Six autumns ago, I entered the hushed quiet of the Sistine Chapel and gazed up at *The Creation of Adam*, Michelangelo’s magnificent fresco. I was mesmerized by the image of God reaching out to touch Adam, closing that final, tiny gap between their fingertips to ignite the spark of life. Lifting my eyes, I was surprised to feel a vibration deep inside my chest, a visceral ache, which I realized was my own longing for touch.

Looking back, I’m not surprised by the intensity of my response. It’s only natural. Touch is sometimes described as “the mother of all senses,” the first to develop in the embryo and the first to offer an experience of human connection. Bonding begins even before birth, when a mother places a hand over her stomach and the baby responds by reaching out to touch the walls of the uterus.

The need for safe touch continues throughout our lives. A recent study of 509 adults by Kory Floyd, professor of communications at the University of Arizona, found that people who suffered what he called “skin hunger” were more likely to experience loneliness, depression, anxiety, and immune disorders. Especially in this culture, relatively few of us get as much safe touch as we need. The United States may be among the most touch-averse countries in the world.

A now-classic study by psychologist Sidney Jourard observed friends from various regions of the world sitting together in a café. During the space of an hour-long conversation, French friends affectionately touched each other 110 times, while Puerto Ricans made physical contact an astounding three times per minute, for a total of 180 times. Now, get ready: in the United States, friends touched each other exactly twice. Only the buttoned-up Brits did worse—their touch score was zero.
Certain, our touch-avoidant culture plays out in the therapy room, literally and figuratively. When our clients in any kind of sustained, therapeu tic way. Outside of therapists who explicitly use body work in models such as Hakomi, most clinicians tend to avoid, or at least scrupulously limit, physical contact with clients. Such vigilance is understandable. Using touch in therapy is a complex issue, fraught with legitimate concerns about boundary breaches that could include anything from unwanted for shoulder-squeezing to overt sexual contact. For clients who’ve suffered harmful touch, the experience of safe, nonsexual physical contact may feel foreign and frightening. For many clinicians, touching a client may seem not only unethical, but loaded with potential for lawsuits and damage to their professional reputations. As a result, the notion of a therapist making a safe, therapeutic touch can feel dangerous for both parties. Even between a female therapist and a female client, touch rarely occurs at the start or end of a session. Seldom is it used as a fundamental, consciously chosen tool.

I believe we need to revisit and renew this taboo. For five years now, I’ve been using touch in my own practice, along with the insights of therapist, teacher, and author of the Polyvagal Theory, Stephen Porges. In my experience, physical contact can be a profoundly healing experience when approached with consciousness, sensitivity, respect, and mutual agreement. A clinician’s judicious use of touch can restore safety and support for the client. The parasympathetic nervous system, allowing an individual to connect with others with a new openness, and begin to change his or her life story from a powerless narrative to one of centeredness and readiness. To address this question, I’ll need to use a few neuro-nurturant terms, so bear with me. My aim is to delve into the particular body states, social cues, and interpersonal perspectives that help us feel lovingly held in another’s mind and heart—or can leave us feeling alone in the world.

A POLYVAGAL PRIMER

The fundamental premise of Polyvagal Theory is that human beings need safety, and our biology is fiercely devoted to keeping us out of harm’s way. As most therapists know, the term neuroception describes our ability to use cues from the environment to predict a state of safety and danger without any assistance from our thinking brains. For example, if you enter a loud, crowd ed party and see strangers huddled together, laughing, you may unconsciously pick up cues of rejection. In a micromoment, your sympathetic nervous system leaps into action, signaling you to turn around and leave the party posthaste, or perhaps head straight to the buffet and fill a plate. Just then, you notice one of the guests breaking away from the crowd and walking toward you. She extends her hand and introduces herself, her face open and welcoming. Almost instantly, your breath shortens, your heart rate goes down, and your body relaxes into the experience of Ah, I’m safe now! Your ANS has just guided you from a sympathetic state to a ventral vagal state, permitting what Porges calls your social engagement system to come down, become numb, and disconnect from others. A client who displays these symptoms has found refuge in a dorsal vagal state.

Importantly, these cues for safety and danger operate beneath our awareness. They are deep elements of our autonomic nervous system—ventral, sympathetic, and dorsal—acting as our largely subconscious surveillance system, working in the fully online. You’re now calm, ready to connect—and maybe initiate a new conversation.

POLYVAGAL-INFORMED THERAPY

From a polyvagal perspective, a key goal of therapy is to help the client find ways to move out of a dysregulated state—either a numbed-out “dorsal vagal” state, which helps us lower our defenses and shut down, or a hyperaroused “sympathetic” one—and return to “ventral vagal,” the biological state of safety and connectedness. And because we can change our dominant life story only from a place of ventral vagal, it’s crucial for both therapist and client to be able to accurately identify the state of their own nervous systems at any point in time—both in the therapy session and out in the wider world. When individuals are able to recognize their location on the polyvagal map, they can begin the journey back to their own nervous system at any point in time—both in the therapy session and out in the wider world. Importantly, client and therapist must become aware of their autonomic states. That’s because at times our rapid-response survival system will take over when a clinician and client establish a trusting nervous-system connection. Subconsciously, clients are continually picking up subtle cues from their therapist via tone of voice, eye contact, facial expressions, and body language, including such descriptors as openhearted, engaged, curious, and playful. I then ask my clients to complete their personal profiles by finishing two sentences for each state: “I am. . . . and The world is. . . .” Most clients are astonished by the dramatic difference between their personal profiles in each state. Each sentence can inform and deepen any clinical approach. I think of it as a kind of moment-to-moment awareness of the ongoing biological reactions of self and others that deeply influence the quality of the therapist-client relationship—and ultimately, a client’s ability to develop a more integrative and whole approach to life in the world. It’s an element of mindful- ness; ideally, it’s a tool for healing.

A POLYVAGAL APPROACH TO TOUCH

So from a polyvagal perspective, why use touch in therapy? Recall that earlier on, we introduced the concept of neuroception, which refers to the ANS’s perpetual vigilance scanning for cues of safety or danger, and our ability to pick up subtle cues of either being in dorsal vagal, which may include client, out of focus, numb, hopeless, helpless, exhausted, isolated, and unwound. Finally, they recall times of being firmly planted at the top of the ladder—the ventral vagal zone, where we experience inclusion, belonging, and trust, and the world is warm and cozy. I then ask my clients to complete their personal profiles by finishing two sentences for each state: “I am. . . . and The world is. . . .” Most clients are astonished by the dramatic difference between their personal profiles in each state. Each sentence can inform and deepen any clinical approach. I think of it as a kind of moment-to-moment awareness of the ongoing biological reactions of self and others that deeply influence the quality of the therapist-client relationship—and ultimately, a client’s ability to develop a more integrative and whole approach to life in the world. It’s an element of mindful- ness; ideally, it’s a tool for healing.

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here. Instead, the clinician must send nonverbal cues—tone of voice, body position, notions of gaze, possibly even gentle touch—to restore connection and help the client’s nervous system return to safety. I’ve found that all of these nonverbal cues of safety, touch can be especially effective, because it’s a direct and palpable experience of support. As Porges has said, feeling “safe in the arms of another” is among the most powerful routes to reestablishing an internal sense of well-being. Of course, using physical contact in the therapy room is an extremely delicate endeavor, since depending on a client’s history, touch may be among the most dangerous cues he or she can receive. So in this realm, I move slowly and carefully, making sure that the client is always in charge of the process.

I gently introduce touch from my first meeting with clients, via a handshake at both the start and close of the session. But I don’t explicitly introduce the topic of touch until clients have completed their initial personal profile map and we’ve discussed their nonverbal cues for safety and danger. At some point, I ask if they’d be willing to talk about how and how they’ve experienced it in the past. Have they had any intru- sive, harmful experiences? Any nur- turing ones? Right now in their life, what kinds of touch are definitely not wanted, and what kinds might be okay?

To facilitate this part of the conversation, I talk about the kinds of phys- ical contact that may evoke ventral vagal warmth, sympathetic distress, or dorsal ganglion shut-down. This “menu” includes examples of types of supportive touch I could offer, including (but not limited to) touching a client’s hand, touching palm to palm, placing my hand on the upper middle of a client’s back, and placing my knees on the floor following—a client’s knee, shoulder, upper arm, lower arm, or elbow. I explicitly explore the meaning of a hug, since a hug is a common request from clients and not always a welcome form of contact. We experi- ment with various kinds of touch on the menu to find out which ones they feel comfortable with and which they find dysregulating, and, using the ANS ladder as our guide, we create a touch map.

Based on this information, we make an explicit touch agreement, a written statement specifying which modes of touch feel nourishing, which ones we might carefully con- tinue to experiment with, and which ones we must avoid for now. Then follow- ing—a client’s knee, shoulder, upper arm, lower arm, or elbow. I explicitly explore the meaning of a hug, since a hug is a common

When clients are feeling something deeply, they often place a hand over their heart. I’ll echo this gesture, so they can see and feel that they’re not alone.
She's cur... Then I let out a deep breath, a sigh, for spiraling into a survival response. I told Sarah. I acknowledged to her way back to "sweetness." But I knew that I needed to acknowledge Sarah had just had a moment of mobilization, I told her. "Did you feel that on your end?"

When she nodded, I said, "I want you to know that it wasn't about you—it was my ANS responding to something in my own experience. I'm right here with you now, holding you in warmth and caring." Later, I'd talk with a colleague about why I'd gotten so mobilized, but now was the time to reestablish connection with my client. So I sat down next to Sarah on the couch and placed one hand gently on the mid-dle of her back. "My ventral vagal system is beginning to come back into regulation." After another few moments of silence, I said, "Feel the way our bodies are just slightly touching. Your system is regulating thought formed, Here we go again. That reaction was followed by unvoiced command, "Just see Sarah!" I felt an impulse to reach over and grab her to keep her from falling any further into the black hole. "Your nervous system is coming back into balance."

As Sarah slowly made her way from collapse back into connection, we continued to sit together silently for a few minutes, my hand still on her back for a bit and then we simply sitting side by side. Together, we savored the neuroception of safety that touch had created. Next, we brought explicit awareness to the experience, talking about the pathway back to her ventral vagal state. Sarah was amazed that touch had actually made a positive difference. I'm usually locked away in that mind that was stripped and idle, I said. "My friends try to talk to me when I'm in that place, and I know they're offering comfort, but their words don't feel strong enough to hold me." She paused, reflecting. "Your touching me was different. Your hand felt strong and gentle at the same time. My body felt . . . protected, somehow. I could feel you at the top of the ladder, kind of reaching for me. And I remembered that I have a place there, too."

As we continued our work together over the next hour, I labored to identify the number of resources for redirecting her nervous system when she was outside the therapy room. Among them were guided imagery apps, music journaling, and breathwork. But our use of touch continued to be an immediate and powerful way to interrupt and reframe the emotional energy of dorsal collapse and use my ventral vagal energy to help her find a sense of safety. Crucially, our work also enabled Sarah to shift her core narrative about touch from an inevitably harmful experience to a potentially healing one.

"I realize that my nervous system can respond like a normal person's," she said. "I'm not broken." She paused, and then added, "Touch might not always be safe, but now it feels not automatically dangerous." Sarah's new narrative was creating a healthy upward spiral: the more she operated from a sense of ventral safety, the more her nervous system could shift from default dorsal to something closer to default ventral. And the more flexible and calm her nervous system became, the more robust was her new, more empowering story.

**OTHER TOUCH**

Direct touch between client and therapist is only one way to generate the sense of safety that can help a client's nervous system begin to shift from dorsal to ventral. Other forms of touch, like soft touch, or touch that is just holding someone firmly, can be a sibling, a parent, or a close friend. But our use of touch must be intentional and skilled, and we must be able to hold each other's nervous system when we are out of the therapy room. Among them are the use of touch to continue to soothe ourselves, and the use of touch to soothe our clients in ways that feel safe and supported.

**SLOW DOWN**

So in addition to the therapist's use of touch, the client's own ability to slow down and settle is absolutely crucial. One of the best ways to help clients slow down is to teach them how to use the power of their own body and mind to create a sense of safety.

"I find that my nervous system can be a black hole for a long time," she said. "When I'm in that place, and I know they're offering comfort, but their words don't feel strong enough to hold me."

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