

# **Holding without Touch: Supportive Touch in Psychedelic-Assisted Psychotherapy**

Invited Commentary to “Supportive Touch in Psychedelic Assisted Therapy”,  
Neitzke-Spruill et al., 2025

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## **I. Introduction**

The role of touch in psychotherapy has been a topic of debate for several decades, now gaining renewed salience with the (re-)emergence of psychedelic-assisted therapy (P-AT), where altered states of consciousness and heightened vulnerability may seem to call for different forms of therapeutic contact. In their valuable contribution, Neitzke-Spruill et al. underline the potential for supportive touch to enhance therapeutic outcomes in P-AT, while also emphasising the importance of mitigating risks through proper training and standardised protocols. But even with standardised safety protocols, the screening out of unsuitable practitioners, and the presence of facilitator dyads, touch in P-AT may unnecessarily complicate an already complex therapeutic dynamic, particularly given that the benefits of supportive touch may well be achievable by other means. A key dimension for establishing how to make touch safer in P-AT will be determining how non-touch methods of comfort compare to touch in terms of therapeutic outcomes. Until we better understand whether touch offers unique benefits that cannot be achieved by other means, the field risks prematurely codifying practices that could complicate the therapeutic relationship without clear justification. This position should not be interpreted as 'anti-touch.' Rather, it acknowledges that the risks and complications of touch in P-AT may outweigh its

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potential benefits. This is especially true when considering the variety of less intrusive alternatives already established in therapeutic settings for providing emotional safety, grounding, and de-escalation.

## **II. A brief history of touch**

The role of touch in psychotherapy has a complex and evolving history, shifting from its early inclusion in clinical practice to a more cautious and debated application in contemporary settings. Contrary to common perceptions of psychoanalysis, Freud initially incorporated physical contact as a therapeutic intervention, supporting patients' heads and using massage to facilitate emotional expression (Breuer & Freud, 1957). Over time, as psychoanalytic theory and practice evolved, the inclusion of touch was largely abandoned in favour of focusing on transference dynamics, ego adaptation, and the creation of conditions necessary for personality development. The emergence of humanistic and experiential therapies in the 1960s broadened the therapeutic landscape regarding touch. These models downplay the primacy of transference and instead emphasise the potential for reparative and novel experiences within the therapeutic relationship. Humanistic and Gestalt therapists, in particular, advocate for the careful use of touch to enhance awareness, reduce defences, and improve relational capacities (Bonitz, 2008). Rogerian therapy recognizes touch as a reparative tool, while Gestalt therapy incorporates it as a technique to promote grounding and holistic healing (Perls, Hefferline, & Goodman, 1972).

Contemporary therapeutic models take more nuanced positions on the use of touch, with physical contact employed to develop therapeutic rapport, support affect regulation in behavioural work, and potentially even feature in facilitating cognitive change. In contemporary analytic practice, decisions as to whether *to touch or not to touch* within are governed by close attention to the meaning of contact - both conscious and unconscious- within the transference, accounting for early and ongoing attachment experiences, object relations, developmental impasses and ego strength. There is thus a clinical impetus to carefully consider the potential implications of touch

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and its potential meanings for the individual, rather than advocating for the presence or absence of touch itself.

### **III. Touch and the therapeutic frame in P-AT**

Undoubtedly, touch serves as a fundamental aspect of how we relate to both ourselves and others, embodying a core expression of human connection. In nursing and medical fields, the use of touch is normalised and often linked to positive patient outcomes, such as enhanced trust and reduced anxiety (Seskevich et al., 2004). Similar to its use in certain psychotherapy models, touch in healthcare settings is thought to promote patient comfort, potentially improving treatment acceptability and adherence.

Yet despite its value in medical contexts, there is no definitive evidence that touch systematically influences clinical outcomes in psychotherapy. While the quality of the therapeutic relationship is well-documented as a key factor in fostering change—often contributing more to therapeutic success than the specific model used (Norcross & Lambert, 2019)—research does not suggest that touch is inherently necessary for creating or maintaining a supportive therapeutic environment. Some therapists may incorporate touch based on a careful, individualised formulation of its potential benefits for the patient. Yet, the absence of touch in other therapeutic practices does not seem to hinder clinical outcomes (Bonitz, 2008). This suggests that across different psychotherapy models, both the therapeutic frame and clinical techniques can offer a form of "holding without touch," providing similar functions of grounding, support, and emotional containment (Mitchell, 2000).

### **IV. How touch complicates**

Beyond the serious concerns of boundary violations and the risk of re-traumatization, which Neitzke-Spruill et al. rightly emphasise, there are additional, subtler considerations that complicate the use of touch in P-AT. Practitioners must not only justify the usefulness of touch but also remain acutely aware of risks that extend beyond obvious “slippery slope” concerns around sexual transgressions. Touch, even when well-intended, may unintentionally obscure or inhibit the emergence of key

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therapeutic material that may otherwise be processed during integration sessions. In such cases, the application of touch may reflect more the clinician's anxiety and related urge to 'act' than the patient's exclusive need for physical contact.

Alterations to sensory processing, as well as to relational meaning-making, render judgments about the wise use of touch in P-AT particularly challenging. In any psychotherapeutic relationship, we would do well to bear in mind that some patients may want to please their therapists, or harbour fears of abandonment or rejection. Such dynamics may lead patients to accept or even request touch that they later experience as boundary-violating, making it crucial that therapists not mistake apparent consent for genuine therapeutic indication. In psychedelic states, even minimal physical contact may be experienced with amplified intensity or imbued with heightened meaning over and above that which is therapeutically necessary or beneficial. While research has begun to demonstrate that attachment history influences psychedelic phenomenology (Cherniak et al., 2024), we are only beginning to understand the interplay between the attachment system and the altered states of consciousness at the centre of P-AT. This uncertainty only adds to the complexity of navigating informed consent in this context: *what it is like* to be in a radically altered state of consciousness is epistemically inaccessible before experiencing it (Jacobs, 2023), and likewise *what it is like to be touched* in that state may be hard to anticipate. This unpredictability further complicates the judicious use of touch, with the risk that it is misinterpreted or has unintended consequences, even beyond that which might otherwise be anticipated in the transference by a relationally-skilled practitioner.

Adeptly navigating these considerations is a serious challenge for any clinician, and given the risks that accompany touching a patient in a heightened state of vulnerability, practitioners must also seriously consider whether the desired outcomes can be achieved by lower-risk, non-touch methods of support. In contemporary clinical practice, particularly within settings where therapeutic approaches are regulated and standardised, most psychology and psychotherapy clinicians have experience of

providing emotional containment without employing physical touch, including to patients in states of high distress.

**V. *Holding without Touch: Alternatives to Physical Contact***

Fostering and maintaining psychological safety is a critical element of any psychotherapeutic intervention, and this is especially true in P-AT. However, the therapeutic relationship in psychotherapy differs significantly from both medical settings and non-clinical contexts, where touch may be more commonly used.

While physical touch may support emotional containment, alternative methods can be effective in creating a safe and supportive environment. Neitzke-Spruill et al. have already highlighted the potential of tools such as pillows and weighted blankets to offer comfort without direct contact. In the context of P-AT, these tools can provide a non-intrusive sense of security. Additionally, there are many existing strategies that can be adapted for use in the P-AT setting, helping to create a non-sterile, therapeutic space that fosters safety and emotional support without the risks associated with physical touch (see table 1 for examples). While we endorse Neitzke-Spruill et al.’s position that application of touch in P-AT must be preceded by empirical and ethical inquiry, such research must be set in the context of its risks and benefits *relative to non-touch methods of support*.

Non-Touch Support Method	Clinical Application and Rationale
<b>Intermediate tools to support physical connectedness without direct touch</b>	E.g., Use of a rope or scarf held at either end by practitioner and patient, through which intermittent grounding contact can be initiated by a non-verbal ‘tug’ from the patient or therapist. Provides physical connection while maintaining boundaries; allows patient control over engagement level; offers

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Non-Touch Method	Support	Clinical Application and Rationale
		non-verbal communication channel during intense experience.
<b>Grounding techniques</b>		Systematic orientation to present-moment sensory experience (e.g., name five visible objects; track breath) to manage overwhelming states of mind, dissociation, visual experiences, memories. Can be practised pre-session to build competence and confidence.
<b>Imagery techniques to contain acute distress</b>		E.g. co-development of safe space imagery and compassionate nurturer imagery prior to drug session for use if external grounding techniques are compromised from sensory overwhelm.
<b>Judicious application of sensory self-soothing techniques</b>		With tool choice guided by findings from sensory profile questionnaires in pre-drug administration phase (e.g., determining the use of light, sound, smell, texture, pressure from weighted or unweighted blankets etc.). Must account for potential shifts in sensory processing, requiring flexible application and ongoing monitoring of effectiveness.

Table 1. *Non-touch methods of comfort and support employed in (non-psychedelic) psychotherapeutic practice*

## VI. Conclusion

We commend Neitzke-Spruill et al. 's careful consideration of protocols to mitigate the risks of touch in P-AT. How to make supportive touch safer in P-AT may be a key question in the field. But just as fundamental, we argue, is whether it serves a

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necessary therapeutic function that cannot be achieved by other means. Crucially, we urge caution in extrapolating the use of touch from other healthcare settings to P-AT without accounting for transference issues which may form an important feature of therapeutic material. The altered states of consciousness induced by psychedelics can significantly change the experience of touch, potentially amplifying or distorting its effects in unpredictable ways. Moreover, given the success of other modalities in providing emotional containment with non-touch methods, we should not discount the value of developing and refining non-touch techniques within P-AT that can provide the necessary support and containment.

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