of Touch

An appendage of man-
designed for dexterity,
fine movement,
adeptness.

Four Fingers and a thumb-
working in concert as
an orchestra
with precision.

An instrument of function-
directed by man's great mind,
to create,
to work.

But more-
The ears and tongue of the inner self-
through the language of touch,
listening,
speaking.

Speaking of precious feelings-
that words cannot express,
gently,
with meaning.

Hearing the feelings of another-
never asking for clarification,
accepting,
caring.

-the hand!(165)

Conclusion

The purpose of this paper has been to reflect on the various meanings and uses of touch, particularly within the context of helping. There has been no attempt to reduce the act of "touching another" to a procedure, to formulate a protocol for touch, or to lay claim to one definitive meaning for touch. Rather, this has been an attempt to support the use of empathic touch in helping relationships. It has been an attempt, also, to communicate the power of touch, and its magic. The magic of touch comes perhaps from the possibility for a larger magic, that of relationships between persons—that which Buber calls the "deeply stirring happening." Some call it mystery. And from that magical possibility comes another, perhaps even more magical: that one person, standing in relation to another, can communicate, can care, can connect, and can share a reality.

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TRANSLATING THE BODY'S LANGUAGE

By Pat Ogden and Anne Peters

Pat Ogden is the Director of Hakomi Bodywork, which is a branch of Hakomi Institute founded by Ron Kurtz. Drawing on 12 years experience, Pat has developed Hakomi Bodywork, a unique synthesis of bodywork and psychotherapy that emphasizes working through the body. Pat leads Hakomi Bodywork trainings throughout the U.S. and Germany, and maintains a private practice in Boulder, Colorado. For information about her work, you can write to Hakomi Bodywork, PO Box 1873, Boulder, CO 80306.

Anne Peters is a massage therapist, student of Hakomi Bodywork, and writer, living and practicing in Boulder, Colorado.

For two weeks since his father died, Tom had consulted massage therapists, doctors, and chiropractors, finding no relief from the shooting pain in his shoulder. When he came to see me, the pain was so severe he was unable to sleep. In working with him, I helped him become sensitive to the tension and impulses in his shoulder, and listen to the message his shoulder was giving him. He discovered that the pain in his shoulder related to the anger he felt at the doctors who had insensitively attended his father's death; he wanted to just hit them! He had been holding back this anger and frustration by tightening his shoulder. The pain immediately released once the meaning became clear and he was able to express the anger. I use an approach to bodywork and therapy that emphasizes working through the body to find the meaning of the pain. Tom is one example of the effectiveness of this method.

When accurately translated, the body's language is a source of wisdom and knowledge, and can be a means to transformation. On a cellular level, our bodies hold patterns of our experience: the contraction of limiting childhood imprints and the expansion of all that is possible for us. This knowing in the body is revealed constantly through gesture, posture, breath, and the multitude of automatic and unconscious way we express through our bodies. The wealth of unconscious knowledge will remain unconscious, however, until, like Tom, we learn to translate the language of the body, and thus discover greater choice and freedom. In this article I'd like to share some techniques and attitudes which can increase your ability to translate the body's language.

As trained bodyworkers, we must first help our clients become sensitive to the impulses, tensions, movement patterns and sensations in the body before we can translate its language. To facilitate sensitivity I usually ask my clients to stand, and become mindful of the body before we move to the table. Patterns and tensions are more obvious, and more easily felt, when the body is vertical in the field of gravity, rather than when lying on the table. I encourage clients to mindfully turn their awareness inward, and notice what they experience in the body.

There are various questions and suggestions that facilitate clients' sensitivity and help them find words for the physical experience. Here are some examples I've found to be useful.

Feel your body and sense what's going on. Maybe some places are tight, some more relaxed.

If you feel tension, exactly how is the tension pulling: up, down, diagonally, back, etc?

What are the qualities of the tension: tight, dull, achy, congested, thick, sharp?

Listen to your body - turn your ear inward. What sounds do you hear? Is it a cry, a scream, a laugh, a sob, weeping, yelling? What song is it singing, what instrument is it playing? Is the music fast, slow, happy; does the song have words?

Turn your eyes inward - what do you see? Colors? Tissue? Landscapes? What do you see in

different parts of your body?

A woman, Julie, came to me for therapy. She had no particular physical ailments. I had instructed her to listen to her body to hear whatever sound it was making. She began to hear a faint cry, very soft, which got louder as she listened inside. I asked her if the cry was coming from someplace in her body. She felt it in her heart. This cry eventually turned into the wail of a small child whose father had died. Julie had not been able as a child to express her grief, so held it in her heart, which had become protected and armoured. We were able to use bodywork around her heart to support the expression of her grief.

Once clients are mindful, or more sensitively aware of their bodily experience, you can use exaggeration, comparison and movement to elicit more information. Instructing clients to exaggerate slightly what they're experiencing in the body can increase their sensitivity. Here are examples of questions to ask:

Make that relaxation a little bigger, just imagine it growing, what is it like? What places in your body welcome this relaxation?

How does exaggerating the tension affect the rest of your body?

Do other parts of your body tighten, contract, loosen, etc?

Exaggerate this sensation in slow motion - what happens? Notice all the little details of what happens.

What impulses do you have as you exaggerate? What does your body want to do? These questions I asked Tom and as he exaggerated the tension in his shoulder, he found the impulse to strike out against the doctors.

Directing clients to compare various parts of the body supports them in becoming aware of differences:

Notice different parts of your body - how do they feel? Do they all feel alike?

Do your feet feel different from your stomach? Are some places hard, some soft; some alive-feeling, some dead; some open, some closed; some blocking, some fluid; etc.

Integrating movement is also useful:

Have your clients walk around the room with instructions to:

* Exaggerate specific patterns and notice what happens.
* Tighten jaw, pelvis, feet, or whatever.
* Imagine walking with their father, lover, kid - what happens in the body?
* Release observed patterns - relax your knees, your smile, drop your shoulders, and notice the difference in your feeling, and your body.

Once sensitivity is developed, you can invite your client to lie down on the bodywork table and begin to find the meaning of the body's experience and the bodywork process. There are three main steps to translating the body's unconscious process into conscious knowledge:

First, notice what is impactful, important or alive for your client. For example, your client may have noticed a great deal of tension in the belly while standing. Once on the table, you can touch the belly, and if your client flinches a little, you notice that, draw the client's awareness to it, and see if she is interested in exploring it further.

Next, deepen that experience by helping your client mindfully stay with it and explore it. You might repeat touching the belly, or have them exaggerate the tension. Asking for precise details like, "Do you flinch more on the right side or the left?" helps a client stay with and deepen the experience. Maintaining a precise touch, and assisting your client in staying with sensation in a felt, rather than abstract way, helps establish mindfulness, a state of awareness where one focuses on the present experience of the moment, thoughts and images that emerge spontaneously.

Third, when the client is deeply in the experience, you can ask for meaning. You want to allow the meaning to emerge from the experience, rather than intellectualizing about it. You can actively direct the client to evoke the meaning while staying in the experience ("stay with that tension and let it talk to you; find out what it wants, what it's doing here...").

Struggling in search for meaning will make getting the meaning more difficult. You want to allow the words to come easily, without effort to find them. As soon as a client exerts, additional tension is created. Don't make it a goal to get meaning, but stay with what's easy.

Meaning can be derived from the following phenomena in the body, and in the bodywork process:

Tension: The first step is to get the details of the tension - how it's pulling (front to back,

side to side, etc.) what direction it's tightening in, how strong is the tension, what are its boundaries (how far up or down or in it goes). You may have the client exaggerate it very slightly so she can feel it more. Exaggerating too dramatically causes the relevance to the original tension to be lost and overrides information that might have been available. Ask questions like, "If this tension could talk, what would it say?", "If your body could speak instead of tighten, what would it be saying?", "Let the words come from the tension itself", and "Stay with that tension and allow it to talk to you".

For example, a client found a tension and tightness in her womb. In going into the tension, and exaggerating it, she found that she had resolved not to be like her mother, and that she hated being a woman.

Relaxation or opening in the body: Often we bypass the pleasurable sensations and stay with the painful ones. The meaning behind a hurtful experience can yield powerful insights, but we don't want to miss the opportunities to get meaning from the body when it lets go, opens, or relaxes. Finding meaning here can access as well as ground new ways of being in the body. This is especially useful in bodywork. After an area has loosened up through the bodywork, finding the words for that opening helps to emphasize options available. For example, a client discovers that the words corresponding to the opening in her shoulder are, "its OK to reach out to others." Now if she notices a tightness happening in her shoulder she can check to see whether she is automatically suppressing a desire to approach someone. She could choose then to give herself permission to reach out.

Breath: A client may have a certain habitual breathing pattern, such as tightening during the inhalation, breathing into the belly but not the chest, or not breathing laterally. Or, a client's breathing may change during a session by constricting in some way, opening up, or changing pattern. Helping them stay with the breath's experience, and allowing the words to come will give you the meaning.

Posture: When a client has a habitual posture (blown up chest, caved in chest, tucked rear-end, protruding belly, and so on), studying these patterns and finding the corresponding words can frequently lead to insights. Our posture reflects habitual ways of being that we are usually not aware of. Again, allowing the words to come mindfully from the experience will be most effective.

Gesture: A client may have a gesture that seems important, like covering the eyes. Sometimes repeating the movement a few times, or repeating it in slow motion elicits the meaning. For example, a client (a successful businessman) had, in a session, the unconscious habit of covering his heart with his hands. I had him mindfully repeat this gesture and asked him, "If your hand could talk to your heart, what would it be saying?" This led to the insight for him that he was protecting a vulnerable little boy inside his heart. He thus discovered a forgotten tender and soft side of himself.

Movement: Movement patterns such as a lumbering walk, leaning more toward one side or the other, swinging the arms very little, walking with an emphasis on putting the weight down heavily on the heels - all these habitual ways of moving are revealing. Draw awareness to the pattern, have the client do it mindfully, perhaps exaggerate it slightly. Search for the words for what the body is saying. If the words do not come, have your client do the opposite movement pattern, then go back to the natural or original pattern. The contrast that alternating the patterns provides often reveals more information.

Response in the tissue: When you are working physically, the tissue itself may respond in some way that is meaningful. It may subtly resist, open, retreat, deflect your touch - any number of responses are possible. You can ask in such a way that the meaning comes from the experience itself rather than from the client's idea of it: "Feel how your body's responding to my touch...let that response talk to you...what's it saying?"

Bodywork: Any kind of touch may be explored for meaning - a still touch, light message, deep bodywork stroke, energy work. First, study the reaction and then find the words. Connecting the touch with what happened may facilitate the emergence of words: "When I work on your shoulder, what might my hands be saying

that makes you tighten up, get sad, hold your breath, or whatever?" Sometimes, meaning will come just from making contact, like, "So you're getting some message from my hands that allows you to relax." Your client may respond, "Yes, your hands are telling me, it's not your fault."

I once worked with a client who felt tension in her diaphragm. As I began working there, I directed her awareness into her solar plexus to notice what happened. She felt herself spontaneously push back physically against my hands as I touched her. As I asked her to listen to what my hands were saying to her that made her push back, she realized they said, "I want something from you." As the meaning became clear, memories emerged, previously unconscious, of early sexual abuse. Recognizing and expressing her feelings about this abuse were crucial in helping her relax and open her diaphragm.

Ask questions that will help the client find the meaning from the experience rather than from thoughts: "If my hands could talk instead of touch, what would they say?" "Let the words come from my hands." "What message are you getting from my hands?"

Learning to speak any new language takes time and practice. Translating the body's language, from nonverbal and unconscious to the verbal and conscious, leads to greater integration of the body and mind. When translating this hidden language, we find not that the mind influences the body but that the mind and body concurrently experience and process information. Your clients can discover valuable insights and find greater freedom as they experience the body's language speaking ever more clearly.

As we develop our sensitivity to the body's language, we can discover its meaning. Knowing the meaning of this language leads to greater integration of the mind and body, which in turn increases our sensitivity.

THE EFFECTS OF PRE- AND PERINATAL TRAUMA

By Albert Pesso, June 1990

Al, together with his wife Diane Pesso, are the creators of Pesso System/Psychomotor. Al is a master therapist/teacher who was influential in Ron Kurtz's development of Hakomi. This article provides an introduction into his work as well as information about pre- and perinatal issues. Information about Pesso books, articles, and trainings are available through writing him at Strolling Woods on Webster Lake, Lake Shore Drive, Franklin, NH 03235, or calling (603) 934-5548/9809.

In this talk I shall address the topic of the effects of pre and perinatal trauma on adult life and how it is recognized and attended to according to the theories and techniques of Pesso System/Psychomotor.

I will give you a brief history and description of Pesso System/Psychomotor Therapy. Following that I shall explain how we look at the effects of pre- and perinatal trauma and finally I shall describe how we treat adults who have that history. I will include one case.

I

But, I would like to describe a way of looking at the issues of having a place in the world and the transition from conception to conscious living, using metaphors and images that include those based on religious and mythological literature. I find these metaphors and ideas helpful in that they evoke ways to understand and treat the problems of early loss.

We do not only live in our bodies, we also live in our minds. Thus, we must find a place in two universes, the physical world and the world of the mind. To have a place in the physical world, we must first be permitted to remain inside something larger than ourselves that willingly gives us the space and conditions needed for life. We are given the right to exist only by something other than ourselves - we do not attain a place in the world simply by our own command and efforts.

To have a place in the world of the mind, we must first exist as an image in the mind of another. That is, we must first be given a place in the mind of another, then we can have a place for our own image in our own mind. The quality of our own image in our own minds, is based on two factors:

1) It is based on the quality of the images of us that exist in the minds of those who give us our physical place in the world, and

2) It is based on how we are physically treated by those people.

So, to be able to have a satisfying and contented life, we must first be given a place in the life and mind of that all important other. From the loving treatment at the hands of that other and from the loved image in the mind of that other, we can create a place for the loved image of our own self in our own mind. Only then can we live in both the physical and psychological worlds in a satisfying way.

Before we are born, before we exist on the physical plane, when we are pre-existent and not yet alive, we can be described as having a place in the arms of God, the creator. In that heavenly place we are immersed and embedded in bliss and one-ness that provides us with total pleasure and security. There, we cannot die, for we are not yet alive; we cannot be hurt, for we are surrounded by safety and power; we cannot be lost, for we are not separate beings. There we have the ultimate experience of place.

To be drawn willingly away from that heavenly fusion, to be born into the world of flesh and reality, we must be led with sweetness and good tasting things, like those found in the creator's presence: unending love, warmth, security and blissful feelings. Why else should a child-soul be willing to come to earth and be

alive, if life will not be as attractive as being in heaven?

The uterus presents the foetus with the earthly equivalent of that godly place and is thus perfect as the heaven-earth bridging vessel. Embedded in the warmth and closeness of a fleshly, child-longing, mother, the soul of the foetus hardly notices the transition from union with the creator in heaven to symbiosis with the mother.

If the experience in the uterus is negative or damaging and further, if the arms, hearts and minds of the parents are rejecting, infants long to go home again - to where things were right and good tasting. In their emotional center, they know when they are not in the right place. They know what it is they deserve - they expect the comfort that they remembered before in heaven to be fulfilled and they seek ways to find it. Or to say it in another, less spiritual way, they expect the promise of earthly satisfaction of basic needs that is implied and embedded in their genes to be fulfilled, and they seek ways to find it.

After the child is born, the arms, hearts and fond gazes of the parents have to sustain the effect of the sweet, loving embrace of the uterus. Parents must let their children know that the spirit of the creator also lives in their hearts, their arms and their gazes - for what else have young souls known but that. If it is not found and experienced on the living plane, they will miss it and long to return to the heaven they knew before life.

Such rejected infants grow up to be children and then adults looking to the sky, to faraway places, the void or even to death as the place where such peace can be found again. As therapists we must find the symbols and images of what it is that has been turned to, and help them create a believable emotionally meaningful dialogue and connection with those symbols. For there, in the symbols they project the hope of final homecoming, peace and connectedness, where they will find a livable place. When those symbols are brought to life in the therapy, the client can finally make intimate contact with them and through them to others and finally experience that they have a right to a place in the living world.

II

Now I shall tell you about the work of Pesso System/Psychomotor. This method of psychotherapy, PS/P for short, was founded by my wife, Diane Boyden Pesso, and myself in 1961. Since that time we have developed it into its present complex form which is applied by many therapists in private practice and in many clinical centers throughout the U.S. and Europe.

PS/P is based on the understanding that all life affecting events including conception and pregnancy during during wars or during other traumatic social and environmental disasters not only leave records in the mind, but make an imprint on the very fabric of nerves and tissues. The memory and impact of those events affect how people think and move as adults and also how they experience themselves in the world. Negative histories critically distort individuals' image of the world as well as severely diminish their own sense of identity and value.

Using PS/P processes, we have learned how to access the information contained in the physiological imprints left by traumas, enabling clients to emotionally reconnect with the psychic states of their early, wounding histories. There are techniques which help clients bring to experiential consciousness those unintegrated, emotional reactions stored in the body as symptoms of pain, tension, stress, etc. Those previously unintegrated, unconscious reactions, are processed during the symbolic reconstruction of those events in the therapy sessions in the group. Then, through the creation of symbolic, healing, antidote-providing (gegengift geben) counter-events, we can offset and neutralize the negative effect of those damaging situations. This healing experience leaves clients with a more satisfying and benign picture of the world, and a higher sense of self esteem, as well as a body relatively free of pain and tension.

The work occurs in groups of between 6 to 12 participants. During each session one or more group members are individually given the time to do a piece of therapeutic work, called a structure, which can last between 40 to 60 minutes. During the structure other group members are called upon to role-play harmful aspects of significant, real figures or healing, ideal symbolic

figures. The structure takes place in the safe, accepting, psychological atmosphere, initiated by the therapist and supported by the group members, called the "possibility sphere".

Although the work of PS/P is not only focused on pre- or perinatal topics, the quality of the possibility sphere is purposefully and distinctly uterine, in that it provides an accepting, nourishing, life-supporting arena in which to work. The possibility sphere, unlike the literal space of the uterus, is also a psychological space which is conducive to the birthing of the unborn parts of the self into reality and consciousness. In this way it is somewhat akin to the notion of the "holding environment" of the Winnicott school. The possibility sphere offers a safe, literal as well as metaphorical space where the client can:

1) become conscious of how they actually experience their lives at the present moment;

2) explore and integrate the painful, submerged parts of their personalities;

3) experience the symbolic satisfaction of previously unmet basic needs.

Like the uterus, the possibility sphere says "yes" to life. Although it is empty and non-demanding, it nonetheless contains the promise of the provision of those necessary elements, caring, time, space, energy, satisfying loving contact, consciousness and understanding that will satisfy basic developmental needs.

Those healing elements are furnished by the therapist in his/her function as leader and by the role-playing group members, so that whatever may be needed for this particular psychological birthing will be provided - just as the literal uterus and reproductive system of the mother provides the conditions and nurturing elements necessary for the literal development of the foetus.

The role-playing group members - verbally and non-verbally - symbolically supply the necessary and longed for interactions that satisfy all expressions of emotion and affect as well as gratifying the unmet needs of the past using the technique of negative and positive accommodation. The role-playing accommodators do not improvise or invent their roles but specifically adapt their behaviour, under the direction of the client and the therapist, so that they respond precisely as the situation requires, based on the notion of "shape/countershape."

For example, if the shape of the emotion being expressed is anger at the frustration of needs, then the countershape provided by the negative accommodators is their reaction as if struck or painfully affected by the anger. If the shape of the need being expressed is a longing for nurture, contact or support, then the countershape by the positive accommodators is the loving, bodily contact, words and behaviours that would satisfy those needs.

"Negative accommodators" are enrolled to represent fragments of the damaging or frustrating original figures and "positive accommodators" are enrolled to represent the wished for, and symbolically provided, "ideal figures" who, had they been there in the past, would have responded more appropriately and satisfyingly to the needs of their child. These ideal figures are not made up of parts of the original historic figures, but are therapeutic healing, archetypical, inventions created to symbolically satisfy unmet childhood needs based on the human capacity to offer love, respect and care.

Structures do not always begin with the direct exploration of a historical event but frequently start with the process of the client first attending to the "center of their truth". By center of truth, I mean that interior collecting point of attention and awareness where the client has access to affective body states (via emotional/physical signs), and to mental states (via thoughts, values, ideas, injunctions, and resistances) associated with those feeling states. By consciously attending to what is felt in their body and what is going on in their mind, clients become more conscious about what they really feel, and what they really think about things at the present moment.

Thus, the act of getting to the center of truth tends to awaken that part of the personality that can oversee the information coming from the body and mind and is able to make choices, assess reality and carry out decisions from that position. The client is then more in control of the therapeutic work.

The next step in the structure is the creation of the true scene. True scene is the name for the symbolic, role-played event created in a

PS/P session that visually illustrates the information discovered at the center of truth by externalizing and interpersonalizing it.

The true scene is created by having the emotion and meaning in the client's body expression be seen and commented on by a "witness figure"; and the thoughts, values, and injunctions coming into the client's mind spoken aloud by "fragment figures". For instance, if the client discovers feelings in the body that lead toward crying, a witness figure might be enrolled to say, "I see how sad you are". And following the client's spoken aloud thought that crying is for weaklings and girls and not to be done by boys, a fragment figure might be enrolled to say, "Crying is for weaklings and girls and not to be done by boys."

The true scene transposes interior truths into an interpersonal, interactive form and is thus a reminder that all interior states are generated and affected by interactions. With their consciousness made more visible, clients are more likely to comprehend the origin of their feelings and thoughts and therefore better able to control and master emotional and mental states.

"Witness figure" is the name used for the role-played, symbolic figure (a fore-runner of an ideal, need-satisfying, validating figure such as an ideal mother or father) who sees, validates, accepts and gives names to the client's emotions and feeling states as they are revealed by their movements, facial expressions, posture, gestures and words. In so doing, the witness figure helps the client consciously experience and accept repressed parts their own emotional truths.

"Fragment figures" are the names used for the role played symbolic figures (a fore-runner of the negative aspects of real life figures) who represent and announce the client's learned codes of behaviour, values, injunctions and resistances.

The "true scene" places the client at that painful juncture where the experience and consciousness about emotions and impulses are met by opposing thoughts and attitudes. There, the client is made more conscious of the conflicting options available to navigate through life.

Seeing this illuminated model of their consciousness, clients readily associate to memories of similarly charged past events which have supplied the content and foundation for their present day reality problems. Then the structure can turn to those incidents.

From years of doing historical structure work we have come to understand the basic needs of human beings and are able to recognize and predict the debilitating effects arising from not having important developmental needs met at the appropriate time. The most fundamental of those earliest needs are: place, nurture, protection, support, and limits. As I said at the beginning of my talk, early traumas, especially those around the birthing process, profoundly disturb people's sense of having natural right to the very first basic need, that of having a place in the world. This feeling that one lacks a place can be detected from the way such clients move as well as in the words and metaphors that they frequently use.

III

I will now list some of the pre-natal and perinatal circumstances that I and other therapists believe can disturb the child's natural feeling of having a rightful place in the world. These circumstances also produce other toxic consequences that affect how the infant feels about itself and how it will form its picture of the world, but the primary focus of this talk will be on the issue of place.

A. Conception and pregnancy during great social disasters such as wars, political persecutions, earthquakes, etc. Hearing the sounds of war and calamity not only affects the child's sense of place but profoundly limits its future capacity to screen out and defend against similar future overstimulating, fearful and anxiety producing events. A mother can offer no shield against intruding sounds and intruding dangers and the child's own ego will not be able to do it for itself later. The loss is felt in the basic need of protection.

B. Incomplete embedding of the fertilized egg. This can be brought about because of emotional problems in the mother, over sedation during pregnancy, or the effect on the mother because the child is conceived by rape or incest. Here, a kind of deficit is suffered which I may best be able to describe metaphorically. When the child is first conceived and its early cells make the journey which ends in their being embedded in the

wall of uterus, the placenta (literally a place center) is established. As the tiny organism attaches to the wall of the uterus, it is as if the child is being literally rooted into the very being and fabric of the mother. If the firmness of the embeddedness is seriously disturbed - due to organic or psychological circumstances - it can result in a miscarriage, or natural abortion. However, if the dislodging is not so critical and the foetus is carried to term, it still may seriously impair the infant's normal physical and psychological experience of tranquil trust and security. People who have had such uterine history long for intimate contact and endlessly wish to be enclosed within an accepting space, that would reconstruct or duplicate the uterus of a loving mother. Paradoxically, such adults may shrink from contact fearful that it might be toxic or that they will be overwhelmed by their desperate, infantile wish to fuse and merge with the person they wish to touch. This kind of history contributes to the dread that such adults inexplicably feel that they may momentarily be torn loose from their physical and psychological moorings and roots. It creates anxious individuals who daily fear that they may be at any moment cast loose and set adrift into the void, or the emptiness of death.

C. Frightening and threatening auditory or physical experiences while in the womb that directly communicate the hostile atmosphere in the home of the parents to be. The foetus certainly reacts to the noise of arguments, the screams of the mother, combined with the sound of her pounding heart and distressed breathing, directly telling of her fear and/or fury. The foetus can be literally injured by the slaps or punches of angry or hate-filled fathers and mothers-to-be, etc. One can easily speculate on the extent of damage this inflicts on a child's psyche and image of itself and the world it will enter. Moreover, a child may tend to withdraw from its body and shrink back to a pre-living and non-experiencing state.

D. Hormonal or physiological transmission of the mother's unwillingness or unhappiness about carrying the child. The child feels the "no" to its existence on a chemical level. This toxic experience while in the womb of the mother creates children who feel ungrounded, out of touch with the real world - separated and isolated from others as well as themselves. They tend to feel unconnected to meaning, the meaning of the world as well as their own and often tend to frequently depersonalize and dissociate. It is as if they do not even have a place in their own psyches for their own experience. Or, that their early experience is so overwhelming that they dissociate from it as there is insufficient place in their egos to contain the full impact of that on their immature nervous systems. This is similar to the circumstances described in B.

E. Foetal development in a uterus of a small mother's insufficient body cavity. The child in the latter part of pregnancy literally experiences too little place to exist. The world is encountered as a suffocating place denying space for the becoming of the self. There is literally not enough space for life.

F. Premature birth. The immature foetus enters a world for which it is not yet completely prepared. Something is missing and the child and future adult often yearn to go to some "longed for home" where it can find the rest of itself. It has not had sufficient experience of the safety of place to create a firm enough memory of it.

G. Being born to a mother who has recently suffered the loss of a child and while pregnant is still mourning the dead one. Such children sometimes feel that they have stolen the right for existence from the one who has been before them and is no longer to be seen. The mother's grief has practically seeped into them through the amniotic fluid. They carry a sadness and a shame about their existence that they cannot shake. In a recent therapy session a client wanted to shrink away from existence and be either in some loving womb, or in the earth - literally the grave of the often visited dead brother who the client felt was still more deeply loved than she ever was.

H. Abandonment after birth. When the mother dies or is critically ill and hospitalized immediately after birth there may not be sufficient care arranged for the infant. In that event the continuity of place is disturbed and the child longs to return to some earlier remembered place.

I. Lengthy hospitalization for a life threatening illness shortly after birth. The pain and trauma of a near-death experience teaches infants to separate from their bodies and keeps them from trusting anything outside themselves. When life is

almost gone from them, when they are struggling to remain alive, they find no familiar face to turn to, only strange nurses and frequently, no one at all. They turn to something within themselves or to something transcending themselves that can sustain them. Their transition from being in the arms of God to being in the arms of their parents has been disturbed and they have landed somewhere in between. They long to feel intimacy, trust and loving-ness with people, but seem never to fully be able to accomplish this step. Coming so close to death, and by implication, God, they become that much less connected to and invested in, earth and living. They tend to lose interest in the real world and as they grow older they might seem far away, often expressing the longing for other places - seeking something more legitimately real than the places they find on earth. They become dreamers of other planes of existence, fascinated with esoteric, other-worldly topics. Alienated from every day experience, not cathected to ordinary living people, but to faraway other things and other places, never feeling at home in their bodies, or in the houses and cities of their upbringing. Those who do not discover or invent sufficient external symbols of God in their struggle for survival may simply succumb to the temptation, and perhaps necessity, of a direct return to God may simply give up and die.

J. A child is given up to adoption immediately after birth. Here there is not a break in attention, but there is a subtle shift in the surroundings which the child can sense. Consider that the child has spent nine months within a body listening to the same voice, heartbeat and breath of a particular mother. In an ordinary birth that child is held in the arms of that selfsame mother. When a child is taken immediately after birth and given up to adoption to another woman, it certainly notes that the voice, the heartbeat, the breathing is different. It must be a shock to the child, just as being transplanted is shock to a young tree. The transplanted tree and child survive, but an effect is certainly registered that will show up in the future.

IV

When these kinds of events are presented in structures, we first help clients to connect consciously to the experiences that are remembered and locked in their body symptoms. In the structures, they can finally feel the dread, the pain, the terror of their damaging foetal and post uterine experiences. With the help of containing figures who hold them and keep them from literally and psychologically falling apart during those emotional and body-wrenching experiences, the client can finally integrate what was un-integratable. In the structure setting, with the physical and emotional safety provided by the possibility sphere, much healing can occur.

Then we provide as an antidote a symbolic experience specifically designed to neutralize and offset the damaging consequences. If the child springs from an unwanted pregnancy occurring during a war, the ideal parents are arranged so that they would have had the child in peacetime when they were perfectly prepared to receive and care for this new soul. If the embeddedness of the foetus was incomplete, the client can organize the symbolic experience of re-embedding in a child-longing ideal mother, etc.

The typical healing procedure creates a physical and psychological counter-event in which the reversal of the toxic history can be symbolically experienced. If the client feels or learns that there were many miscarriages before he/she came along and that he/she barely made it into the world, he/she might construct the foetal experience with a young ideal mother, who never miscarried and who has a perfect lodging place for him/her to be rooted in her body. The client may be held in a foetal position in the arms and laps of group members enrolled as extensions of the ideal mother's uterus, and feel as if they are now provided with all the softness and tenderness that they imagine should have been available there. Attention is paid so that the antidoting is done with all the appropriate figures, words, body surfaces, and when necessary, cushions that will produce the feeling that is necessary to build a new, believable, symbolic experience that will be laid down as a new healing memory with the same value and force as a real literal event.

Thus with all the above mentioned conditions the antidote is similarly constructed.

V

I will now describe a structure from a recent professional workshop with psychothera-

pists. There was some question as to who would have the next structure when one of the women in the group raised her hand to say that she wished a turn. I looked about and saw that no one else had raised their hand and I said to her that it was her turn then. She turned red, looked a bit anxious and smiled with a look of surprise and dismay, saying, "I didn't expect to have a turn or that I would be the one to have a turn. I was sure some one else would get it."

Moving directly toward creating the true scene, I said to her, "If there was a witness here now, he or she would say, 'I see how shocked, surprised and unsettled you are that you were the one to get the turn.'"

"Yes", she said. "Things aren't supposed to come so easy."

"That would be the voice of your truth saying that," I said. "It would say, 'Things don't come so easy.'"

"Yes." she said in agreement. "You have to work for what you get in this world."

At my suggestion she enrolled both the witness and the voice of her truth and the scene was created. The witness saw how surprised she was, and she flushed again remembering that feeling.

She said, "I really didn't expect that I would get it."

"That implied a voice of negative prediction," I reminded her, "that would say, 'you won't get what you want.'"

"That's true," she said. "My sister always got there first. My mother preferred her and she was always the favorite."

She said she was an adopted child and her eyes filled with tears when she said that she was taken from her biological mother on the day she was born and given to her adoptive mother.

I asked her if she wanted to enroll her adoptive mother in the structure, and she asked one of the group members to do so and placed her further away in the room.

"My mother never really wanted me or liked me," she said.

The adoptive mother was instructed to say that.

Hearing that, she looked forlorn and slumped as she sat on the corduroy covered foam couch. I suggested that the witness could see how forlorn or dejected she felt when she remembered that her mother never really wanted or liked you. She agreed.

"How does that feel in your body to hear that?", I asked.

"It hurts in my chest," she said.

I instructed her to contract the muscles around the feeling and see what movement, sounds, or emotions arose from there. She made a sound that gave me the impression of a wounded animal, or a very small injured child calling weakly and hopelessly for help.

"How does it sound to you, hearing that?", I asked.

"I heard it, but it didn't seem like it was coming from me," she said. "It didn't feel like it came from my body."

I suggested to her that the feeling was split away from her or she was split from her feelings and that this might be the time to enroll a voice of dissociation, which would say "Don't feel what is happening to you."

"Yes," she said, "I often dissociate. It is an old habit and problem of mine."

I suggested to her that it was normal for people to dissociate when encountering too powerful or uncomfortable feelings.

Then she looked at the negative mother and said she was angry, at her for rejecting her and favoring her sister. She spoke forcefully and made gestures emphasizing her aggressive feelings. I asked her if she wanted her negative mother to act as if the anger had struck her. She said yes and the accommodator did so. She was pleased to see the effect of her anger on her and then directed the accommodator to fall as she aimed her blows in her direction. The accommodator fell to the ground.

Seeing that, the client suddenly began to cry. "I feel so alone," she said. "Now I have nobody."

The witness said that she could see how sad she was now that she had nobody. She wrapped her arms around her body and tightly gripped her own shoulder and leg, her fingers digging into her flesh.

I asked her if she wanted to have someone other than herself that she could hold onto like that, as it appeared she was doing so in the absence of having someone to hang onto.

She chose a group member to enroll as a figure she could hold onto. In my mind I was

associating that clutching, finger penetrating, gesture with my understanding of the child wish to be embedded in the flesh of another and was doing it to herself in the absence of having someone to do it with, but at the moment I did not say that to her.

She held on to that figure and began to smile and look happy. The witness duly noted that. Then she began to have motion in her pelvis and I asked her to find a way to move that part of her body in some way that would produce a satisfying interaction with that role figure. She maneuvered her body and the accommodator's body in an interesting fashion. For a moment it even looked like she was about to separate the legs of the accommodator as if she wanted to climb into her. Then she began to rock together with the role player and a look of pleasure and delight came over her face.

"It is as if we are on a boat together and sailing. It feels wonderful." She continued that for some time with a look on her face that was near ecstatic. I saw a combination of infantile feelings and sensual feelings showing on her body. But mostly I imagined that the water metaphor had to do with the wish to be rocked and safely intimate with a female figure.

All at once she stopped and said, "It can't last. Nothing good lasts." She separated from that figure and lay crumpled on the couch. The voice of negative prediction was instructed to say, "Nothing good lasts."

She agreed with that statement and her body got more and more shrunken. She said, "I feel like I want to shrink until I disappear." I said let yourself follow that feeling and give movement to it. She wound up in a little ball.

Once again she said, "I feel a tension in my throat."

"Tighten the muscles around that tension and see what comes of it," I said. "Make the sounds that would seem to come from there." Once more she made those helpless sounds, this time they escalated until she began to cry with bitter desperation.

"Do you want a contact figure to hold you while you cry?" I asked, softly. This is an intervention I often make when there is deep grief that seems unbounded and without sufficient physical support to handle it.

She said, "No, I have to be alone. I have to take care of myself."

This attitude was underlined by the voice of her truth.

She stretched out on the couch. She was limp and looked helplessly upwards as if to an absent God. Once again her pelvic movements began and she reached up helplessly.

I said, "What do you need that would bring some satisfying interaction?" She said, "There is nothing and no one that I can turn to."

When people make that kind of statement I assume that somewhere, they have projected satisfaction and I asked her if she had such thoughts. After some time, she said that in the afterlife she knew she would be happy, but not in this one.

I said, "Create a place in the room where that afterlife condition would be and then place someone there to be the voice or the spokesperson of that place." She chose another woman in the group to enroll as that figure.

She said that there she knew she would find peace. The accommodator was instructed to say, "Here you can find peace."

On hearing that she began to cry, saying, "There I wouldn't have to do anything to get things, I would just have to be myself." The role player said back to her, "Here you wouldn't have to do anything to get things, you would just have to be yourself."

I asked her if she wanted to be in contact with that figure. She said yes, but looked puzzled. She said, "Does this mean that I am suicidal or that I want to be dead?"

I reassured her saying that she could be in contact with that figure knowing that she had projected peace and relief there and that it would be a symbolic process and not an expression of a wish for literal death.

She asked the role player to sit on the couch and then moved her and herself until she found a way to climb into her lap pulling the arms of the accommodator around her.

Being held in that position brought up a great well of sadness, longing and relief and she began to cry deeply in a way that was very moving to the group as several members began to weep.

While sobbing, she began to clutch

desperately at the figure and at an appropriate moment I suggested that perhaps the wish that had shown up before was again being expressed and that she should try to squeeze that figure as tightly as she wished. She said she was afraid to do that thinking it would hurt the role-player. It was not that she wished to hurt her but she felt the wish to clutch was so great she was certain it would be too much to bear.

The voice of her truth could then say, "Your need to clutch someone so tightly is too much for anyone to bear."

She cried desperately at that and buried her head in the shoulder of the accommodator.

I asked her if she wanted that figure to say that she could bear how much she was clutching her. On hearing that she dared to hold her tighter and her crying this time included the relief that bespoke the possibility of having the new license.

Here, I thought it useful to point out to her that this was no longer merely a figure from the next life but was functioning more in the style of an ideal mother. I suggested that we change the enrollment of that figure into an ideal mother category, for that was what was wished for in the first place but had not expected to be experienced until the next life.

She agreed and then began to feel the beginning of pleasure and relief that had surfaced with the earlier figure of contact, but this time she was not holding her in a way to ride on the waves but clearly as a little child holds onto a mother.

After some time she said, "This won't last either."

Here was the latest expression of the pattern established early in her history was that all good things came swiftly to an end. The voice of negative prediction said, "This won't last either.", and she agreed with it.

Now I thought would be the appropriate time to provide an antidote. I felt sure that her life had been one long continuous series of losses after another. The root of which was the first loss of being too early plucked from her biological mother.

Therefore I suggested that she construct this figure as an ideal biological mother who would not have given her up for adoption as her original mother had, but would have raised her herself.

The remembrance of the pleasure of a few moments before, coupled with the possibility that it could last with this ideal mother who would never have given her up, lit up her face. Clearly, this new thought presented hope and she began to return to the peace and satisfaction she had felt when she first contacted that figure as someone representing the next world.

To cement the connection between the two images, I asked her if she would like to hear her ideal mother say, "I would make you feel as wonderful as you expected to feel in the next world." She agreed and thus linked the two experiences.

Now she settled into the embrace of the mother, her breathing got deeper and slower and her body visibly relaxed.

She said, "I could stay here forever."

I asked her if she wanted to hear from her ideal mother that she could stay there forever, meaning that on the feeling level that she need never leave this state of bliss with her mother.

The ideal mother said, "You can stay here forever."

I asked her to make an image of herself at that age, with all the blissful feelings that she was having included in it. And then to make another image of the ideal mother providing those feelings around her. That way, she could internalize that composite image within herself so that when the structure was over it was not as if the ideal mother was leaving. Her adult mind could note that the structure had come to an end.

She stayed some time in the arms of the ideal mother, consciously establishing and recording the feeling of acceptance and bliss. She wanted one more thing, she said. She wanted to hear her ideal mother say that she didn't have to do anything special to have attention or have her needs met but that she would be there for her just as she was. The ideal mother said that and she smiled with her eyes closed nodded her head as if saying yes as she included that feeling in the image she created.

After some moments she opened her eyes, having the look that people have when they are at the end of the structure. I asked her if she had the images firmly in place. She said yes, and I asked her if she was ready to de-role the figures. She said she was. She first de-rolled all the negative

figures and ended with the de-rolling of the ideal mother.

The accommodators returned to their places and thus the structure came to an end.

Afterward the client spoke to me and told me how much she appreciated the work. Although it was only one structure, it did give her new perspective and the healing reconditioning nature of the antidote gave her some of the means as well as the hope that she could effect positive changes.

And now I have come to the end of my talk. I have given you an outline of basic PS/P theories and techniques, described how we apply those process to the issues of pre and perinatal trauma and finally given you a description of its application in a recent structure.

I will finish with a plea for the rights of the child. Children deserve to find on earth the warmth and meaning they found before birth figuratively or literally immersed in and surrounded by their creator. They deserve to experience all of their developmental needs, but more importantly, they deserve to enjoy the gratification of those needs, for why else were they born with them? They deserve to have a place on earth where they can grow and become the adults that it is possible for them to become. It is an important task to help those who have been denied those rights. It is an important task to teach would be parents how to be respectful of the souls they have brought to life. Damaged children can be handled and given hope with this kind of work. Symbolic reconstruction can heal deep emotional and psychological wounds.

To all involved in this life giving work, I wish you success.

Thank you.

LAUGHTER AND PASTORAL CARE

by Stephen Pattison

At the time of writing, Stephen Pattison was Lecturer in Pastoral Studies in the University of Birmingham, England. This article first appeared in modified form as a chapter in this book *A Critique of Pastoral Care* (London: SCM Press, LTD, 1988) and is used with permission of the author and publisher. It is one of the rare treatments of laughter and humor from any therapeutic field which Hakomi therapists, who use them both so liberally, can apply to their own reflections on the subject.

> Men will confess to treason, murder, arson, false teeth or a wig. How many will own uo to a lack of humor?[2]

The capacity to have a sense of humor and to be able to laugh is greatly valued in our own culture. But the significance of laughter as a fundamental feature distinguishing humans from animals was made in ancient civilizations.To be human was to be rational—but also to laugh. It is probably not overstating the case to say that laughter is one of the things that makes life worth living. for happy people their laughter is icing on the cake of good fortune. The laughter of unhappy and suffering people may be the only thing that keeps them going. For everyone ,laughter has gracious and unbidden qualities similar to those ascribed to the Holy Spirit. Where it enters in, lives and situations can be transformed and transfigured, even if only temporarily, and the richness of new life in solidarity with others seems possible. Laughter, like love, cannot be commanded, contemplated or preserved. Like failure, laughter is so much a part of human experience that it is difficult to contemplate anything approximating to good total pastoral care which finds no place for it. Unfortunately, so far as one can tell, the Christian tradition and the pastoral care which accompanies it have found it very difficult to accommodate laughter and the humor it betokens in any very direct way. Cambell builds on Heije Faber's image of the clown as a model for ministry in suggesting that pastoral care must be expert yet spontaneous, immediate and simple, loyal and vulnerable and able to join in prophetic divine laughter at itself and the world.[8]

Meister Eckart locates joyous laughter in the Godhead itself in the following, rather enigmatic, words:

> The soul gives birth to the person of the world 'when God laughs at her and she laughs back'; the Son and the Father thus delight in each other 'and this laughter breeds liking and liking breeds joy, joy begets love,love begets the person (of the World), who begets the Holy Spirit'.

The experience of laughter is universal and commonplace, yet theology has almost completely ignored it. It is a consolation in these circumstances to find that other disciplines have given it almost as embarrassingly little attention. If there is laughter in heaven, surely it does not arise from aggression, defeat or frustration. I therefore want to distinguish the laughter of delight which flows from a sense of well-being and being loved. This kind of mirth can be sen in children and particularly in babies. The beloved child in whom its parents delight seems, at least sometimes, to laugh just because she is alive and secure. The laughter of children cannot betoken much self-awareness or perception of incongruity because of their lack of mental development and it sometimes seems to betoken sheer joy and delight in existence.It has very little to do with humor, jokes, or perspective. In many ways, then, it is this naive or primal laughter which flows from an unreflective and total awareness of loving and being loved which is idealized and sought after by the theologians reflecting on the relationship of a loving Father with his children. It is unambiguously good and desirable, the consummation and outward sign of loving intimacy which totally involves rather than distancing. something of its essence is sensed by Helen Merrell Lynd:

> Humor that arises from enjoyment of the predicament of others may betoken a cynical self-interest which can be a warping experience for the observer as well as for the person observed. This is not all of laughter. 'When you laugh' says Turgenev,'you forgive and are ready to love.' This existence of

> primal, or naive laughter highlights another very important and obvious fact, namely that there is not always a connection between laughter and humor. The presence of laughter does not necessarily imply that something amusing or funny is happening.Laughter is a reflex, but it is not a simple reflex.It is under the control of the nervous centers and is affected by consciousness. When laughter is associated with humor and the latter's possibilities for gaining a different perspective on a situation, it has enormous value in pastoral care. Of course, in a very real sense, the value of laughter cannot be measured, any more than that of happiness. Nor could laughter be programmed into pastoral care self-consciously, for it has the quality of an elusive and spontaneous gift. Nonetheless, it is possible to make some observations on the positive aspects of humor and laughter for carers and those cared for, in very general terms.

The first thing to point out is that laughter is distinctively human. Where laughter is heard, albeit that it may be low, angry or even insane, there can be no doubt that people are involved. The sound of laughter can remind pastoral carers and those for whom they care that they remain human and have the hope of human potential, however unlikely that may seem in any given situation. When laughter and the humor in can betoken is entirely absent, there may well be cause of anxiety that a person or a situation is losing contact with humanity. It is only slightly overstating the case to say that to lose one's sense of humor and the capacity to laugh is to lose at least part of one's soul. The same thing can be said about pastoral care in general; where all is given up to serious planning for people's good and to sober intense individual encounters, where there is no ghost of a smile, pastoral care may be in danger of becoming inhuman. There is much to weep about and despair of in the human condition. But there is much to laugh about too; the furrowed brow of concern needs at least occasionally to give way to the raised eyebrows of hilarity. Where people cannot laugh at all,and are gripped by despair,it is a signal that the best and most urgent kinds of pastoral care are badly needed to stand by and assist wounded humanity. This pastoral care might be bereavement visiting of a very depressed person or trying to alleviate unemployment with its attendant misery. There is much which prevents people from laughing today.

Laughter points to essential humanity in pastoral care and its absence can be an indicator of inhumanity and diminishment. Since laughter is usually a thing experienced with other people and is usually enhanced if shared,it is also something which has the capacity to indicate and create greater mutuality in pastoral care. Of course, it is possible for laughter to be a sign of distance and contempt, but more often in sensitive pastoral care it bears witness to and generates real warmth, mutuality, sharing and solidarity. Humor can cement people together in a unique way, helping them to realize that they are not on their own in the situations they face. Indeed, the more threatening and awful reality may be, the more it may be possible for people to join together in laughter in the face of a common enemy.

By far the most important benefit conferred by humor and laughter in pastoral care is the sense of distance and perspective. It will be recalled that this lies at the heart of some of the main theories of laughter discussed above. somehow, humor requires a step back from the situation in which one is involved so that the incongruities in it are seen. This is the process of'seeing the funny side' of the situation, or even of the self and its actions. When people can take this step back, things come into proportion and can be seen in perspective more easily. For those who are suffering or involved in deeply troubling circumstances, the advent of laughter can be a sign of great hope, for it means that they are in some way transcending themselves and their circumstances. It means that they have the problem or the difficulty, rather than the problem or the difficulty having them. A sense of some control,or mastery, can at least be glimpsed through humor even if there is no prospect of easy solution or quick release from bad circumstances. It os certainly true that there are some situations which defy humor and laughter and where no distance is possible; severely depressed people, for example, are completely caught up in their own suffering and attempts to joke with or 'cheer them up' can be misplaced. But many very serious situations do have their funny side which can be recognized and used to lighten them. It is possible, then, for problems and difficulties to be faced in a 'euphoric' rather than a 'dyphoric' mode. This does not minimize or seek to escape from harsh reality but allows it to be coped with more adequately and pleasantly.[40]

Sometimes the perspective provided by humor allows people to change and grow; their past ways of behaving and responding seem literally ridiculous and so can be surrendered. At other times, it simply helps people to endure and retain their self-respect in overwhelmingly difficult circumstances. These remarks are summed up by the following comment on the Jews:

> For Jews, life is funny in every possible sense, but Jewish humor, born of accumulated anguish, actually takes life very seriously. It is an attempt to root out the meaning of experiences, to posit a certain control over them and exercise some independence from them, to penetrate the heart of suffering so as to rise above it, to save some sanity and to find just a little compensation. It bespeaks the poignancy of Jewish life: the tears of laughter and the laughter through tears.[41]

At the same level of the individual the humorous perspective seems to be able to accomplish results which no other approach can touch. In a very positive way it can liberate people from self-absorption. They can, as it were stand outside of themselves and in so doing become open to others. IT Can do a great deal to set people free from two very destructive attitudes to themselves, pride and self-humiliation, allowing a more realistic and healthy humility or true self-acceptance to enter in:

> Sometimes humor can expose the fantasies which underline my pride or my self-humiliation, rendering them vulnerable to an insight in which they lose their own power over me—for a crucial moment at least... A sharp, penetrating joke can prick my pompous pretensions, bringing me down to earth. Or, alternatively, it can pierce through the prison walls of my sober self-abasement, jolting me into an initiative towards freedom.[42]

It is important to add the words with which Evans goes on:

> But the humor must be gentle and humane, generating a kindly chuckle at another of the funny foibles of humanity. If the exposure is too stark and savage, it may destroy me along with pride, or shame me into deeper self-humiliation.[43]

The theologian Harry Williams believes that laughter is the beginning of self-acceptance and forgiveness, mirroring God's forgiveness and acceptance. It helps to get the self in proportion and opens the path to forgiving others:

> God, we believe, accepts us, accepts all men, unconditionally, warts and all. Laughter is our purest form of our response to\God's acceptance of us. For when I laugh at myself I accept myself and when I laugh at other people in genuine mirth I accept them. Self-acceptance in laughter is the very opposite of self-satisfaction or pride... In laughing at my own claims to importance or regard I receive myself in a sort of loving forgiveness which is an echo of God's forgiveness for me.[44]

At their best and most positive, humor and laughter can be enormously enriching. They can reveal and reinforce a sense of humanity, rediscover a sense of mutuality, re-define and relieve even the most difficult situations, help reconcile people to themselves and others and help them to recognize the reality of situations and selves from a different angle. But there is a problem. Humor and laughter relativize; that is to say that with their 'as if' perspective they tend to de-bunk established ways of seeing and traditional authorities. There may be a difficulty here for those who exercise pastoral care in a very traditional perspective, for once they start ' seeing the funny side' in pastoral care they may find that all sorts of other areas also dissolve in ridicule and laughter. Some people would argue that this is one of the reasons why humor and religion are incompatible.[45] Religion is absolute and can only be seen in one way. When it becomes possible to see things from different (and perhaps irreverent) angles, the gods fall from heaven and things can never be quite so certain again. Pastoral care in this context cannot therefore simply 'use' humor and laughter; it will be transformed by it also and, like religion, it may find its pomposity pricked and its solemn good order destroyed for ever. There is a price to be paid for the entry of the non-orderly phenomenon of laughter into pastoral care.

It should also be remembered that laughter is an ambivalent thing and has a hard side which may manifest itself in pastoral care. Humor and laughter can be signs of callousness, cynicism, escapism and lack of involvement. They can be

used as nothing more than an analgesic to take away present pain while distracting people from facing up to reality and seeking to change it. To the extent that laughter enables a relatively passive tolerance of the intolerable it must be regarded with grave suspicion in pastoral care. That fact is that, in themselves humor and laughter are not necessarily unequivocally food and desirable. Their value and appropriateness must be carefully assessed in each pastoral situation. With this warning in mind can we go on to look at the meaning and use of laughter in the individual pastoral encounter.

LISTENING TO LAUGHTER: WHAT'S IN A LAUGH?"

It should be becoming clear by now that humor and laughter are very complex. In terms of the individual pastoral encounter this has direct practical implications. It is not enough to assume that laughter is a sign of happiness and well-being, though of course sometimes it is. Instead, the meaning of laughter must be discerned and interpreted. The questions must be asked: 'What is in this laugh? What is the meaning for this person of her laughter in the present context? ' If laughter is carefully listened to and its significance is successfully elicited, it can cast a great deal of light on the situation of the person being cared for. People laugh for all sorts of reasons. Sometimes, for from expressing their true feelings, laughter can be used as a mask for feelings. In this defensive usage, the logic might run, 'I am laughing therefor I must be all right and happy. I do not need to look inside myself and I do not need help from anyone else. Everyone can see I am OK.' This kind of laughter can easily put a pastor off, making it very difficult to get beneath the surface and to offer help which may be very much needed.

Another kind of laughter is occasioned by feelings of embarrassment or shame. A person feels that some innermost thing has been revealed and in the absence of any alternative, such as running away, they may dissipate their tension in laughter which may well sound shallow and nervous. There is nothing amusing about being embarrassed, ashamed or anxious, so this kind of laughter has no particularly humorous connotation. In the same vein, it is quite common for people to direct shorn and derision at themselves in their laughter. They have stood back from themselves, but they despise what they see within or their own behavior and their laughter becomes a way of directing hostile feeling towards themselves. There is nothing more painful that to witness a person cynically and vindictively making themselves the butt of their own bitter humor. It is almost a kind of self-mutilation and it is very important that pastors should not join in by laughing along with the person they are caring for. There is also a more defensive kind of laughter which is associated with self-mockery. The logic lying behind this is that is a person criticizes and mocks herself, this will prevent others from doing so. Holding oneself up as an object of ridicule may prevent others from criticizing, but it also keeps them at arm's length. Judgment and support are both pre-empted.

Not all laughter has these negative connotations, however. Mercifully, people do sometimes find things which are genuinely amusing in pastoral encounters and laugh at them. They may laugh at themselves in a genuinely accepting way. Often, laughter accompanies some new insight into the self or the person's situation—they see the funny side of things with its incongruities and limitations. When support and understanding is offered, there may be the laughter of relief from anxiety or the delight of solidarity. Sometimes it betokens a complex mixture of feelings. Types of laughter are endless, as are the moods which they indicate. People laugh joyfully, angrily, bitterly, nervously, and so on. The point is that it is absolutely necessary to discern the meaning of laughter for the person concerned if the pastor is to be able to help them. Sometimes it will be useful to ask a person what their laughter means the them, for they may not themselves appreciate its significance.

But it is not enough for pastors just to listen to the laughter of those they care for. They must also try to understand the significance of humor and laughter in their own lives, interactions and ministry. Some pastors pride themselves on their sense of humor and their love of a good joke. This may be a good thing, but is it always a good thing in every circumstance? For them, as much as for anyone else, humor can be a defense against being open about their real feelings which may be far from jolly and benevolent at times, or against having to take people seriously. Again, humor can be a form of disguised aggression against people. Many pastors feel constrained to be nice and kind to people under all circumstances but may inwardly harbor a sense of grievance against

those who make demands upon them. One way in which they can express hostility in a relatively acceptable way is through humor. The trouble is that those who seek the pastor's are may well pick up the veiled aggression contained in jokes and wisecracks so trust is damaged. People seeking care may also very well be put off by someone who appears to laugh a great deal, whatever the circumstance. Laughter is an ambivalent communication and persons desiring care may be puzzled or worried by it, particularly if they do not know the pastor personally very well. People who are deeply distressed my find a laughing pastor difficult to approach as they may assume that he is unsympathetic to the sorrowful. They may even feel that they do not want to make her sorrowful! Pastors who have a sense of humor and laughter can also be seduced into trying to impress or amuse the people in their care with jokes and repartee. There is certainly a place for this at time, but it is an obstacle if the person cared for becomes no more that an audience. Lastly, it is sometimes possible for people who need care to deflect the pastor's attention from their needs by appealing to her sense of humor. It is easy for pastors to be drawn into a web of laughter which may be ultimately very unhelpful to the person being cared for who needs to face up to the real difficulties and opportunities of a situation. All this means that the pastor has to listen to her own laughter as well as that of those she offers care to. In doing this she will stand a better chance of making humor and laughter an appropriate and liberating aspect of pastoral care rather than an obstacle to it.

A pastor who tells jokes to those who come to her for help is using an unoriginal form of humor which is not specifically related to the present situation of the needy person. If she adopts a light-hearted bantering tone this may help some people, but it may make others feel rejected or belittled. By far the best way of engendering humor which is likely to be helpful in pastoral care, then, is to help the person seeking care to develop their own humorous perspective. This will not crush or attack her and will become a real part of her own view of the world. Pastors can encourage such a perspective by having one themselves and by trying to reinforce humorous awareness in those they care for. If they are willing to discover and disclose the incongruities in their own situation, this can create an environment of mutuality where those who seek care can also begin to experiment with humor and laughter. The key factor is that the person cared for is not made the victim of the pastor's wit. The pastor may be willing to make a fool of herself and reveal it to those in her care, she does not make them feel fools! The social worker, Bill Jordan, is a leading exponent of this 'humor by example' school:

> I believe that social workers have to be prepared to make fools of themselves from time to time, and to be made fools of by others ... If a social worker spends his time trying to safeguard himself against being made to look ridiculous he is likely to limit his opportunities for giving real help to his clients. It is better to let the ridiculous happen, and then try to use it creatively; or failing that, simply to endure it.[46]

There is a real place for becoming a fool in pastoral care, for Christ's sake, for the sake of those who seek pastoral care, but also for the pastor's own sake. Pastors, after all, have just as much right to be foolish as the rest of the human race. If they can give up their claims to professional earnestness and intensity, a difficult thing to do for people who sometimes want to be taken very seriously indeed, their care might be enriched, the burdens of those they care for might be lightened—and pastoral care might be a lot more fun. [47]

CONCLUSION: CONTEMPLATION, LAUGHTER AND PASTORAL CARE

It is a curious fact that very saintly people often seem to possess a very fine sense of humor as well as very real compassion for other human beings. Those who spend a great deal of time in the solitary, difficult and sober business of prayer can often appear to be more involved, sensitive and humorous than those who never pray and remain firmly involved in the humdrum activities of everyday life.

So, for example, a person like the Cistercian monk Thomas Merton fled the world into a monastery but paradoxically became more involved in, and compassionate towards that world by campaigning for peace in his writings. At the same rime as he became more involved in passionate struggle for world peace, Merton also managed to cultivate a sense of compassionate but humorous detachment about himself and even about the things he thought were most important. In a way, as he

grew older he took himself and the world in which he lived both more and less seriously.

It is not an accident that deep spirituality or contemplation can be associated with a humorous outlook on the world. Contemplation consists in coming to see the nature of reality through God's eyes.

It puts a different perspective on life and throws its tragedies, but also its incongruities, into relief. In contemplation, as in humor, a sense of distance and perspective is created and so laughter can burst through. It is not a sign of ironic detachment, or contempt for creation, or people. It is more the laughter of delighted recognition and acceptance which springs from the knowledge of God as loving Father. This kind of laughter betokens simultaneously the possibility of intense involvement but also detachment. It puts failure and success into their correct proportions and resists totalitarian fanaticism and utilitarian benevolence without belittling human efforts to change and create a better future.

Humor and spirituality are inextricable intertwined in Christianity but modern pastoral care has often seemed to lack both, to judge from much of the material reviewed in this book. In the thick of its intense and proper battle against dehumanizing sin and sorrow, pastoral care can easily lose any sense of perspective.

Perhaps it is this which has led to its being seen by some people as no more than social work undertaken by a religious agency. IN the end, the thing that Christian ministry distinctively has to offer people is not good works or righteous actions, but a way of seeing reality: "To contemplate is to see , and to minister is to make *visible.*[48] Christian pastoral care badly needs to rediscover the possibility of involved detachment based on the perspective gained by trying to see the world through God's eyes and so seeing reality as it is. The outward sacrament of this rediscovery will be the sound of laughter. This is as it should be, for Christianity embodies the truth of the resurrection. And what is resurrection but a laugh freed for ever and for ever.[49]

Paradoxically, it may be that it is only when pastoral care gains the perspective which allows it to see itself as a joke— a bad joke even— that it will be beginning to take God and reality seriously.

FOOTNOTES

2. Frank Moore Colby, quoted in Anthpny J. Chapman and Hugh C. Foot, 'Introduction' in Tony Chapman and Hugh Foot, (eds), *Humor and Laughter: Theory, Research and Applications, Wiley 1976* ,p. i.
8. Cf. Heije Faber, *Pastoral care in the modern Hospital,* SCM PRESS 1971, pp. 81-92. The clown image receives its full exposition in a book about pastoral care in psychiatric hospitals, Roger Grainger, *Watching for Wings,* Darton, Longman & Todd 1979.
21. Quoted in Rowan Williams, *The Wound of Knowledge,* Darton, Longman & Todd 1979, p. 134.
38. Helen Merrell Lynd, *On Shame and the Search for Idendity,* New York: Harcourt Brace 1958, p. 147.
40. See Harvey Mindess, *'The use and abuse of humor in psychotherapy' ,in* Tony Chapman and Hugh Foot (efs), *Humor and Laughter: Theory, Research and Applications,* Wiley 1976, p. 335.
41. Angela Wood, 'Telling it like it is: Teaching Judaism through story and humor', *British Journal of Religious Education 3,* 1981, 151-6,p. 151.
42. Donald Evans, *Struggle and Fullfillment,* Collins 1980, pp.115-16.
43. Ibid.
44. Harry Williams, *Tensions,* Mitchell Beazley 1979, p.111
45. See Cox, op. cit. ,p. 154.
46. Bill Jordan, *Helping in Social Work,* Routledge & Kegan Paul 1979, p. 120.
47. Cf. Mindess , op. cit. ,p.341.
48. Henri J. M. Nouwen, *Clowning in Rome,* New York: Doubleday 1979, p. 88.
49. Patrick Kavanagh,' Lough Derg', quoted in Hardy and Ford ,op. cit.,p. 73.