Touching, Encounter & Group Psychotherapy:

Personal Memories of an Old Therapist

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"Exploring the Use of Touch in the Psychotherapeutic Setting: A Phenomenological Review." (2009). The author presents a number of personal perspectives derived from 43 years of practice. It includes empirical findings regarding patients' attitudes toward touching, as well as practical guidelines regarding physical contact in psychotherapy. The paper concludes with a long vignette illustrating the nature of the psychotherapeutic encounter.

KEYWORDS: Touching; individual psychotherapy.

INTRODUCTION

My attitude toward physical expressions of support may be better understood within the context of the changing culture in the United States as well as changes in the psychotherapeutic community. Fifty years ago, physical contact—especially between members of the same sex—was rare and often considered improper. It was sad to witness fathers and sons, or close friends, embarrassed and tense, when aware of affection for each other. It was incongruous to see them limit the display of such affection to a handshake or a fake punch on the arm or shoulder. Later, while serving in the armed forces, I experienced that same sadness and emptiness when witnessing the visiting families of my friends, who left with tears in their eyes but without embracing. I often wondered if the tears were not only because of the pain of separation but also because they could not share their love for each other in a complete manner.

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LEARNINGS AND OBSERVATIONS

I learned what every therapist already knows, that is, how important a human touch can be.

When one is lonely and afraid, feels unloved and unlovable, a simple touch can be the life-saving bush stopping one's fall into a precipice.

More than 30 years ago, I was working with a bright, tough medical resident. Nobody knew that he suffered from incapacitating anxiety. He obstinately refused to try medication, and his attacks became more frequent and severe. During one of our meetings, he seemed to withdraw and shrink within himself, and I spontaneously put my arm on his shoulder. As I did so, I noticed tears coming down his face. This was one of the two times that I saw him cry, and that session was a turning point in his therapy. He later joined a group, and that is when I saw him cry for the second time. The event was so moving that I wrote about it in the form of a poem to be included in a collection of memories:

> We were sitting in a circle and the tall man spoke. He said: "My grandfather died three days ago, and I held his hand. I told him that I loved him and would miss him very much. He squeezed my hand and smiled. He died later that night. Had it not been for you, my friends, I could not have told him. Thank you!" And he cried.

I also learned that, needed and desired as a touch can be, it can also be terrifying for someone who has never experienced human warmth. A week after a marathon group of Catholic Sisters, I received the following letter from one of the participants:

> I was so terribly jealous when you hugged Sr. Corinne. Nobody, ever, had hugged me or ever held me as a baby. At the same time, I was sure that if you had touched me, I would have died or would have turned to stone.
>
> And then, when we did that psychodrama about my father, you put your hand on my shoulder, and I did not die. On the contrary, it felt so warm, and I wanted you to leave your hand on my shoulder for ever and ever.

I have also learned that to reach for someone in pain and be rejected, to extend love and see that love spurned, can be a painful experience. It is a fact of life that to reach for another person can be risky and scary. At the same time, it can be rewarding, exciting, and a marvelous challenge:

> The group that evening was in a somber mood, and suicide was the topic of conversation. To various extents, most group members owned to having entertained, at one time or another in their lives, fleeting fantasies of self-destruction. Patrick, a group member in his early 40s, who had remained silent until then, spoke one single sentence: "I still

do." The group was jolted. Indeed, Patrick, a much-liked member of the group, was a priest. Under the group's gentle probing, Patrick revealed his extreme loneliness, his tiredness at having to do so much for so many while there was no one he could turn to, no shoulder he could lean on, no one with whom he could be weak. The group's verbal expressions of support seemed to serve no purpose. Patrick accepted them with a sad little smile that bespoke gratitude. It was evident, however, that all the group's efforts were in vain in shaking his feelings of loneliness and futility. It was one of these rare times when the "content" of the interaction could not be dealt with by the group, and I decided to take an active part in what was happening. The following interaction, then, took place:

Tina	Why would he want to die? He had so much to live for. So much to give.
Joe	I am going to miss him so much.
Jane	Whenever something would bother me, whenever I felt hopeless, it was enough to know that he would be here and I'd immediately feel better.
Tina	We all loved him so much.
Liz	But we never really told him.
Therapist	Liz, if by some miracle, he could come back to life, would you tell him?
Liz	(cries, then, in a very soft voice): Yes, I would.
Therapist	Try it.
Liz	(she kneels by Patrick, raises his head and holds it against her chest, gently rocking it, crying and saying over and over again): We love you Patrick ... we love you.

At that moment, I began to turn the rheostat light up and features again became distinguishable. Patrick seemed transfigured, his eyes wide open and shiny. He was crying and kept repeating as a refrain, "They love me, they love me ... I made this happen, I made this happen ... ."

During the preceding scene, Paul, a brilliant, somewhat aloof young man, had remained silent. Paul had been with the group for several months, and although respected by everyone, no closeness had developed between him and the rest of the group. As Patrick stood up, Paul went toward him and, without a word, embraced him. The group was quite astonished because that behavior was so uncharacteristic of Paul. He held on to Patrick for a long while, then turned toward the rest of us and said, "For a long time, I wanted to tell you all how much you all mean to me, but I was afraid that you wouldn't understand." Then, after a moment of silence, he added, "It's the first time in my life that I've hugged a man and, by golly, it feels all right."

Note: Several years after the above group session, I ran into Patrick and told him of my intention to write a book on group therapy. He reminded me of his "death" and asked that I include the episode in the book. He called it a "very important event in my life."

I learned that the therapist who wishes to offer a supportive touch must be comfortable with physical contact. Discomfort at touching someone while forcing oneself to do so is always discernable. The gesture of support loses its significance, may be experienced as patronizing and even become damaging in that the recipient may lose trust in the therapist. If uneasy about physical contact, the therapist is much better off abstaining altogether. His or her warmth and care, if genuine, will become apparent anyway.

I learned to accept the fact that the therapist derives gratification from providing support. We must always be sure that while we accept the fact that we get some gratification from providing a supportive touch, the primary motivation must always be the welfare of the patient. I acquired a few additional learnings more specific to group than to individual therapy.

In a group, the therapist serves as a model. It is of the utmost importance that the therapist promote and establish the kind of milieu within which group members feel free to follow or not to follow the therapist's example and still feel certain of being fully accepted by the group and the group leader.

A related learning is that, having provided the necessary example, the therapist must *never* preempt group members who choose to become supportive.

I learned the obvious, that is, that the therapist is endowed by his or her patients with quite imaginary powers. His or her verbal and nonverbal behaviors acquire much greater significance than that of group members. Therefore, while I believe that a therapist must not shrink away from genuine physical expressions of support, he or she must use them very sparingly.

I learned that, in a group, there can be instances when active encouragement of a physical expression of support is appropriate. Such encouragement, however, must be given cautiously, gently, and only when there is no doubt in the therapist's mind that it is desired by the giver and the recipient:

> Francine was a young woman who had recently lost a mother to whom she was very attached and so she spoke of her loss. The intensity of her pain and grieving was evident and moving. Laurie, another woman of approximately the same age, listened intently, bringing her pillow close to Francine's. There were tears in her eyes, but she stood rigid, with her hands in her lap. I leaned behind Laurie, took her hand and, very gently, placed it on Francine's shoulder. Laurie turned to me and smiled. Francine reached over her shoulder and held Laurie's hand while she continued to talk. At the end of the session, Laurie, turning to me, said, "How did you know I wanted to do that?"

I learned, of course, that physical contact is not always associated with pain and sadness. Affection, joy, gratitude, even levity can be translated into physical exchanges. I have fond memories of clients hugging me and saying "thank you" as

they terminated therapy or as a happy event brightened their lives. I always remember the following incident with a chuckle:

> Guillermo, a South American member of the group, was a rather straight-laced and conventional gentleman. Another group member, Deborah, a lady in her early 40s, was even more conventional than Guillermo and was very gifted as a *raconteuse*. She was reporting a rather funny incident with her usual talent and Guillermo impulsively said, "This is beautiful. I want to give you a kiss on the cheek." Deborah looked puzzled and said, "Huh?" while the group burst out in uncontrollable laughter. To fully appreciate the flavor of Deborah's expression and her puzzled "Huh?" one must remember that Guillermo's English, although flawless, was quite accented. His "kiss on the cheek" came out as "kees on the chick." Deborah joined in the laughter and, good naturedly, presented her cheek to Guillermo, a gesture that would have been unthinkable for her under different circumstances.

Perhaps one of the most important learnings that I acquired is that there are times when a person hurts so much, is in so much pain, that he or she folds within and no expression of support or love can penetrate the numbness—or, at times, the acute intensity of the pain. At the risk of using a cliché, I will say that one must first embrace, taste, face the pain demon by oneself before being able to respond, to resonate to any kind of support, verbal or nonverbal. This is illustrated by the story of Nancy, one of my most poignant memories of my life as a psychotherapist.

Nancy, an attractive 42-year-old, had managed to overcome a deprived childhood and the early death of her mother, had raised a much younger sister, and put herself through college and graduate school. She had married a man with whom she had spent some very miserable years and divorced him shortly before the group session during which this incident occurred. Nancy, who had been with the group for several months, arrived at the session and, contrary to her usual behavior, greeted no one and sat in silence (the group room had no chairs but comfortable pillows on the floor). After some superficial exchanges, a group member turned to Nancy and asked if something was wrong, and, in a very flat tone of voice, Nancy informed us that she had been to two physicians and that both had diagnosed breast tumors and suggested a double mastectomy. The group was stunned. After several minutes of silence, there was a warm outpour of sympathy, concern, and expressions of sadness and fear. Nancy remained immobile and silent, impervious to whatever was being said. I reflected on Nancy's silence, stating that sometimes the hurt is such that it numbs. The group became silent again. After several minutes, I remarked that there is nothing more frustrating than to witness a frightening thing happen to a person close to us. I also wondered what fantasies each of us might have regarding the fact that we all were vulnerable. My comments had no effect on the silence. After a while, it felt as if the group was descending into a spiral of depression and I decided that some action, in addition to just dealing with the group process, was called for.

The following interaction took place:

Therapist: You know, Nancy, life is sometimes like Penelope's tapestry. Do you remember the legend of Ulysses and Penelope? He was gone to the wars of Troy and when he did not return, the courtesans wanted Penelope to marry. She accepted but asked them to wait until she finished weaving her tapestry. She, then, would spend her days weaving and, at night, would get up and undo her work of the day. You busted your ass getting through school, raising your kid sister, putting up with all that shit your husband has been giving you for years and now that you can see daylight and are beginning to enjoy life, this is what happens.

Nancy nods in silence.

Therapist: You know what I want to ask you to do? Imagine that all those who undid your tapestry are there, on that pillow: fate, doctors, illness, husband, whatever. Talk to them and tell them what is going on inside you right now.

Nancy: (in a very low tone of voice): I feel … I feel I want to talk to my mother.

Therapist: Go ahead.

Nancy: Mom, Mom … I need you. Why did you leave me? Why? I need you so much …. (Her voice trails off and stops.)

Therapist: Nancy, I … I feel like this very minute you wish you were dead.

Nancy nods.

Therapist: It's all right, Nancy. Why don't you go into that corner and let yourself die for as long as you want to. Then, you will be ready to come back to life and you will join us.[1]

Nancy stands up, goes into a corner, and rolls herself up into a fetal position.

By that time, dusk had come and no one had made an effort to turn on the lights. The group members silently began to move and formed a tight ring around Nancy. No one said a word, no one reached for or touched her. It was as though by some miracle of subliminal communication, they all sensed that Nancy had to taste alone the depth of her loneliness and despair before being able to recognize and accept love.

After what seemed to be an eternity but was, actually, no more than 12 to 15 minutes, Nancy raised her head and was startled by the physical closeness of the group. She was directly facing a male member; he almost instinctively opened his

[1] Any variations of a scene involving the protagonist's death are potentially dangerous. The therapist must be thoroughly aware of each group member's ego strength as well as the ego strength of the group as a whole.

arms and Nancy flew into them and burst into sobs. The other group members gathered around, put their arms around her and held her and rocked her like a baby. After a while, the tears subsided, Nancy smiled and said, "I'm all right now, I am fine." A pall of gloom seemed to have been lifted, and the group settled to discuss Nancy's condition in a practical and matter-of-fact fashion.

Note: Nancy, upon the advice and with the encouragement of the group, went to a nationally known specialist. Her breast tumors turned out to be benign, and Nancy did not have her breasts amputated. While I do not wish to make a dogmatic cause-and-effect statement, I wonder if Nancy would have been motivated to seek a third opinion were it not for the session that lifted her out of her despair.

EMPIRICAL FINDINGS AND GUIDELINES FOR TOUCHING

These learnings were acquired over time and I tried, of course, to apply them to my practice. In the process, I devised some simple guidelines about touching in therapy. They have helped me and, perhaps, will help others. Before listing them, however, I will present some empirical findings which I incorporated into my guidelines.

Empirical Findings

The fall 1969 fall issue of *Psychotherapy, Theory, Research and Practice* contained a flurry of articles dealing with the issue of touching in psychotherapy (Forer, 1969). These articles will not be discussed or summarized here except to point out that not only do opinions widely diverge, but well-known, reputable therapists have, over the years, modified their attitudes and ways of thinking on the matter (Mintz, 1972). All these articles had one feature in common: Knowledgeable and sensitive as the expressed opinions were, they reflected the authors' points of view. None of the writers had chosen to explore the opinions and points of view of the patients themselves.

Spurred by that realization, I mailed a questionnaire to 23 individual patients who had terminated therapy for at least six months but for no longer than one year, and who had been in therapy for at least one year.

A Questionnaire: The Voice of the Patients

Method:[2] A questionnaire was mailed to 23 patients, accompanied by an explanatory letter and a self-addressed stamped envelope. Participants were requested, of course, to maintain the anonymity in their replies. The questionnaire had three parts: The first part attempted to tap the respondent's feelings and attitudes toward physical contact. The second and third parts dealt

[2] It is interesting to note that my practice at that time was constituted almost entirely of female patients. Since then, for the past 25 years, however, 55% of my patients have been men. There are many reasons for this welcome change in patient population, but I believe that it is primarily due to the feminist movement, which liberated men from cultural inhibitions around seeking psychotherapy.

with the fantasies of the clients and their perceived changes as a result of therapy. They will not be discussed here except to state with some satisfaction that 18 of 19 respondents felt that they had reached most of their goals in therapy. A reproduction of Part I of the questionnaire follows:

Touching, Encounter & Group Psychotherapy Questionnaire

Age: _______ Sex: _______ Background: ________________________________
____

Until recently, communication between therapist and client has traditionally been of a verbal nature. Comfort, reassurance, support, and so on was provided through words only.

Recently, some psychotherapists have advocated the use of nonverbal communication in addition to the verbal interaction. They feel that comfort or support can better (or equally well) be expressed by a gesture, a physical contact, a gentle touch at a moment of crisis or despair.

Both schools of thought present good theoretical and practical reasons for their positions. The purpose of this questionnaire is to find out the feelings and attitudes of clients themselves regarding the two questions below.

While this is obviously quite difficult to do and will necessitate a great deal of remembering and introspecting, try to answer the following questions not as you feel now but as you would have felt, then, while you were in therapy.

Your help will be greatly appreciated.

1. If during therapy, at times when I was feeling particularly lonely or depressed—at a time of crisis or despair—my therapist had reached for me and touched me in some way:

   I would have felt (PLEASE CHECK ONE OF EACH FIVE CHOICES):
   ☐ a. Very reassured ☐ b. Reassured ☐c. No different ☐ d. Worried
   ☐ e. Very worried
   I would have also felt:
   ☐ a. Very relaxed ☐ b. Relaxed ☐ c. No different ☐ d. Tense
   ☐ e. Very tense
   I would also have felt:
   ☐ a. That he liked me a lot ☐ b. That he liked me
   ☐ c. That his feelings about me were neutral ☐ d. That he disliked me
   ☐ e. That he disliked me a lot
   I would also have felt:
   ☐ a. That he trusted me a lot ☐ b. That he trusted me ☐ c. No different
   ☐ d. That he distrusted me ☐ e. That he distrusted me a lot
   I would also have felt:
   ☐ a. Like a very worthy person ☐ b. Like a worthy person ☐ c. No different
   ☐ d. Like an unworthy person ☐ e. Like a very unworthy person

2. Please write in your own words (saying whatever you would like to say) what you think or feel about nonverbal communication in therapy; how could it

have affected your own therapy and relationship with Dr. Naar, and how could it have affected your therapy and relationship with a different therapist.

RESPONSES: RESULTS

Results: Two of the questionnaires were returned, the addressees having moved without leaving a forwarding address. Nineteen of the remaining 21 clients answered, and their answers are summarized below.

Summary of Responses

Question 1. If during therapy, at times when I was feeling particularly lonely and depressed—at a moment of crisis or despair, my therapist would have reached for me and touched me in some way, INSTRUCTIONS: (PLEASE CHECK ONE OF EACH FIVE CHOICES). There was a total of 65 positive, 20 neutral, and 10 negative responses.

Question 2. The answers to the second question, however, were puzzling. All 19 respondents, without exception, agreed that a physical contact as described in the questionnaire would be helpful; yet, in discussing their own therapy, they split into groups. The first half stated that had I resorted to a physical gesture, our relationship and the therapeutic process would have been damaged. The other half wrote that both the relationship and the therapeutic process were enhanced because I had used physical contact. Quoted below are two sample comments; the first comment reads as follows:

> This is a difficult question. I feel so much more secure now than I did at the time of my therapy. As I think about the possibilities of nonverbal communication from others, it seems as though it would be an invaluable way of relaying the trust and true concern of the therapist for the patient. I do, however, think that in my case it would have injured my relationship with Dr. Naar. During that time I was very insecure and my feelings for Dr. Naar were not clear. I wanted to be very important to him. He gave me that feeling without reaching for me or touching me. A touch would have confused me or given me doubts about his sincerity. He worked much longer and harder with words and kindness. This effort convinced me that I must be a person worthy of this labor. I am a woman. If my therapist had been a woman (and if I liked her), a touch would have been a reassuring experience.

The second comment is quoted below:

> The nonverbal communication used by Dr. Naar was often the most meaningful part of my sessions with him. His facial expression of deep concern immediately made me feel comfortable. His eyes have a way of saying everything from "You can trust me" to "I think you are a good person." On several occasions when I became tearful and was feeling tremendous emotional pain in expressing some very deep thoughts, Dr.

> Naar drew his chair closer to me and held my hand. It was a much longed-for experience but one I had never had except from my husband. It was something I had always wanted from a parent figure and never got. For the first time in my life, this physical reassurance and closeness made me feel like it was okay to cry and that, in the process, I wasn't behaving like a child. Termination was an extremely difficult time for me because I didn't want to let go of what I felt had become a deeply meaningful relationship, not only for me but also for Dr. Naar. He really made me feel that he enjoyed seeing me as much as I enjoyed seeing him and that both of us were learning through the encounter. On our final meeting, he gave me a handshake and a hug, which I'll never forget because it said without words that he was sharing in the excitement of my changing self and that he would always be there if I felt the need to come back.

Reflections. The puzzle was somewhat clarified when I checked the periods during which the respondents had been in therapy. Approximately one half of the respondents had been in therapy during the first 10 to 15 years of my career. The opinions and feelings of that first half were similar to the first comment quoted above. During that period of my professional life, I considered even a handshake to be totally inappropriate. The second half of the respondents had come into treatment when the psychotherapy *zeitgeist* was changing. I had begun attending encounter groups both as a member and as a learning experience. I became strongly attracted to some of the tenets of humanistic psychology and my attitude toward touching began to change, both toward men and toward women. Having been raised in a Mediterranean country where physical contact was part of everyday life, it was easy to revert to my old ways of communicating. The way in which my experiences affected the answers of my patients will be discussed below.

The overwhelming positive answers to the first question clearly suggest that clients may not have the same aversion as therapists to a gesture of friendship or support. In fact, the dogmatic attitude of some therapists in their blank indictment of any kind of physical contact may represent their own fear and discomfort rationalized under the guise of concern for their patients.

The responses to the second item of my questionnaire strongly imply that my attitudes were sensed by and affected my clients. During the years when I considered touching an absolute taboo, my clients felt that such an experience would be damaging to our relationship but would be beneficial to other people. When I felt more comfortable with this mode of communication, my clients felt that it had been of help to them.

A good way to summarize the above is to remember that joy and levity, sadness, grief, pain, happiness, affection, and support can all be expressed in so many different ways. Each therapist may use all these ways or only the one with which he or she feels comfortable. No mode of expression, however, if used appropriately, honestly and with respect for the other person, should be forbidden or avoided; it is also good to remember that *the more levels at which a message is communicated, the clearer the message becomes*.

GUIDELINES FOR TOUCH

As stated above, the experience and learning which I have accumulated led me to the formulation of the following guidelines:

1. Physical gestures of support and affection are desirable and should be encouraged. Indeed, they represent an important mode of communication of which people should not be deprived.
2. Such expressions should be limited in scope. More extensive physical contact could easily become erotic and be used for the sexual gratification of the giver rather than being an expression of support or affection for the recipient. Erotic physical contacts are seen as unequivocally unethical behavior on the part of the therapist.
3. Physical (as well as verbal) expressions of support or affection should be used only when they are meant and never in a ritualistic, mechanical, or manipulative fashion.
4. The therapist must be comfortable with physical contact. Discomfort at touching is discernable, and the gesture of support may lose its significance and even become damaging.
5. Because of the importance that the therapist acquires for the patient, physical expressions of support must be used sparingly. In a group, the therapist will never preempt group members who are willing and able to offer the same kind of support and affection to the person in need.

I reserved for the end what I consider, perhaps, the most important learning that I and, probably, all my fellow therapists have acquired in our work with people: I learned that I receive more than just the joy, the satisfaction of helping another person. I experience something more subtle and more profound, something that transcends just one person but is derived from a genuine encounter between two human beings, a brief sharing of the same reality, a mutual rather than unilateral unconditional acceptance and empathy (Rogers, 1961); perhaps what Moreno meant by "tele" (Fox, 1987). The story of Christine[3] that follows best illustrates a concept difficult to define operationally.

CHRISTINE'S LAST GIFT

I was in my mid-40s when I met Christine. I am now nearing 87, but my memory of her is as vivid as it was 41 years ago. I hadn't thought of her for a long time until Koocher's (2006) moving "APA President's Column" brought back to me the many memorable hours I spent in Christine's company. Dr. Koocher drove home a point that therapists of my generation have always known, what research-oriented young therapists have long forgotten, but which is being gradually rediscovered (Naar, 1970, 1981; Norcross, 2005). The point, to use Dr. Koocher's own words, is that " … the ability to form an emotional connection and forge an alliance with the client will

[3] "The Story of Christine" was initially published in *The Pennsylvania Psychologist* in 2008 and is included in this article with the permission of the Pennsylvania Psychological Association.

create a far stronger foundation for change and quality of life than any treatment manual validated by a plethora of randomized clinical trials."

To this, I would like to add that when a human being truly encounters another, the richness generated flows both ways. Hence, the story of Christine.

I met Christine while she attended a graduate course in Personality Assessment, which I was teaching at the University of Pittsburgh. I can still see her, blond, blue-eyed and freckle-faced, sitting in the front row and listening intently to what I was saying. She was exceedingly bright and often challenged me in such a good-natured way that I always looked forward to her challenges and fine sense of humor.

At the end of the course, Christine came to see me and asked if I would accept her as a patient. Since I was an adjunct professor, teaching only one course—and with the consent of my Department Chair—I was only too glad to say "yes."

Christine had no psychological problems, at least not in the sense of the DSM IV. She was not psychotic, depressed, or obsessive-compulsive. She had no personality or character disorder and had been raised within a warm and loving family. Christine was going to die.

She was afflicted with a rare but fatal skeletal-muscular disease. She had made her peace with the fact that she would never have a normal life and that her death was imminent. She had not accepted the fact, however, that she would not achieve the things that she wanted to do, although her impending death never prevented her from starting them. She wanted to write children's books, she wanted to be an advocate for the handicapped. She was enraged at the realization that she would not ever complete her projects. Christine could not accept the time limitations of death.

For the best part of two years, we met once, often twice weekly. We would talk, philosophize, argue, laugh and, sometimes, cry together.

I became very angry once. She came to our session with tears in her eyes and, eventually, blurted out that she had been refused service at a select restaurant and she was certain that is was because of her appearance. There was no doubt in my mind that she was right. Christine had a gentle and pretty face, but her body was deformed. One of the symptoms of her condition was a severe scoliosis, resulting in an unusual gait. I became instantly furious and, in spite of her protestations, we went to that restaurant and had lunch. I noticed a certain annoyed expression on the faces of the waiter and the maître d' but not a word was said.

I wondered often if I should have helped Christine process and accept her pain, anger, and sense of rejection. At the time, and even now, the idea seemed and still seems ludicrous. Christine was going to die, and what she needed was the feeling that she could, even once, prevail upon a society sometimes hostile, sometimes rejecting. She said as much when, upon returning to my office, she grumbled, with a glint in her eyes, "That will teach them."

I said "no" to Christine only once when she asked me to meet her parents. Christine was born in Germany and came to the United States at the age of 12. I am a concentration camp survivor with everything that this title implies. I was aware of Christine's German ancestry but, somehow, I never gave it a thought and

it did not matter. I could not, however, bring myself to meet her parents. Christine had told me that her father had been in the German army and, for all I knew, he could have been an SS soldier or a concentration camp guard. This was also the only time I lied to Christine by making a lame excuse for not meeting her parents. I am sure, however, that with her marvelous intuition, Christine understood, for she never brought the matter up again.

The Gift

Almost two years into our therapy—friendship—Christine died, and I went to her funeral. Her parents, of course, had heard of me. Her father came toward me. He wanted to speak but couldn't. Tears were streaming down his face. He opened his arms. I opened my arms and we hugged . . . and, at that moment, there was no German soldier, no Holocaust survivor. There were two men . . . one crying over the death of a daughter and the other over the loss of a friend.

This was Christine's last gift to me.

Endnote

Patients' choices listed in order below the following questions.

I would have felt:

a. Very reassured b. Reassured c. No different d. Worried e. Very worried

Numbers of Responses

a. 3 b. 10 c. 4 d. 0 e. 2

I also would have felt:

a. Very relaxed b. Relaxed c. No different d. Tense e. Very tense

a. 1 b. 11 c. 0 d. 5 e. 2

I also would have felt:

a. That he liked me a lot b. That he liked me c. That his feelings about me were neutral d. That he disliked me e. That he disliked me a lot

a. 6 b. 10 c. 3 d. 0 e. 0

I would also have felt:

a. That he trusted me a lot b. That he trusted me c. No different d. That he distrusted me e. That he distrusted me a lot

a. 2 b. 10 c. 7 d. 0 e. 0

I would also have felt:

a. Like a very worthy person b. Like a worthy person c. No different d. Like an unworthy person e. Like a very unworthy person

a. 3 b. 9 c. 6 d. 1 e. 0

REFERENCES

Forer, B. R. (1969). The taboo against touching in psychotherapy. *Psychotherapy: Theory, Research & Practice, 6*(4), 229–231.

Fox, J. (1987). *The essential Moreno*. New York, NY: Springer Publishing Co.

Koocher, G. P. (2006). On being there. *Monitor on Psychology, 37*(4), 5.

Mintz, E. E. (1969). On the rationale of touching in psychotherapy. *Psychotherapy: Theory, Research & Practice, 6*(4), 232–235.

Naar, R. (1970). Client-centered and behavior therapies: Their peaceful co-existence: A case study. *Journal of Abnormal Psychology, 76*(2), 155–160.

Naar, R. (1981). Psychotherapy: A non-school approach. In C. J. Golden, S. S. Alcaparras, F. D. Strider, & B. Grober (Eds.), *Applied techniques in behavioral medicine* (pp. XX–XX). New York, NY: Grune & Stratton.

Norcross, J. D., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration*. New York, NY: Oxford Press.

Phelan, J. E. (2009). Exploring the use of touch in the psychotherapeutic setting: A phenomenological review. *Psychotherapy: Theory, Research, Practice, Training, 46*(1), 97–111.

Rogers, C. (1961). *On becoming a person*. Boston, MA: Houghton-Mifflin Co.

Zeldow, P. B. (2009). In defense of clinical judgment, credentialed clinicians, and reflective practice. *Psychotherapy: Theory, Research, Practice, Training, 46*(1), 1–10.