A Psycho-Tactile Approach to Trauma

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Abstract: In this article, the author reviews some of the very latest neuroscience regarding the impact of touch on the limbic brain. In particular, he explores the relationship between gentle soothing touch and the role it may now have in dissolving traumatic triggers in the Amygdala. Transactional Analysis theory is used to integrate this exciting new science into psychotherapy, through a case study and the consideration of the role of the Adult Ego State, Script Protocol, Physis and 3rd Degree Impasse in working with trauma.

Key Words: Transactional Analysis, Massage & Bodywork, Neuroscience, Limbic Brain, Amygdala, Touch, AMPA receptors, Brain waves, Electrochemical, Trauma, Grief, Fight, Flight, Freeze, Child ego-state, Impasse, Psychotherapy, Psycho-Tactile, Adult Ego State, Script Protocol, 3rd Degree Impasse.

The Massage Client Who Did Not Want to be Touched

'Marion' (27-yrs old), walked into the treatment room looking nervous and without confidence. When I asked her why she had come for a massage, the first thing she said was that she "did not want to be touched". A little confused, I asked her why she had come and what did she want? She told me that she could not sleep and was having trouble making herself go outside the house. She avoided eye-contact whilst talking to me and said that she had lost all her confidence. Marion then went on to relate how she had recently been attacked and raped at knifepoint by a group of three men. She told me that she had come to me because she just knew that she needed to experience safe touch from a man. At this time, I had not even begun my psychotherapy training and only had the faintest inkling of trauma and its profound effects. A bit confused, I asked Marion what she thought I could do to help? She said that she knew "deep down" that this was what she needed to do, but that she felt too scared to receive touch right now. I re-assured Marion and suggested that perhaps we could start with me explaining to her how a session normally goes (remarkably, she had never had a massage before).

I showed Marion where people get undressed, how they lie on the table, what draping is used and what happens at the end of each session. When I explained that people decided how

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much clothing to keep on during the massage and that I was comfortable working with people anywhere from fully naked to fully clothed, her eyes lit up and she said, "So you can massage me fully clothed?" When I said that this could often be as effective as oil-on-skin massage, she asked if she could have that right now?

So, I agreed, and Marion got onto the table lying face down, fully clothed. Before I touched her, some instinct made me ask her how she felt just lying there with me standing so close. She said that she felt a lot tenser than before she got on the table. So, I asked her to direct me to a place in the room where her body felt more relaxed. Nothing made a difference as she suggested different places in the room and we even tried me sitting on the floor. I then asked her if I could open the door and stand in the corridor. As soon as I did this, she said that she could feel her body relax.

When I said that I thought I might struggle to massage her from out in the corridor, we both burst out laughing. I then gave complete control to her by inviting her to instruct me to move closer and closer at a pace that she felt comfortable with. It took about 20 minutes as she told me to move closer, one step at a time, and then away for one step, whenever she felt that it was 'too much". By the end of this first session, Marion had allowed me close enough to lightly place my hand on her back for about 5 minutes and she ended the session saying that she felt that this had helped. We booked another session for a week's time.

At the second session, I asked if she wanted me to start out in the corridor again. She agreed to this, but this time she brought me into the room much more quickly and I was touching her back within 5 minutes. I then explained the 5 different movements of massage and asked her which she wanted next. In that session. she chose gentle, light and slow stroking. Although receptive to the touch, there was a sense that she was 'watching and waiting'. A week later at the start of the third session, she asked me to start right away and not to waste any more time "mucking about in the corridor". During this session, she asked to experience the other strokes I used on my clients. I let her experience kneading, compression, rocking, swaying and tapping. She enjoyed this exploration and we spent quite a lot of the session discussing what she could feel with the different strokes and which ones she liked the most. At the fourth session, she asked for "just stroking", the same as in her second session.

On several occasions during this fourth (stroking) treatment, I noted that she sometimes sniffed or sobbed gently, often for just a few seconds. On these occasions, I asked her if she wished me to stop or to continue – and she always wanted me to continue touching her during these moments. At the beginning of the fifth session, she asked if I would use oil-on-skin strokes for her, which I did. This felt the most profound session of them all to me, as she seemed literally to drink the touch into her being, again with some gentle sobbing. I was deeply moved by the atmosphere of healing in the room. At the end of the session, she was smiling brightly and simply said, "Thank you - that's all I need. I am better now". I never saw her again.

In my work with Marion, I could call upon very little that I had learned whilst training as a massage therapist. I would like to say here, that I have spent the last thirty years working as both a psychotherapist and a Bodyworker trying to understand just what happened with Marion, and what role touch might play in my work with traumatised clients. Over the years, I have seen many massage clients make significant changes to their lives and to their general outlook without any psychological input from myself. Working with two separate practices, one as a psychotherapist and one as a massage

therapist, I was sometimes hard pressed to say which client group had made the most 'script' changes. How was it, I wondered, that clients who turned up with tight backs and necks and had simple touch, were making similarly profound script changes as those who came for psychotherapy?

I now firmly believe that the reason for this is that certain types of touch are able to reach the most traumatised parts of the brain. This article sets out to show how touch can literally soothe the amygdala, release procedurally-held trauma, and help clients to rebuild their overall resilience.

The First Human Transaction

It should not come as a surprise that touch may have profound psychological properties. Touch is the very first sensory system to develop in the embryo – the skin is highly developed by the time the embryo is still less than an inch long. In fact, both the skin and the brain arise from the same embryonic cell layer – the ectoderm. The fact that the brain and the skin share the same stem cells has been confirmed recently by scientists growing brain tissue from human skin cells (Yoo *et al.*, 2011). This suggests that the most direct way to reach directly into the brain may be to touch the skin.

At birth, we are subjected to massive compressive traumas to our tissues, as well as suffering the inevitable trauma of expulsion from a known and familiar environment. The only thing that soothes this distress is to be touched and held. Much has been written about the many traumas that have been (and often still are) inflicted upon babies and mothers at the time of birth through the denial of this reparative touch (LeBoyer, 1975). Most readers of this article will come from a generation in which such soothing touch was taken away from us by an ill-informed and essentially male-dominated medicalisation of birth.

What 'script protocols' are likely to have been laid down in all of us regarding touch and relationship through the denial of such a vital evolutionary and healing touch experience? Lacking a fully formed hippocampus, such experiences are not remembered in our declarative memory, yet they remain in our bodies through 'procedural memory' (Scaer, 2014). This is just one example of how most of us are carrying a level of early and unremembered trauma in our bodies that words may never reach. It is a fundamental tenet of Transactional Analysis that such early experiences form the 'script protocols' that will shape our future life scripts. Eric Berne illustrated this idea with the analogy of medieval palimpsests, where ancient documents are written over again and again with more recent material, yet still the original vellum remains (Berne, 1963/75).

The act of reaching out to be held, and the act of being held then, is the first and most primal of all human transactions. It is life's primal soothing transaction. In many ways, we could look at all other human transactions as simple developments (or palimpsests) of this first attachment protocol. Such early experiences will inevitably become the foundations for later variations of our attitude towards touch, relationships and the world:

> *"The first script programming takes place during the nursing period, in the form of short protocols which can be later worked into complicated dramas. Usually these are two-handed scenes between the baby and his mother, with little interference from the onlookers..."* (Berne, 1972, p. 83)

Berne links these early tactile experiences directly with our later adult life positions as he then goes on to write:

> *"Already the feeling of OK-ness or not-OK-ness, which separates the now and future 'princes' from the now and future 'frogs' is being implanted and several types of 'frogs and princes' are being set up."* (Ibid)

Berne is clearly writing about this pre-verbal stage of human development as laying down the foundations of our future 'life scripts'. As touch is the primary language of such early attachment protocols, if we wish to speak to this part of the psyche, we may need to consider conversing with our clients in this language, the language of touch.

Touch and the Amygdala

Traumatic Encoding

Over the last thirty years, great strides have been made in our understanding of the way that trauma actually affects the brain and what this means for psychotherapists. Much of this neuroscience has already been well summarised (Novak, 2008). More recently, new information has appeared about just how trauma becomes encoded within the amygdala and why this is so hard to change (Clem *et al.*, 2010; LeDoux, 2012). For an event – or a series of events – to be encoxded within the brain as "traumatic triggers", Ruden (2010) has proposed that *all four* of the following conditions are necessary:

1. There needs to be an event that carries an intense emotional component.
2. This event needs to carry attachment meaning, either to our own life or to a significant other.
3. The landscape or 'state' of the brain needs to be vulnerable to stress.
4. There needs to be an element of inescapability to the situation.

Ruden has also summarised the neuroscience into the following sequence of electrochemical events, taking place within the limbic area of the brain:

> *"Sensory information related to the threat passes electrically to the thalamus and then to the amygdala in the limbic brain. This takes place under the excitatory conditions of high frequency stress-induced Gamma brain waves (30-100 Hz). Under these conditions, the chemical neurotransmitters of glutamate, cortisol and noradrenalin are released in large amounts. Within the amygdala (specifically the lateral amygdala), glutamate receptors respond (or are raised) to these chemicals and this triggers an electrical impulse to the hypothalamus, where all of our fight, flight or freeze responses are initiated throughout the rest of the brain and the body. In addition to this, all the memories associated with the trauma are stored in the hippocampus for future reference. When the trauma is sufficiently extreme to fulfil the four conditions above, then the receptors within the amygdala (called AMPA receptors) are glued 'open' permanently in a process called 'phosphorylation'. It is this permanent availability of the AMPA receptors for traumatic re-triggering that explains the hyper-vigilance of traumatised individuals."*

This 'phosphorylation' process has an important survival function, namely that we can have a heightened awareness of such danger in the future. After the instance of the 2001 Twin Towers disaster, for example, many people reported being traumatised by the sound of aircraft flying anywhere near a building. When these 'trauma' receptors become 'cemented' open, it means that we are continuously on alert for these signals, even after the threat or trauma has long passed. This is an electro-chemical way for us to understand traumatic memory and PTSD and I have summarised it in Figure 1.

No matter how much common sense (or adult awareness) we might bring to a situation (i.e., "That plane is not necessarily a terrorist plane."), if the amygdala is sending "life threatening" signals to our hypothalamus, then we will react as if the threat is really present in the here-and-now. Basically,

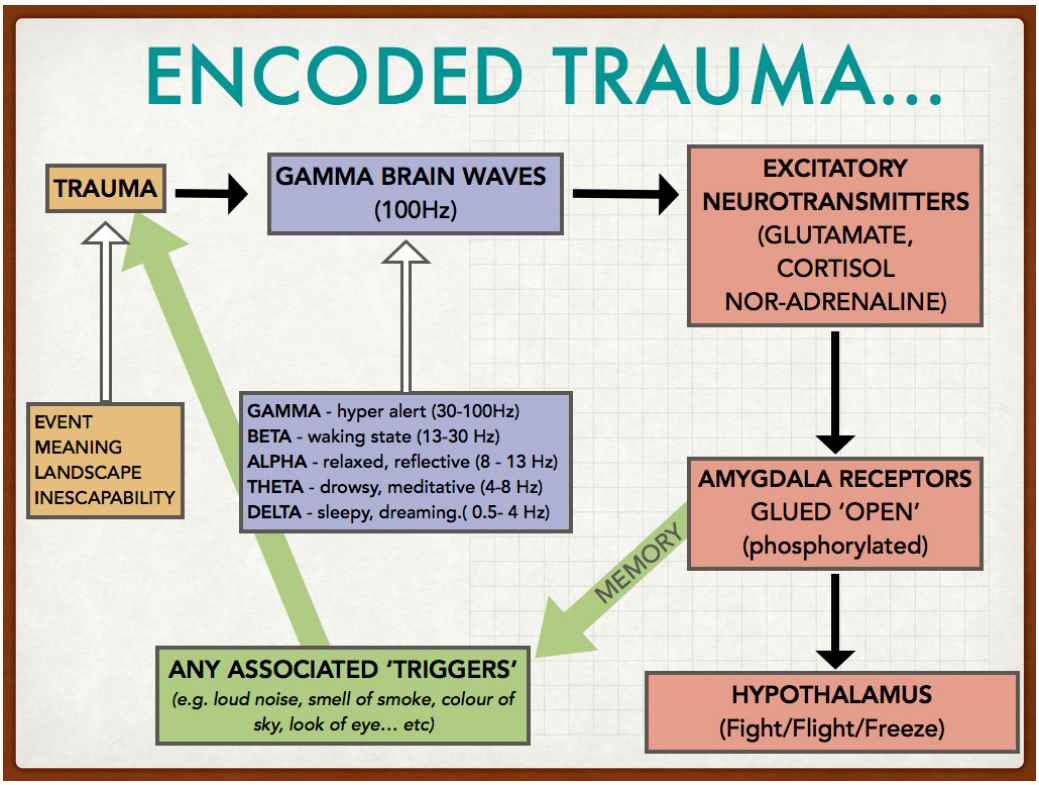

Fig. 1: *The Electrochemical Story of Trauma*

what the amygdala decides, nothing overrides. Neuro-chemically, we now know that this is because of these raised AMPA receptors (Kim *et al.*, 2008; Clem *et al.*, 2010; Hendler *et al.*, 2003).

By the time our higher brain functions in the cortex respond with a "Don't Be Silly" message (what LeDoux calls, "The High Road"), our limbic system has ensured that we are already running for cover. This is why it is almost impossible for the upper brain to contradict the limbic section of the mid-brain (LeDoux, 1996; Bromberg, 2006). Apart from anything else, the thalamus-amygdala "Low Road" travels much faster than anything that has to go through the higher part of the brain in the cortex.

This explains the inability of clients to distinguish the "there-and-then" from the "here-and-now", which is the very essence of PTSD. Research has also shown that repeated traumas actually erode our hippocampus, which is the part of the limbic brain where we lay down new and healthier associations and memories based on subsequent positive experiences (Bremner, 2006).

With respect to Transactional Analysis, this means that the more trauma that we have experienced, the harder it is to 'cathect' to our Adult Ego-State. Each trigger literally "rubber bands" us right back into the earlier Child Ego-State of the original trauma (Woollams & Brown, 1978). The more trauma that we have experienced, the more triggers lie cemented in the 'open' position in the amygdala. This means that we now have a clear neuro-scientific explanation for the observable process that we (in TA) have been calling 'ego-state contamination' and 'ego-state exclusion' for over 50 years (Berne, 1961).

Decoding Trauma

The good news is that neuroscientists are also

discovering that these raised levels in AMPA receptors are susceptible to extinction. In one study, researchers found that by simply stimulating the amygdala with slow electrical pulses, the alertness in these receptors was dissolved and the 'trigger' then re-absorbed into the neuronal body (Clem, 2010). This remarkable study was able to remove fear conditioning in rats through low frequency (Delta brain-wave-like) pulses. Research has also shown that, in the presence of touch, human brain waves drop into the slow Delta brain-wave state (Harper *et al.*, 2009).

In a tactile environment, a whole different chemical environment is created within the amygdala. The soothing or calming neurotransmitters of serotonin, GABA and oxytocin are all released in a calcium-rich 'soup' and this causes the encoded AMPA receptors to literally dissolve. When this 'de-phosphorylation' occurs, there is sometimes no longer any memory of the trauma at all, as the triggers have literally been dissolved (Ruden, 2010). This means that there is no future activation of the hypothalamus into our "Fight, Flight or Freeze" responses and there is no re-kindling of the trauma through repeated re-enactments. This decoding of trauma is captured in Figure 2.

This suggests that touch reaches directly into the amygdala and can set in motion a powerful change to the chemical environment of our limbic system, and that this change dissolves and removes our traumatically encoded triggers. This connection between touch and the amygdala is therefore a potential 'game changer' in the treatment of trauma.

C-Tactile Nerve fibres

Originally, it was thought that the only sense that could influence the amygdala directly was our sense of smell. However, with the recent discovery of what neuroscientists are now calling "C-Tactile afferent neurons", it seems

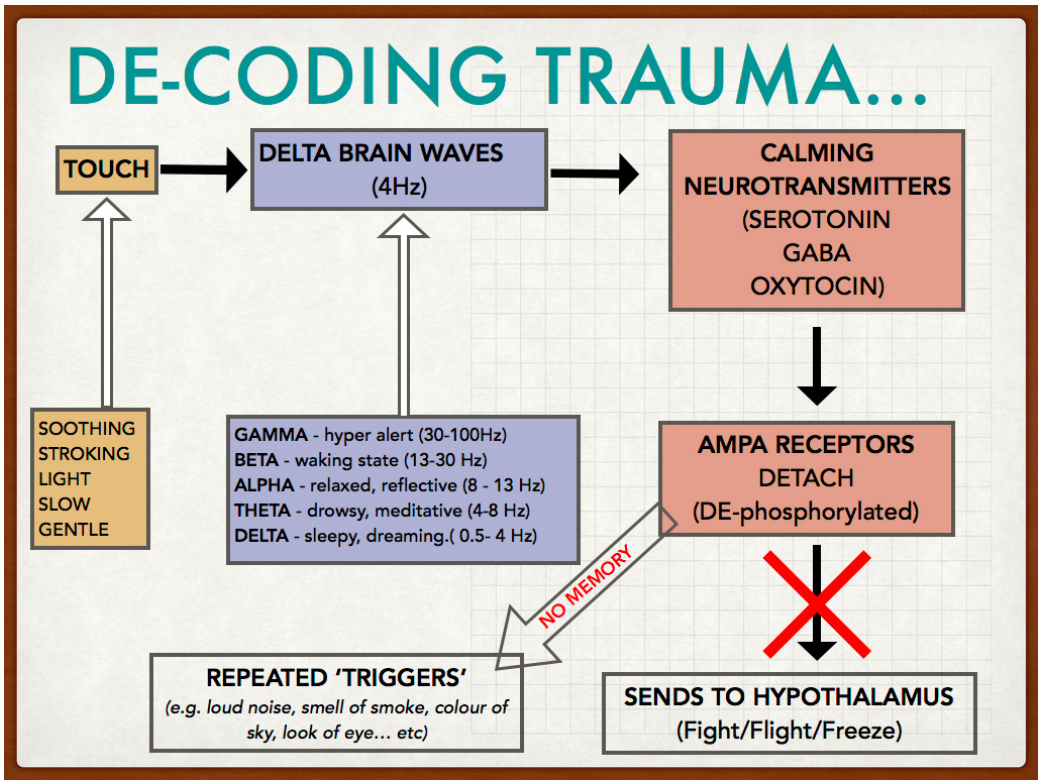

Fig. 2: *The Electrochemical Story of Decoding Trauma*

that we are beginning to discover just how touch can have an instant effect on the limbic system (McGlone *et al.*, 2007).

The many different types of nerves that innervate the skin generally inform us of where we are in our environment through proprioceptive nerves in our muscles, tendons and joints. Mechano-receptors in our skin inform us about our environment and whether it is safe or dangerous. These nerves all fire at very fast speeds (150-250 mph) and connect up to the sensorimotor regions of the cortex within milliseconds. The newly discovered C-Tactile neurons, however, send their signals at a leisurely 2 mph and end up in the limbic brain a lot later than the other sensory nerves (Linden, 2015). They are thus too slow to have any function for helping us assess the safety of our environment.

These nerve fibres do not seem to respond to heavy or fast movements, but they are only triggered by a gentle and light caressing touch, and the signal travels at 3-10 cm per second. It seems that these are our 'pleasure nerves' and our 'soothing nerves' (Morrison *et al.*, 2011). At the Liverpool Festival of Science, Professor McGlone (2008) stated that:

> *"...neuroimaging studies with fMRI and PET have corroborated both these findings [about CT-afferents], showing that the brain areas that respond to such pleasant forms of touch are those areas that are known to process emotions – of both pain and pleasure.*

When we provide a soothing touch, it seems we may be encoding pleasure into the emotional centres of the brain. Scientists are linking this soothing touch to mammalian grooming behaviours and now regard these CT afferents as our primary nerves of social interaction (Line et al., 2009). These nerves may well be the key that help us to understand, not only the healing power of gentle touch, but also the loss of resilience in people who have not had safe attachments in their early years. If we are not soothed, then it seems we are likely to interact with the world from a more vulnerable brain landscape. This is the stuff of hyper-arousal and hyper-alertness, as well as of frozen hypo-awareness (Siegal, 2011).

Soothing Touch

With the discovery that gentle soothing touch travels directly into our emotional brain, it seems that simple stroking may now be one of our most direct routes into the traumatised amygdala (Francis *et al.*, 1999; McGlone *et al.*, 2007). So, neuroscience is now pointing us towards the idea that gentle soothing touch may be one of the most powerful and direct therapeutic interventions that we can use in the treatment of trauma:

> *"The description of a 'new' touch modality in human skin, one that shares the same nerve type as pain, is seen as of potential relevance to not only a better understanding of the role of touch in human social behaviour and personal well-being but also to a better understanding of human pain mechanisms and their treatment. We have new evidence that stimuli that excite CT's, reduces activity in pain C-fibres. We are also interested in studying a range of clinical conditions, from depression to autism, that are also known to have links with touch – most autistic children hate being cuddled and stroked, and many depressed people show clear signs of lack of body care, such as lack of grooming behaviours, and a susceptibility to depression may have its roots in poor maternal care and early life experiences with touch starvation."* (McGlone, 2008)

McGlone shows how these findings in neuroscience take us right back to the issues of our early maternal care and our first attachment protocols. He also suggests that that the pleasure signals produced by touch actually reduce the pain signals in the limbic brain. The

role of touch in removing pain has long been documented and initially led to the 'gate theory of pain' within the spinal cord (Melzack & Wall, 1965). It seems that neuroscience is now offering us another 'gate theory', namely that touch replaces pain with pleasure in the limbic brain. This is consistent with the other neuroscientific findings that touch actually extinguishes traumatic triggers in the amygdala. It should come as no surprise then, that studies have shown that the very same 'touch aversive' autistic children mentioned by McGlone (as well as children suffering from ADHD and also abused children) have actually responded positively to the reparative experience of safe touch (Field, 2015).

All of this suggests that psychotherapists may be able to use simple human touch to affect the amygdala – almost surgically – and transform the electrochemical landscape of the traumatised brain. This takes place through the creation of Delta brain-wave patterns and the subsequent dissolution of raised AMPA receptors. It may also take place through the replacement of pain stimuli with pleasure stimuli from the actively stroked CT-afferent neurons.

In Marion's case, her instinctive choice of gentle soothing touch in a safe environment that did not re-trigger her traumatic response suggests that the depotentiation of her AMPA receptors was taking place and that painful triggers were being replaced by pleasurable ones. This is one way to understand her growing resilience over just five weeks of treatment.

Theoretical Considerations

1. The Adult Ego-State

Significantly, when Marion received touch, she remained in control of just *how the touch was given* throughout the process. Massage therapists working with veterans suffering from PTSD have found that – for touch to be beneficial – the client must be in total control of everything that happens in the session (McCafferty, 2016). Instinctively, I had repeatedly invited Marion to be in control and we both engaged our Adult Ego-States in the challenge of exploring what types of touch might work for her. This meant that the touch that she experienced was accompanied with a great deal of "here-and-now" discussion throughout. This means that she was repeatedly cathecting her Adult Ego-State in order to integrate her experiences of touch. This demonstrates graphically how touch can be used to actively strengthen the Adult Ego-State of our clients.

Dan Siegal (2011) would later call this *"staying within her window of tolerance"* and Peter Levine (1997) would later coin the phrase *"penduluming"* to describe this process of dipping in and out of Adult awareness – a process that had already been well documented in TA writings for more than half a century. Both writers believe that maintaining such "here-and-now" awareness is crucial for the medial pre-frontal cortex to stay sufficiently 'on-line'. This is what enables us to find new meaning and construct coherent narratives. These findings in neuroscience perhaps explain one of the main reasons why TA has proven itself to be such a popular and clinically effective approach to therapy, worldwide.

Without the ability to construct such narratives, clients struggle to process and move on from trauma. Marion's touch journey showed a gradual increase in her Adult Ego-State and consequently of her resilience to the point where she could finally receive oil-on-skin. It was also clear that her internal Parent Ego-State "watcher" now felt content that the massage was safe. This meant that she was able to "let in" the touch during a largely silent fifth session in which she clearly felt safe enough to sob gently. This would have simply been unimaginable at her first session.

2. Script Protocols

Another way to understand the neuroscience is to consider how touch may give us a unique form of access to our early 'script protocols'. Berne (1961) wrote: *"In script analysis, the household drama which is first played out to an unsatisfactory conclusion is called the protocol"* (p. 117). This suggests that protocol is essentially a response to traumatic events or surroundings. If encoded, then such trauma will reside as raised AMPA receptors in the amygdala. This should place the depotentiation of AMPA receptors in the amygdala (through touch) at the forefront of the future of the psychotherapy of trauma and changes to our 'script protocols'.

Cornell and Landaiche (2006) write of the unchangeable nature of experience at this pre-verbal level of early scripting: *"The most salient aspect of protocol, as distinct from script, is that it cannot be cognitively changed, re-decided, or re-scripted."* (p. 204). However, this does not fit with my own clinical experience when using touch. As a massage therapist, I am witnessing significant life transformations in many of my massage clients from simple touch on a regular basis. That early and somatic aspects of such scripts have been addressed is demonstrated by the physiological and postural shifts that accompany significant life changes, often characterised by growing affect and increased resilience. Such script protocol transformations are expressed by my clients across all three realms of cognition, affect and physiology – and often occur without any psychological contract or verbal input from myself.

Far from merely helping our clients to re-organise how they must live with such 'unchangeable' early script protocols, as Cornell and Landaich suggest, it seems that we can now use touch to remove these early traumatic triggers and create an environment where re-scripting occurs naturally across multiple ego states. My client, Marion demonstrated such a shift eloquently in her recovery from a recent trauma with a massage practitioner who had had absolutely no psychotherapy training or experience. Her physical difficulty in leaving her house after the rape suggests that her recent trauma may well have triggered earlier traumas held in her Child Ego-State. Bessel van der Kolk (2014) asserts that PTSD is almost always co-morbid with earlier traumatic experiences. This would mean that Marion's self-stated 'cure' involved her making *actual changes* at the level of her early script protocols.

3. 'Physis'

Such a natural re-scripting through simple touch brings us to one of Berne's (1947/86) most cherished and enduring of concepts, namely the concept of *'Physis'* or *"...the force of nature which eternally strives to make things grow and to make growing things more perfect"* (p. 98). Clarkson (1992) writes that, *"Physis is Berne's unique addition to the other two great, unconscious forces (Eros and Thanatos) in human life, and he sees all three as the background of psychological life."* Berne also described *'Physis'* as *"...the growth force of nature, which makes organisms evolve into higher forms, embryos develop into adults, sick people get better, and healthy people strive to attain their ideals"* (p. 11).

I believe that this essentially biological definition of change and growth brings us closest of all to the cellular and visceral structures of our 'script protocol'. Just as changing the alkalinity or acidity of the soil is sometimes needed in order to stimulate the innate *'Physis'* (or life force) of withering plants, I believe that changing our therapeutic 'soil' to that of human touch is sometimes needed to stimulate the innate *'Physis'* of traumatised human beings. In the same way that soil speaks to changing the primal language of alkalinity and acidity in plant biology, so I believe that touch

speaks to changing the primal language of 'alkalinity' and 'acidity' within the microscopic biology of the neuronal endings in our amygdala. This neuronal shift from a phosphorus environment (under traumatic circumstances) to the soothing calcium environment (that touch produces) actually mimics a similar acid-alkaline process in the soil: in acidic soil, phosphorus reacts with aluminium, iron and manganese, while in alkaline soils the dominant fixation is with calcium. It seems that the fragile eco-system of the internal neuronal workings of the human brain may well parallel the fragile eco-systems in the soil of our planet and link us right back to Berne's instinctive focus on the biological concept of *'Physis'*.

4. Impasse Resolution

At this 'script protocol' level, it is also possible to view such neurochemical transformations as biological expressions of the intra-psychic resolution of an early somatic impasse that occurred in the presence of relational trauma and ruptures. Mellor (1980) describes such third-degree impasses as occurring between the Parental and Child with any re-decision happening from the Adult. I interpret such non-verbal re-decisions as a direct consequence of the *somatic delivery* of a permission.

Gentle touch conveys that it is both OK to "feel" and to "be safe" in the only language that this somatic ego state actually understands, namely the language of touch. Far from declaring that *"we find it hard to conceive of a "re-decision" being made at a level of psychic experience and organization that has no real capacity to observe or think"* as Cornell & Landaiche do (Ibid), I believe that such resolutions can be seen happening daily through changes in physiology, affect and cognition as a consequence of simple and safe human touch.

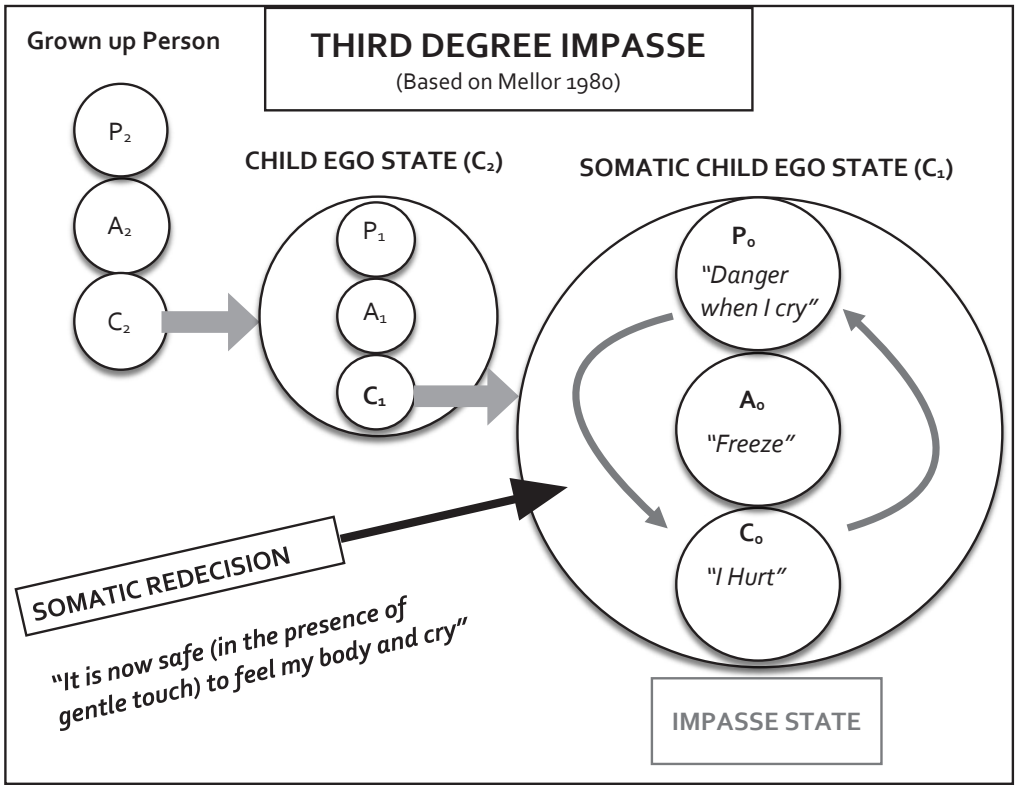

Fig. 3

Such a somatic re-decision can be understood as a 'Child' experience that goes something like: *"I hurt"* (from the rupture of neglect) and a 'Parent' experience that could be understood as *"I am shouted at when I cry"*, which results in a visceral 'freeze' solution of the 'Adult' that means *"I must numb my lungs and rigidify my arms in order to survive"*. This is shown in Figure 3 (below).

What I am proposing here is that touch provides a somatic permission that reaches deep into Child and it is this permission that facilitates the change of cathexis needed for a somatic re-decision. As the AMPA receptors are dissolved (de-phosphorylated) in the calcium rich environment that touch creates within the neuronal endings of the amygdala, so we can imagine the heavy weights of the somatic and visceral injunctions of our early 'script protocols' being gently dissolved, thereby releasing energy for a new cathexis and the appearance of new and more resilient behaviours. In Marion's case, such a visceral re-decision was visible in her gentle sobbing and also in her gradual change of posture from collapse and defeat into one of empowerment over just five sessions.

Summary

Neuroscience is now showing us that touch can reach into the mammalian limbic brain where deeply held emotional triggers are stored and that touch can extinguish these triggers. This de-phosphorylation of raised AMPA receptors could be happening due to a shift to delta brain-wave patterns or because painful signals are being replaced by pleasure signals, via our CT-afferent neurons, or both.

This means there are now compelling scientific and biological reasons for using touch in psychotherapy for the treatment of trauma and PTSD. Such touch can be used in helping clients to self-regulate and build resilience through decoding their traumatic triggers. Touch may also be a vital tool in helping us to access the preverbal decision making of our earliest Child ego-states and empowering our clients in resolving some of their earliest somatic impasses (namely those experienced at P_o and C_o levels).

The touch described in this article is most definitely not the touch of qualified massage therapists, nor professional bodyworkers, most of whom are only trained to fix and readjust the structural imbalances of the physical body. Very few bodyworkers have any training in how to deal with, or understand, this level of psychological release and processing. The touch described in this article is the gentle and soothing touch of normal human interaction. It is the universal language of all humans regardless of their spoken language or culture.

Quite how ethical touch is introduced into our work with clients, and what additional training is needed for psychotherapists to be competent and confident in using touch, is beyond the scope of this paper. However, I would suggest that – whilst years of training are needed to bring bodyworkers up to the level of psychological understanding and personal awareness necessary to understand the implications of their touch – only a short amount of additional training would be needed for qualified psychotherapists to learn how to introduce ethical touch safely into their practices.

Author

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