

1976 Eleanor Clarke Slagle Lecture

Touch With Care or a Caring Touch?

A. Joy Huss, MS, OTR, RPT, FAOTA

For 18 years my career as an occupational therapist has been predicated and developed on the premise that sensory input can influence motor output if used appropriately. As I studied the literature, worked with and observed patients, students, and colleagues, and had been a patient as well, I have come to an additional conclusion—the theme of this presentation. Since effective sensory input includes handling or touching the client, what implications does touch have in our culture, in the framework of occupational therapy, and as individuals? As I informally surveyed colleagues and students, I have been surprised to find that approximately 60 percent indicate that they are personally uncomfortable touching clients. Some have even expressed feelings of fear. Why? Is this necessary? If touching is therapeutic, how can we learn to be comfortable with it? What implications does this have for our educational curricula and for continuing education? Is touching applicable not only in physical dysfunction but also in psychosocial dysfunction? Are touching (handling) with care and a caring touch mutually exclusive or inclusive? Is touch to be used indiscriminately, or are there some possible guidelines? What is the neurophysiological rationale?

Review of the Literature

The neurobiological literature indicates that, first, the skin and the nervous system are derived from the same germ layer, the ectoderm, which provides a critical link between the two. Second, there are basically two major avenues for reception of touch/tactile information (1–3). Various terms have been used to differentiate between the two types of information. In the strict sense, touch is described as the spinothalamic system—protopathic, primitive, or protective—and is carried primarily in the ventral half of the spinal cord. Tactile information is described as the lemniscal system—epicritic, discriminative, or exploratory—and is carried principally in the dorsal half of the spinal cord. The sense of

Originally published 1977 in *American Journal of Occupational Therapy*, 31, 11–18.

touch is older, whereas the tactile sense is newer phylogenetically and ontogenetically. Both provide us with information regarding the environment, although each may be processed differently and have different effects on higher centers. Until the touch system is integrated within the functioning of the central nervous system, the tactile system apparently cannot function adequately (4). Tactile areas, especially the lips, index finger, and thumb, have the largest cortical representation both sensorially and motorically. Because the nervous system functions holistically, final interactions of the touch/tactile inputs have effects on the autonomic, reticular, and limbic systems, thus having a profound effect on emotional drives. Moore, in the 1975 Slagle Lectureship, spoke of the need for Tender Loving Care (TLC) as a basic primary drive of the limbic system for survival (5). One of the important components of TLC is touch/tactile input.

Developmentally, touch is one of the first systems to myelinate and thus become functional. The fetus will begin to respond to touch at about eight weeks gestation. In utero, the skin is constantly stimulated by the amniotic fluid and the touch/pressure of the womb. There is tremendous stimulation of this sense during birth. Leboyer has been concerned with providing soothing input to tactual and other systems with his method of *Birth Without Violence* (6). After birth, the baby experiences the environment through touch: by being handled, by clothes, surfaces, objects, and by experiencing himself. It is through this system that the infant gathers information about his body and his external environmental relationships (7). Studies have shown that, without appropriate touch/handling, the infant will not thrive normally even though nourishment and other needs are attended to carefully (8). Does this not speak to the need of the nervous system for meaningful tactual input?

Does this need not stay with us throughout life? Our vocabulary reflects this need with a multitude of references to touch: "keep in touch," "handle with care," "I am touched," "I feel . . .," "how does it feel?" "it feels like . . .," and an experience is "touching." We use such expressions as "being tactful," "rubbing someone the wrong way," "we all need certain strokes," someone has a "soft touch," or "human touch," or is "touchy," and we speak of the need for "tangible" evidence. In addition, many adjectives such as rough, smooth, tender, and painful would have no meaning without previous tactual experience.

Frank (9) indicates that, because the tactual system is one of the first functional systems, the infant uses this as a primary mode of communication. As other systems (auditory, visual, and kinesthetic) mature, they gradually supercede the tactual mode, leading eventually to symbolic communication. The individual learns the taboos of tactual experience through satisfaction and conflict so that eventually the child inhibits touching and operates on a symbolic level. This is said to lead to ego development. Frank further states that: "Since living in a symbolic world of ideas and concepts is a most difficult and subtle achievement, denial or deprivation of primary tactile experiences may be revealed as crucial in the development of personalities and character structure, and also in the configuration of a culture."⁹ (p. 230)

Initial tactual experiences assist in the development of internal homeostasis. Without internal homeostasis, there will not be an adequate awareness of the external world; thus there arises an inability to shift from tactual dependency to linguistic-symbolic communication. Therefore, with early deprivation we see not only the physical manifestations of speech

retardation, learning disabilities, and other gross disturbances, but also emotional and affective problems such as schizophrenia (8, 9).

Tactual contacts begin to diminish at about ages five to six in our culture, with the evasion or denial of touch directed more strongly toward the male. The desire to touch and be touched suddenly increases at puberty, first between members of the same sex and then heterosexually. However, in our adult culture, it is reserved primarily for that most intense of human experiences, the sexual process (8–12). Frank indicates that, in this sexual form of interpersonal communication, the primary mode of tactile communication is reinstated “provided the individuals have not lost the capacity for communication with the self through tactile experiences.”⁹ (p. 233)

We learn the boundaries for tactual communication culturally. These boundaries vary from culture to culture. Those of Anglo-Saxon origin, especially the English and German, are relatively nontactual. Those of Latin, Russian, Black, Jewish, and primitive cultures are highly tactile peoples. People in the United States are generally considered nontactile (7–16). There are even laws that legislate against touching. Within these cultural groups there will be individual variations that appear to be somewhat dependent on one’s experiences within child rearing practices. The need for tactual input is there, however, and may be one explanation for the plethora of pets found in the American culture. Touching and being touched by a pet is acceptable when human touch interaction is denied.

The American culture tends to substitute verbal interaction for body contact with specific distances delineated for various types of communication. Hall has found these verbal interaction distances to be up to 1.5 feet for intimacy; 1.5 to 4 feet for personal subject matter; 4 to 12 feet for nonpersonal, social information; and 12 feet or more for public disclosures (8, 11, 12, 17). It is much easier to talk with an individual or a small group than with a larger one because of the greater distance involved and the smaller amount and kind of feedback received as distance increases.

Goffman (18), however, indicates that middle class Americans are handling one another all the time, if we keep our eyes open to see it. Handling punctuates communication at times when there can only be one meaning received. Thus, the context is all important. It is also involved with status (10, 13). For example, it is all right for an adult to touch a young child and for a doctor to touch a patient (high status to touch low status). However, it is generally not acceptable for the patient to reach for the doctor. A group of therapists recently said to me that it was all right to touch the patient, but it was not all right to touch others. In the psychoanalytical tradition it is even taboo for the doctor to touch the patient.

The fact that touching goes on all around us and is ignored indicates our attitude toward it. We equate tactual contact with sex unless it is perfectly clear there is no connection. Thus we use it sparingly to express warmth, affection, understanding, and acceptance. Contact tends to be perfunctory between individuals of the same sex, between parents and their grown children, and in medicine, including the occupational, physical, and speech therapies. The touch is often mechanical and without feeling for fear of revealing too much of oneself or of being misinterpreted, especially if that contact occurs on any part of the body other than the upper extremities. Unless involved in lovemaking, most of us tend to be disembodied,

with our bodies disappearing from our experience. We suffer from "skin hunger" (10, p. 139) as children, as adolescents, and throughout the adult years. Fortunately, child-rearing practices are changing with breast feeding, child backpacks, and the use of cradles on the increase. Rocking chair use by adults is also on the increase, but that form of tactual input, important as it is, is still an impersonal one because it involves only one person. Encounter groups are positive attempts to help us get in touch with our bodies and those of others through various experiential activities.

Perhaps the elderly in our society are deprived the most because of impersonal care in nursing homes and the loss of loved ones. Their distance receptors of vision and hearing decrease in functional capacity; thus limiting experiential capability. These disabilities, compounded by the lack of meaningful touch with others, make their isolation even more acute. The elderly cling to those possessions that can be handled or that evoke memories of lost contact.

A recent, informal survey of 12 individuals in a comprehensive retirement home included the following questions. What is your most valuable possession? Why? The group consisted of eight women and four men; three are still married (two men, one woman), five are widows, two are widowers, and two are single women. Their status includes six in fair to very good health, two who are ambulatory with cardiac problems, three with cataracts, one with emphysema, and three in wheelchairs either because of rheumatoid arthritis, multiple sclerosis, or brain stem, cerebellar involvement.

I found their responses quite revealing. The single women responded with "my health," because it permitted them to do the things they wanted to, which included enjoying their friends. One of the married men also indicated his health. His wife was quite ill and I felt it significant that he did not respond to the question until about two hours later, after he had been to visit his wife. He was not asked "why."

One of the men, a minister, replied "my Faith because I have built my life on it and it keeps me going." The lady with multiple sclerosis gave a dual answer. "My husband because I love him the most, and my Bible because it is my hope and inspiration." This woman is quite dependent on her husband for care as the only movement she has is in her right hand.

Of the nine people whose spouses or children or both are still living, six responded that their most valuable possession was their spouse or their children. Their words were different but the basic reason for this was that they are "a part of me, make me feel needed and wanted, and are there if I need help."

One lady's response to the question was her diamond ring because her husband gave it to her. A widower replied "The picture of my wife. I loved her very dearly." Finally, one widow with two married daughters said, "If we had a fire I'd grab the picture of my husband and two girls because it can't be replaced."

All of the responses are expressions of a loving, reciprocal relationship that, in one form or another, includes touch, although the word "touch" was never used. Money and other material possessions as such were not mentioned.

As Americans we have tended to make a distinction between mind and body. The products of the mind, which rely heavily on the distance receptors, are considered clean,

trustworthy, and good. Conversely, those products of the body, which depend on touch, taste, and smell, are considered unworthy—even bad. Some have said that the current sexual revolution will change our tactual habits. But touching is even more basic than sex as a primary drive. Until there is a change in early contact experiences between parent and child, it will be difficult, but not impossible, to change adult behavior (10).

Other cultures and eras placed a great emphasis on touch for healing, destruction, power, or the transference of a life force. Primitive cultures construe the use of touch as magical in curing both mental and physical illness. Many of history's great healers cured their patients by a "laying on of the hands." Galen, Mesmer, Greatrakes the Stroaker, and others in the early history of European medicine wrote of the healing powers of touch. Why then did the strong taboo regarding touch found in the psychoanalytical tradition emerge? Mintz (19) provided us with some historical insight. She thought one of the reasons for the taboo might be that Freud developed his theories during the Victorian era, which, in contrast to the Elizabethan era, was one of sexual prudery with a strong emphasis on the products of the mind. Freud and his associates probably had a strong desire to dissociate themselves from magic and religion in order to be established as scientists. Freud originally used stroking, hypnosis, and therapeutic massage in his practice. However, since he and his associates were viewed as sexual perverts because of their practices, it became important to avoid any contact with the patient no matter how neutral its intent. Although external circumstances at least played a role in the establishment of the taboo, two basic principles of the traditional psychoanalytic approach do seem to contraindicate touching: the rule of abstinence; transference should occur with minimal influence by the real personality of the therapist.

Many contemporary therapists have moved away from the traditional principles of psychotherapy. A review of their tenets finds a variety of attitudes toward touching ranging from nontouch to somewhat mechanical use of tactual input; to the use of contact as a natural part of the relationship; and to its use as a means of knowing through feeling. The literature is replete with the controversy—space not permitting, the reader is referred directly to the literature (8, 16, 19–38).

The nursing literature has been the most productive in providing controlled studies on the effects of touch (20, 39–41); theoretical concepts (42–44); guidelines for the use of touch in a variety of settings (17, 45–48); and student reactions (20, 46, 49).

Generally, it has been found that the areas most often touched are the patient's forehead, shoulder, and hand. McCorkle's (40) study on seriously ill patients indicated a significant difference between those patients who are touched and those who are not touched during verbal interaction. Ninety-three percent of the experimental group (those who were touched) versus 70 percent of the control group (those who were not touched) responded positively to the interaction. The analysis indicated that, although the patient may be unaware of the touch, he seems to be more aware of the nurse's concern, interest, and caring when touch is used.

Aguilera's controlled study in a psychiatric setting showed that the use of touch "resulted in increased verbal interaction, rapport, and approach behavior"²⁰ (p. 13), especially with the

schizophrenic patients. Since the patient population was relatively small and some variables were not controlled, she suggests further study. She does not suggest that touch be used indiscriminately, but that the judicious use of touch may be one means of nonverbal communication with psychiatric patients.

Krieger's (39) research indicates that there is a significant change ($p > .001$) in hemoglobin values as a result of therapeutic touch. Research with plants and animals, where understanding by the recipient is not a factor, has shown significant changes in enzymes when therapeutic touch is used (50). So there is more to touch than just the emotional aspect of being accepted and cared for by someone who understands.

Burnside (45) and Preston (47) directed their interests toward the geriatric population with chronic brain syndrome. The basic premises of these studies are that:

1. In a regressed patient the inability to communicate has led to isolation;
2. Unless repeated contact is made with him he will continue to withdraw;
3. With a nonintact nervous system there is difficulty with the registration, retention, and recall of information;
4. Since tactual input has the characteristic of a conditioned response learned very early in life, the ability to use this system appears to remain viable (47).

Burnside's (45) goals were to:

1. Decrease inappropriate behaviors such as babbling, withdrawal, hallucinations, exhibitionism, and refusing to make eye contact;
2. Encourage appropriate behaviors such as laughing, smiling, spontaneous behavior, expression of negative feelings, display of affection, and tenderness;
3. Develop an awareness of clothes, food, and other people through eye contact and touching.

Touch was the primary method used to reach a small group of six patients. She used an Indian handshake at the beginning and end of each session; a hand on the shoulder when speaking to them; simple hand games; dancing; and other contact activities. And what were the results? The patients began touching each other and the group leader; there was an increase in appropriate verbal communication and eye contact; and they began to respond to music. She noted that they like polkas the best! I believe Ruesch's statement is most apropos. "Nonverbal language takes on prime importance in situations where words fail completely."⁵¹ (pp. 189, 190)

For some time we have heard that under stress there is a tendency for the individual to regress. This has been said in regard to reflex activity when the primitive reflexes reappear, to emotional reactions, and to behavior patterns of the mentally ill and geriatric populations. Can you, from your own professional experience, think of other instances in which this supposition has been used? The scientific literature supports this premise (8, 14, 17, 18, 20, 30, 42, 43, 46, 52-54). Under stress the individual reverts to an earlier, more primitive method of coping, which at some point has been successful. This occurs whether we are healthy or ill physically, mentally, or emotionally. Since the nervous system acts holistically, and ultimately controls our physical, mental, and emotional states, stress can affect any or all three areas of function. Just as we need food, water, and sleep for physical survival, we have a

constant emotional need for comfort, reassurance, and security. These needs are particularly active when there is increased stress. The need for body contact, which signifies being loved, comforted, accepted, and protected, can be affected by illness, anger, anxiety, and depression. Due to cultural influences body contact may be seen by the individual as unavailable, inappropriate, or childish, and therefore, he tries to conceal his need or seeks satisfaction through sex. However, if the person's sexual activity is looked at carefully, it may be seen that being held is really what is being sought (53, 54). Could this be one explanation for the increased popularity of massage parlors? It has been suggested that one reason people depend on drugs may be because they do not receive enough body contact, which is the first tranquilizer we experience (14).

Implications

If touch is as therapeutic and necessary for homeostasis as the literature appears to indicate, then what are the implications for us as therapists? How can we learn to use a caring touch? How do we learn to give and receive it comfortably?

At this point in the history of occupational therapy there is a great deal of emphasis on the sensorimotor treatment approaches of Ayres, Rood, Bobath, Knott, and Brunnstrom in both physical and psychosocial dysfunction. All of these include, to some degree, handling of the patient. As I taught these approaches to students and clinicians, I have become aware of those who learned the mechanics of application but were unable to use the approaches effectively. It is not uncommon to have therapists to students able to discuss the basic principles and, on paper, plan good programs. Yet, when provided with the opportunity to "lay on the hands," they sit back and wait for someone else to do it. I have also observed those who perform the treatment in a perfunctory way. They do not use their tactual sense to perceive the changes or lack of change in the patient and thus modify their approach accordingly. For a long time I wondered why this was so.

In other areas of occupational therapy, such as general medicine and surgery, orthopedics, geriatrics, psychiatry, and education, how is touch used, and is there a place for the caring touch? Based on my own professional and personal experience, I reply to that question with an unequivocal "yes," there is a place for the caring touch.

During my own hospitalizations, I became very sensitive to the difference between perfunctory touch and a caring touch, and their effect on my homeostasis. During a one-month stay two years ago, I was the recipient of physical and occupational therapy as well as the care of many nurses, aides, and physicians. I became aware of the fact that most communication was carried on in the 4- to 12-foot social distance range. When it was necessary to be close, the nonverbal message was still, for the most part, that of the greater distance. When touch was necessary, it was mechanical and gave no message of caring. Instead, it was a job to be performed. Being on complete bed rest and knowing that they really did not know what the problem was or how to treat it, I became acutely aware of the effects of sensory-tactual-deprivation. 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. I was experiencing what Dominian (43) calls the "anxiety of disintegration," since my body refused to perform its daily tasks. At such times, physical contact is of great importance.

During my last hospitalization for surgery, I was able to compare the effect on my psyche by an intern who had not yet learned the caring touch, with the effect created by my primary physician who had learned it. I was distressed by the intern who invaded my intimate space with indifference. He appeared to be very uncomfortable. When the surgeon came to see me the day after surgery, he approached the bed, placed his hand on my knee, and asked how I was doing. I knew immediately that he cared about me as a human being. "The behavior of caring can elicit the feeling of caring."³⁰ (p. 173)

It has been observed that most patients coming out of anesthesia or some other unconscious state first begin their reorientation through tactual exploration. They reach for the bed rails or the nearest person and hold on tenaciously (42). My own experience was no exception. I shall be forever grateful for the presence of three people whose touch conveyed "I care." It is interesting to note that these three were not a part of the hospital staff but were two occupational therapy students and a retired nurse. The entire staff, with the exception of my surgeon, were quite distant throughout my hospital stay. I find this rather frightening.

Professionally, I have been aware of the number of individuals of all ages who have demonstrated the anxiety of disintegration and in one way or another reached out for understanding and acceptance. Does anyone hear their cries, or has the medical machine grown so large and impersonal that it zeros in on the specific problem, ignoring the broader aspects of the total human being? Occupational therapists have said that they treat the total person, that mind and body cannot be separated. And yet we, too, get caught up in the specialization process and concentrate on the problem presented by the patient. The educational process encourages this with compartmental learning. We may talk about the necessity of total care, the acceptance of the individual and the use of therapeutic touch, but our actions reinforce the cultural taboo regarding touch. Goffman (18) has said that touching can occur in an acceptable way when there is a medical perspective, but we still find that practitioners are uncomfortable using it. Following discussions about the effects of touch, students and colleagues have said to me, "Intellectually I can understand the importance of touch, but how can I learn to use it when my culture says no?" That question haunts me.

It is obvious from the literature and my own experiences that talking about it may be necessary, but talk alone is not sufficient. There must be experiential learning to reinforce it. I am also convinced that we must first experience it with our peers and understanding instructors who can help us sort out our feelings. Second, we must experience it with those in distress and be able to discuss it with a clinician who understands.

Touching involves risk. It is a form of nonverbal communication and, therefore, may be misunderstood by one or both parties involved. It invades intimate space and may be a threat. If we are not in tune with ourselves and the one we touch, it may be inappropriate. However,

non-touch may be just as devastating at a time when words are insufficient or cannot be processed appropriately because of disintegration of the individual.

Some of us have had to learn to use therapeutic touch the hard way. Some use it and are not aware of the fact until someone points it out to them. Some perhaps assume that it “goes along with the job” and give it no thought, while others unconsciously fight it and wonder why they are so tense. There have been individuals who have told me that the kind of treatment I do is physical therapy, not occupational therapy, because I handle the patients. Could this possibly be an unconscious reaction to their own discomfort in touching and being touched by others? At the other end of the continuum, there are some therapists who experience an energy flow between themselves and the clients as they work with them.

How, then, can we learn to use touch appropriately? It is not feasible for all of us to participate in encounter groups. For those who do, it can be a very rewarding experience. What can we, as educators and clinicians, do to help our students, colleagues, and ourselves tune in to this vital form of communication?

I believe it is important first to be aware of our own use of and feelings toward nonverbal communication before we can use touch effectively with others. There are many techniques from Gestalt therapy and the Encounter movement that can be used either individually or in small groups. Books, such as *Joy* by Schutz (16), *Awareness* by Stevens (37), and *Sense Relaxation* by Gunther (55), can be very helpful in providing direction in experiential activities.

I would like to share with you some of the activities that I have found helpful. One very simple way to begin to look at your own feelings is to take time to write your name as slowly as you can. When you are finished, reflect on what you felt while doing this. Can you correlate your feelings with some of the reactions you have seen in your clients? One student said to me, “Now I can really understand the frustrations of the patient when he has to concentrate consciously on every movement he makes! No wonder he feels frustrated!”

A period of time spent relating with others without verbal communication can be very revealing. We tend to conceal ourselves behind the use of words, but when forced to communicate without them, we have to share our feelings and thoughts through body language. This can be very difficult for some, enjoyable and easy for others. But again, whatever your reactions, consider them thoughtfully and relate them to your experiences with clients.

There are many people who find it difficult to make contact with others. “Small talk” is threatening. (“How do I make a meaningful contact?” “What do I do or say?”) For some it is easier to withdraw, saying “I don’t care,” and then live with the agony of loneliness. Others may overreact, becoming boastful or boorish, to cover up their insecurity. All of this may occur quite subconsciously.

One technique that helps to alert us to the conflict of being alone and together is called *Feeling Space* (16). The group sits close together. For five minutes, with eyes closed and hands outstretched, they feel the space all around themselves. They are instructed to feel their reactions to this space and to the contact made with others. Do they prefer to stay in the empty space and resent any intrusion of it by others? Do they feel uncomfortable when invading the space of others? Do they enjoy the touch contact? Do they seek it out or

withdraw from it? What are the reactions of those around them? This is followed by a discussion of those feelings.

Similar but more generalized feelings about a total group awareness of others as human beings and one's role in a group can be experienced by milling around the room with eyes closed. There should be no verbal communication. When people meet they explore each other for however long and in whatever way they wish. Discussion follows the experience.

The blind walk is extremely helpful in awakening one's senses, and becoming aware of one's dependence on others, and one's reactions to touching and being touched. The participants pair up with someone they trust. One is blindfolded. They are not allowed to communicate verbally. It is the responsibility of the sighted partner to provide an opportunity for as many varied experiences as possible, including the senses of taste, touch, smell, and movement, as well as to provide for the safety of his partner. The blindfolded person is instructed to experience his environment and to identify those individuals with whom he comes into contact. At the end of the allotted time, 30 minutes or longer, they trade places. The immediate reaction upon reconvening is a flood of verbiage. Some have found it extremely difficult not to talk during the experience. They find that their senses of touch and smell are extremely important in orienting themselves and that touch is very meaningful in relating to others, developing trust, and a sense of caring, as well as being necessary for communication with their partner. This can then lead to a discussion of the use of touch with their clients.

These are only a few of the many experiential activities that might be helpful. You are urged to explore further.

In our educational process, sensitivity to the effects of touch could be incorporated into many different courses, and the earlier it is begun the better. The faculty, as a group, should first explore their own feelings through experiential activities. It would not only make us better instructors but also better coworkers, since we would be able to sense the feelings and reactions of ourselves and others. The experiential activities could then be incorporated into courses such as kinesiology, neuroanatomy, evaluation procedures, growth and development, physical and psychosocial dysfunction treatment theories, group process, community relations, and administration-supervision. As clinicians explore and become comfortable with a caring touch, it could then be incorporated into the students' field work assignments as well.

To assist the clinicians in their development, this course material could be included in many of the existing continuing education workshops. State associations could sponsor workshops for this purpose. Finally, we can also learn from our clients once we are tuned in to observe our behavior and theirs.

Conclusion

I believe that a concerted effort on our part could make a difference in our own lives and in the lives of those with whom we live and work. If we, as occupational therapists, would begin to use touch in a caring manner, in time we could make a difference in our culture.

Occupational therapists have the necessary academic background in the biological and behavioral sciences to be cognizant of the implications of a caring touch. What we need is an awareness of our feelings as human beings. We need to experience the touch that releases the energy that can refresh, regenerate, and revitalize us whether we are well or ill. "In the hands of a person who understands, touch can sometimes be as effective as drugs or surgery." (55, p. 112).

We must learn that touch can be an effective means of nonverbal communication as long as it is acceptable to the touchee and the toucher, together with the understanding that it has a unique meaning to those involved (20).

I urge you to not only review some of the literature, but, more importantly, to experience the caring touch.

*"Reach out and touch
Somebody's hand
Make this world
A better place if you can."* (56)

References

1. Barr ML: *The Human Nervous System*, 2nd ed. New York: Harper and Row, 1974
2. Noback CR, Demarest RJ: *The Human Nervous System—Basic Principles of Neurobiology*, New York: McGraw-Hill Book Company, 1975
3. Williams PL, Warwick R: *Functional Neuroanatomy of Man*, Philadelphia: W. B. Saunders Company, 1975
4. Ayres AJ: *Sensory Integration and Learning Disorders*, Los Angeles: Western Psychological Services Corporation, 1972
5. Moore JC: Behavior, bias, and the limbic system. *Am J Occup Ther* 30:11–19, 1976
6. Leboyer F: *Birth Without Violence*, New York: Alfred A. Knopf, 1975
7. Gibson JJ: *The Senses Considered as Perceptual Systems*, Boston: Houghton Mifflin Company, 1966
8. Montagu A: *Touching—the Human Significance of the Skin*, New York: Columbia University Press, 1971
9. Frank LK: Tactile communication. *Genet Psychol Monogr* 56:209–255, 1957
10. Davis F: *Inside Intuition*, New York: The New American Library, Inc., 1973
11. Hall ET: *The Silent Language*, Garden City, New York: Anchor Press/Doubleday, 1959
12. Hall ET: *The Hidden Dimension*, Garden City, New York: Doubleday & Company, Inc., 1966
13. Gorney R: *The Human Agenda*, New York: Simon & Schuster, 1972
14. Jourard SM: An exploratory study of body accessibility. *Br J Soc-Clin Psychol* 5:221–231, 1966
15. Lomranz J et al: Communicative patterns of self-disclosure and touching behavior. *J Psychol* 88(2d half):223–227, 1974
16. Schutz WC: *Joy—Expanding Human Awareness*, New York: Grove Press Inc., 1967
17. Durr CA: Hands that help—but how? *Nurs Forum* 10:392–400, 1971
18. Goffman E. *Relations in Public*, New York: Basic Books, Inc., 1971
19. Mintz EE: Touch and the psychoanalytic tradition. *Psychoanal Rev* 56:365–376, 1969
20. Aguilera D: Relationship between physical contact and verbal interaction between nurses and patients. *J Psychiatr Nurs* 5:5–21, 1967

21. Burton A, Heller L: The touching of the body. *Psychoanal Rev* 51:122–134, 1964
22. Carvell P: The loving touch. In *Man and Woman. The Encyclopedia of Adult Relationship*, Vol. 1. London: Greystone Press, 1970
23. DeThomaso MT: “Touch power” and the screen of loneliness. *Perspect Psychiatr Care* 9:112–118, 1971
24. Fromm-Reichman F: *Principles of Intensive Psychotherapy*, Chicago: University of Chicago Press, 1950
25. Horner A: To touch—or not to touch. *Voices* 4:26–28, 1968
26. Linden JI: On expressing physical affection to a patient. *Voices* 4:34–38, 1968
27. Lowen A: *The Betrayal of the Body*, New York: Macmillan, 1966
28. Mercer LS: Touch: comfort or threat? *Perspect Psychiatr Care* 4:20–25, 1966
29. O’Hearne JJ: How can we reach patients most effectively? *Int J Group Psychother* 22:446–454, 1972
30. Pattison J: Effects of touch on self-exploration and the therapeutic relationship. *J Consult Clin Psychol* 40:170–175, 1973
31. Perls FS, Hefferline RF, Goodman P: *Gestalt Therapy*, New York: Dell Publishing Company, 1965
32. Rogers CR, Stevens B et al: *Person to Person—The Problem of Being Human*, New York: Real People Press, 1967
33. Rogers CR: *On Encounter Groups*, New York: Harper & Row, 1970
34. Seagull AA: Doctor don’t touch me, I’d love it! *Voices* 4:86–90, 1968
35. Searles H: Transference psychosis in the psychotherapy of schizophrenia. In *Collected Papers on Schizophrenia*, New York: International Universities Press, 1965
36. Spotnitz H: Touch countertransference in group psychotherapy. *Int J Group Psychother* 22:455–463, 1972
37. Stevens JO: *Awareness: Exploring, Experimenting, Experiencing*, New York: Bantam Books, 1971
38. Warkentin J, Taylor JE: Physical contact in multiple therapy with a schizophrenic patient. *Voices* 4:58–61, 1968
39. Krieger D: Therapeutic touch: the imprimatur of nursing. *Am J Nurs* 75:784–787, 1975
40. McCorkle R: Effects of touch on seriously ill patients. *Nurs Res* 23:125–132, 1974
41. Rubin R: The maternal touch. *Nurs Outlook* 11:828–831, 1963
42. Barnett K: A theoretical construct of the concepts of touch as they relate to nursing. *Nurs Res* 21:102–110, 1972
43. Dominian J: The psychological significance of touch. *Nurs Times* 67:896–898, 1971
44. Luckman J: What patient’s actions tell you about their feelings, fears and needs. *Nursing* 5:54–61, 1975
45. Burnside IM: Caring for the aged: touching is talking. *Am J Nurs* 73:2060–2063, 1973
46. Johnson BS: The meaning of touch in nursing. *Nurs Outlook* 13:59–60, 1965
47. Preston T: Caring for the aged: when words fail. *Am J Nurs* 73:2064–2066, 1973
48. Riehl J, Chambers J: Better salvage for the stroke victim. *Nursing* 6:24–31, 1976
49. Amacher NJ: Touch is a way of caring—and a way of communicating with an aphasic patient. *Am J Nursing* 73:852–854, 1973
50. Grad B: Some biological effects of the laying on of hands; A review of experiments with animals and plants. *Human Dimensions*, 52:27–38, 1975
51. Ruesch J, Kees W: *Nonverbal Communication*, Berkeley: University of California Press, 1956

52. Barthol RP, Ku ND: Regression under stress to first learned behavior. *J Abnorm Soc Psychol* 59:135–136, 1959
53. Hollender MH: The need or wish to be held. *Arch Gen Psychiatry* 22:445–453, 1970
54. Hollender MH et al: Correlates of the desire to be held in women. *J Psychosom Res* 14: 387–390, 1970
55. Gunther B: *Sense Relaxation—Below Your Mind*, New York: Macmillan, 1968
56. Ashford N, Simpson V: *Reach Out and Touch (Somebody's Hand)*, Hollywood, CA: Jobete Music Company, 1970