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In This Issue:

DISDAIN: ITS DESTRUCTIVE ROLE
IN RELATIONSHIPS,
AND ITS TREATMENT



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A STATEMENT OF PURPOSE

This journal is part of The Bar-Levav Educational Association's (BLEA) general program to advance the science of psychotherapy and the understanding of the hidden forces that shape individuals and societies. Such an understanding is derived from our clinical work and is useful in the ongoing treatment of patients. Additionally it has been found to have wider implications in practically all areas of human endeavor.

Learning to think critically requires first that we make room for it by diminishing the domain of feelings. These have the power to bend thinking and to distort one's view of reality.

The ability to think critically develops only in the absence of fear and with freedom from the dictatorship of other feelings. The *Journal* is dedicated to examining psychotherapy and human behavior and motivation with the yardstick of critical thought.

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All articles reflect the point of view of the respective writers. They are not necessarily those of the Bar-Levav Educational Association. We invite readers of any ideologic bent to participate in the discussion of topics presented in the *Journal*. Subject to the availability of space, we will publish all thoughtful comments.

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INTRODUCTION TO THIS ISSUE

The Disdainful Patient

In recent years, a great deal has been written about narcissistic personality disorders and narcissistic vulnerability. The etiology of these phenomena has been explored in depth and the dynamics have been elucidated. However, there is still much to learn about overcoming the difficulties peculiar to treating such patients. This issue of the *International Journal of Psychotherapy and Critical Thought* will address one such difficult situation: the patient for whom disdain is a typical response and may serve such purposes as a defense against narcissistic injury or as a resistance to intimacy. As most of us know, defects in self-esteem and the patient's sense of self are likely to come to the surface over the course of treating even those patients not initially presenting prominent narcissistic features. As depression lifts and fears of losing the "good mother" fall away, some of these patients are likely to manifest a disdainful demeanor toward others as part of their shifting defensive structure. Robert is a case in point.

I care about Robert, not in the way a parent cares about his child, but as one learns to care about another adult with whom one has been "in the trenches," struggling against difficult odds. For over seven years I had been Robert's weekly individual therapist as well as a co-therapist in his psychotherapy group twice per week. At the beginning of therapy Robert was deeply depressed and rarely able to identify his emotions. Grossly limited in his ability to form relationships, he was socially isolated and remained professionally underdeveloped. Now, seven years later, he is married with two children and a new job. Our relationship likewise has gone through many changes as his initial positive transference slowly gave way to a real relationship based on mutual commitment to the reality principle. It was the relationship based on this commitment that remained stable and dependable in spite of positive and negative transference reactions. As his depression lifted, he had become much more alive and his playful smile and powerful, demanding voice had become familiar to me. Nonetheless, he still tended to limit his involvement with others.

Fellow group members liked him very much, extending themselves to help him recognize the many ways he pushed them away. As he became more involved with others in his group and in his life, it became more clear how much he wanted things "his way." Having lived in a withdrawn, socially isolated fashion, he had never developed the patience and skill necessary to resolve conflicts with others, instead finding ways to

either avoid them or to subtly manipulate situations to get what he wanted. As these tendencies were confronted, however, he made use of his new-found freedom to be openly defiant. With a disdainful sneer, he would roll his eyes: "I don't agree with you, Mr. Shultz. That's what you want to see." At such times attempts to engage him in reality-testing were doomed to fail.

In such a case, the patient may seem psychotic-like since the observing ego and the working alliance seem absent. However, Robert's level of anxiety was relatively low, and his reality-testing in all other areas was intact. He had gained the freedom, at long last, to openly behave like a typical two-year-old: "I want to believe what I want to believe, and no one's going to change my mind." Implicit in his manner was a refusal to join in the process of reality testing. His disdain was a dismissal not only of me but of the principles our relationship stood for.

The possibility of counter-transference confusion is great at such a time; there is even a risk that the therapist will unconsciously want to "get rid of" the patient. This issue of the Journal will attempt to address such issues of counter-transference, explore the dynamics underlying disdain, and demonstrate effective approaches for helping patients get beyond this difficulty. With a clear understanding of the issues involved, a clinician is likely to find this so-called "difficult" patient not so difficult after all.

Paul P. Shultz, M.S.W.
Associate Editor

WORKING WITH HATE AND DISDAIN IN GROUP THERAPY

David A. Baker, M.S.W.

A conscientious colleague had just heard a spiteful story about himself circulated in the community by a former patient. He shook his head as he reflected back on her treatment.

She had been a seriously depressed, withdrawn, bitter woman when years earlier she had first sought him out for treatment. With hard work in both individual and group therapy, her depression gradually lifted as the underlying hurt and anger came to the surface. Trying to help her work this through, he invited her to express her feelings of rage directly at him in her group therapy sessions, and she eventually did so with venom in her voice and hate in her eyes. This process continued for many months as she became more free to express herself without restraint or fear of rejection.

Then a crisis arose in her therapy, and she terminated without thoughtful observation of her decision. Efforts to reason with her proved futile. She seemed to have lost awareness of the real relationship with her therapist, including a rich history of several years. She had shifted from her depressed state to a more alive but hateful one, and apparently remains there to this day.

What my colleague realizes now, and didn't know then, is that he unwittingly encouraged the hardening of this patient's hatred instead of working it through. In the context of what he believed was a well-developed relationship he invited her to express her hatred directly toward him, as he would have done with other transference feelings she needed to work through. However, this approach overlooked the fundamental difference between hate and the other emotions. In hate one loses sight of others as human beings and seeks to obliterate them. With disdain, a first cousin of hate, one dismisses other people as if they do not matter. In both cases the foundation of the therapy relationship—basic respect for each other as human beings—is eroded and eventually destroyed (Bar-Levav, 1995).

Unlike the healthy expression of anger in which this basic respect is maintained, hate is a psychotic position which seeks to destroy the other person without concern for the potential loss of a relationship or awareness of the other person's value as a fellow living creature. Hate, not

anger, contributes to the many brutal crimes of passion which fill the tabloids.

The patient's impulse to kill the relationship is what so consistently challenges the therapist's clinical skills. If in the midst of strong feelings the patient loses all awareness that the person sitting before him is his therapist, the therapeutic process stops cold. Instead of working through the transference, the emotions at that moment are being lived out as if they reflect reality. Urgent intervention is necessary to re-establish the working alliance and the real relationship. No further therapeutic work can take place until the real relationship is restored and the psychotic-like process is broken up by reality.

The roots of hate apparently develop in the first year of life; the foundation of disdainful behavior occurs somewhat later. Meissner (1984) described the struggle of the one-year-old child as his primary narcissism is challenged more and more. The child painfully discovers that he is not omnipotent and that his wish is no one's command. In normal development, a steady mothering person supports the ego boundary development by being emotionally available as needed through this time. But according to Mahler (1975), when the experience of impotence comes too suddenly or painfully due to an unsettled or withdrawn caretaker, the child may react in angry outbursts and tantrums. For some children this crisis may even be experienced as emotional dissolution or a loss of self (Horner, 1979).

What can an infant do at such a vulnerable and helpless time? "Destroying" the apparent source of the hurt, the caretaker, is a natural primitive attempt to reduce the panic and agony (Higgins, 1993). The splitting defense allows the infant to also maintain a parallel positive relationship with the caretaker until the psyche can begin to integrate the two powerful emotions. However, when this integration does not occur through the involvement of a responsive, steady, non-punitive caretaker, splitting remains a major defense into adulthood, at a high cost. Such people swing back and forth between idealizing and hating others, and have few real relationships. Pain and disappointment fill their lives. Often they develop a harsh, severe, seemingly angry edge to defend against further experiences of hurt and panic.

Disdain is similar to hate in that the relationship is for the moment broken. The fact that the parent's existence is still acknowledged suggests that disdain develops at a somewhat later stage when object relations are more secure. While not a psychotic process like hate, disdain is more

subtle and at times more difficult to recognize. In disdain a child does not imagine obliterating the parent who is experienced as hurtful but rather dismisses him or her out of hand. Such disdainful dismissal is a defense against feeling pain and disappointment. As adults, overt and covert disdainers live self-righteous and lonely lives, isolated from those good human beings whom they look down upon.

Klein (1975) suggested that anxiety from two sources is at the root of hate. One is the anxiety of the birth process and all the attendant difficulties to which the baby must adapt without understanding; the second is the anxiety stimulated by angry wishes to destroy the mother who seems to cause the unavoidable frustrations of infancy.

Bar-Levav (1988) ties hate more directly to anxiety, noting that the basis for hate is panic:

Hate packs such a powerful punch because punching is a perfect, if temporary, antidote for panic. The more destructive and dramatic the impact of insane violence, the more useful hate is for plugging up the gaping emptiness and the better it harnesses panic and dread: In panic, people are often frozen in total helplessness, waiting immobilized for the ax to fall. The alternative of picking up an ax and hatefully chopping up the enemy generally seems much more desirable at such moments. (p. 168)

He attributes such a powerful reaction to the most profound and often unconscious panic that people feel. Like a cornered alley cat blindly bites and scratches its way to safety, persons in such panic marshal the "power" of hate to blindly strike out at any and all who threaten their sense of emotional security.

Working clinically with hate requires a very safe setting and a solid therapeutic relationship which has been well-tested over time. Since most people are socialized enough to disguise or hide their hate, some patients initially need guidance and encouragement to express their anger powerfully at the therapist for awhile before daring to show the ugliness of their hate. The psychotherapy group is the best setting for this work since the other patients and a co-therapist can provide needed reality-testing and are often experienced as allies for the patient at the height of the split transference.

Making room for the patient's expressions of rage without opening the expression of hate is a unique and technically refined task. First, therapists must have resolved their own fears or distortions about anger and hate (HarPaz, 1994). Otherwise they will unconsciously discourage their

patients from expressing anger or, on the other hand, carelessly encourage expressions which slip into hatred. The therapist's own personal boundaries must be strong and flexible enough to truly welcome the patient's anger directly at him or her, keeping in mind the panicky "baby" who is often behind the loud fury.

How does one differentiate between necessary expressions of anger and harmful expressions of hate and disdain? Attention to the patient's eyes provides the most obvious clue. When the eyes go "blank" or seem to cloud over, patients must be helped to focus on and to truly see the person in front of them in the here and now. A second clue is language which is disrespectful of the other person, such as contemptuous name-calling. By contrast, the words "I hate you!" or "Damn you!" are not in themselves disrespectful, and occasionally can even be used powerfully to work through anger without losing sight of the real relationship. A third clue is behavior which reflects distortions in the real relationship, such as willfully ignoring the therapist. And a fourth is a curl of the lip or a dismissive toss of the head.

Case Example 1

Eric, a middle-aged, married businessman with three children, has serious difficulties with impulse control, self-esteem, and judgement. The older of two sons, he describes his mother as critical and self-serving and his father as concerned but passive. His brother still lives in his parents' home. Eric's first marriage ended painfully, and he often feels hurt by his current wife and by his children. Externalization became his trademark in his therapy group.

In one group session Eric increasingly fidgeted and then began to mutter sarcastic comments at one of the therapists. When invited to complain openly, he spoke up and criticized the therapists.

Eric [loudly]: You people haven't done a thing for me and my problems! I'm still not earning enough money, I'm making mistakes with my children, and I just keep paying you all this money...for what?! I'm furious!

Therapist [suggesting an exercise familiar to the patient and occasionally used in our groups]: I suggest you express your anger in a word or two toward me. Powerfully.

Eric [yelling powerfully and deliberately pausing between each statement for a breath]: Damn you! Damn you! Damn you! [pause] Damn you! DAMN YOU! [escalating now] You stingy, bald-headed jerk! You aren't worth a thing as a therapist. You're

a selfish, greedy bastard. You won't get another penny out of me...

Therapist [loudly enough to interrupt Eric and get his attention]: Eric, stop! I can't allow this to continue! [He continued firmly but more quietly.] You are welcome to be angry here but not if you lose sight of who I really am. Make an adjustment! Be angry, but see me.

Eric [catching his breath, pausing, squeezing his eyes shut momentarily]: OK, I understand.

Therapist: Now continue if you can.

Eric [powerfully and angrily]: I want more from you! More! More! More!

For the next few minutes Eric continued to powerfully rage at his therapist; but now he sat taller and sounded more solid as he did so. Several times he caught himself sneering and paused to adjust himself so as not to become disrespectful. His eyes focused steadily on his therapist's eyes without the wild, desperate look from a moment before.

Later in the group session he spoke thoughtfully about what had occurred emotionally for him when he temporarily ignored his observing ego: "I know I feel so powerless to change anything sometimes, and I want someone else to do it. I was feeling very scared about my finances and just wanted to blame you." As a veteran of many previous similar interventions, he was able this time to change his course immediately when firmly and respectfully interrupted by this therapist. But this followed numerous times when he had not stopped so quickly, and then had pouted for the remainder of the session, or threatened to leave therapy when his therapists firmly thwarted his attempts to prevail.

Had the therapist been anxious himself, and expressed it by being overly challenging, Eric would likely have escalated instead of hearing his ally. He would have unconsciously reacted to the therapist as his over-protective mother. And the embarrassment which typically followed such outbursts would have further damaged his self-respect.

Case Example 2

Mary is a divorced, 45-year-old woman with a history of serious relationship difficulties and an hysterical character. She grew up with a critical, narcissistic mother and an efficient, business-like father whom she admired and with whom she identified. Understandably frightened of real intimacy but longing for it nevertheless, she spent many of her young adult years living communally. Articulate, colorful, impulsive,

and very sensitive to criticism, she developed a strong negative transference toward one of her therapists who consistently set limits regarding her hysterical expressions and refused to gratify her infantile wishes for exclusive attention and approval. At the same time he was realistically supportive of her adult efforts to control her impulsivity, to develop her thoughtfulness and to advance herself professionally.

As Mary began expressing her anger in the early years of her therapy, one aspect of her character came into focus, demonstrated by the following vignette. For the first twenty minutes of one group session Mary had been sitting quietly and staring away from the therapist, her body turned aside and shoulder hunched protectively.

Therapist: Mary, why do you not say hello to me?

Patient [bitterly and still staring away]: Why should I say hello to you? Every time we talk I get slammed down again. I'm tired of getting hurt by you.

Therapist [firmly]: I'm not willing to engage you unless you look at me.

Patient [rolls her eyes]: I don't want to look at you.

Therapist [more firmly]: Regardless of your feelings at the moment, I will not continue to talk with you now if you dismiss me.

Co-therapist: Mary, take a breath. Give yourself a moment before responding.

Patient [tentatively looking at the therapist and somewhat sarcastically]: OK, what do you want?

Therapist: I will not respond to your sarcasm. Change your voice if you want me to respond to you.

Patient [softer now]: I really don't know what you want from me. I really don't understand. [She begins to cry quietly] I guess I wish I could just talk to you sometimes without feeling hurt...

Therapist [tenderly]: What is this hurt all about? Do you know?

Mary continued to cry quietly for some time. Later in the session she spoke painfully about her unresolved yearnings for her father's attention.

Mary's disdain served as her defense against her pain. By "looking down her nose" at others she defended against feeling vulnerable and disappointed, at a high cost of both loneliness and missed opportunities in her career. Her disdain covered much fear and a self-image battered by self-blame.

Case Example 3

Margaret, a very depressed 37-year-old accountant, reluctantly came to therapy at her husband's insistence. They had been living together for years as strangers with little communication and no sexual involvement. With an emotionally distant mother and demanding military father who died when she was ten, Margaret grew up to be a competent, hard-working, but dowdy professional who had never known the rewards of close emotional involvement.

She approached therapy with understandable skepticism, a sarcastic bite in her voice, and a hard push away when others attempted to involve themselves with her. The fact that her fellow patients in her group openly disliked or at least avoided her appeared to not faze her in the least. Her therapist patiently tried time and again to gain her trust and to welcome her into the relationship, but her bitter face and heavy ungraceful walk showed little change over several years. It was clear that her fear of emotional involvement remained very high despite the efforts to reach her.

And yet she stayed in therapy, her marriage seemed to stabilize, and she got several promotions. Then, almost imperceptibly, she began to soften. Occasionally she made more neutral comments to her group members, or with help related a personal vignette from her office environment. These breaks from her characteristic way naturally scared her, and sometimes she would retreat to her former bitterness for several weeks before venturing out again.

As she entered the middle phase of her therapy, she began to feel more openly and powerfully the anger which lay beneath the sarcastic tone and bitter comments. She expressed this often in her group and particularly focused on her female therapist who in the transference represented the patient's disappointing mother. Margaret's challenges and raging generally did not rattle her therapist except for one repetitive situation. When the two of them met by chance in the hall or women's rest room, Margaret consistently ignored her, never initiating a greeting and only muttering in reply.

In a situation like this the benefit of a psychotherapy team approach becomes readily apparent. The co-therapist in the group, as well as other therapists in the practice who knew the patient, reviewed the situation to check for counter-transference distortions on the part of the therapist and to plan the next step. In the team conference it was clear that Margaret would need to repair the damaged real relationship with her thera-

pist. She had stepped out of the bounds of basic mutual respect, and her treatment could not continue until that foundation of the therapy, or any relationship, was reinstated.

After much work with her own initial overreactions, the therapist carefully prepared a plan. Her intervention had to be firm but not punitive, and powerful enough to reach through Margaret's defenses, using the health which Margaret had already demonstrated over several years in the relationship.

In the following group session, the therapist sat forward, asked Margaret to do the same, and spoke to her about what had happened between them. A hush fell over the group.

"Margaret, I've been troubled since I saw you in the hall on Tuesday, and you again did not say hello or acknowledge my presence in any way. I have talked with you about this in the past a number of times, but I must tell you something about myself now. I'm not willing to continue to work with you as your therapist unless you correct how you treat me. I expect the same basic human respect which I show to you. You can express your feelings in your sessions as much as you need to. But I will not accept your acting these feelings out when we meet outside your sessions."

Many of the group members were stunned. How often does a therapist speak this way to a patient? But Margaret shrugged nonchalantly. "I guess I'll leave then." It took much hard work in that session to reach the hurt underneath her cool exterior, but eventually she cried as the possibility of losing her therapist sank in. She spoke thoughtfully of how her disdainful behavior had kept her from feeling hurt for many years and how frightening her current involvement with her therapist was becoming. After several sessions of focused work she apologized and made a commitment to more attentively separate her feelings from her behavior.

Conclusion

In summary, hate is seen here as a defense against very powerful fear stemming from the first year of life. At that very vulnerable time when an infant is forced by the pressing realities of life to give up primary narcissism, the lack of sensitive, firm caretaking can be disastrous. One's very sense of self may be threatened. Disdain, developing as a slightly later time, protects one from feeling shame and embarrassment by projecting onto the caregiver the weakness or incompetence one feels.

To effectively help a patient change such destructive behavior patterns and work through the underlying panic, a very safe psychotherapy setting and well-tested real relationships are necessary. Since hate and disdain usually stir up fear, hurt or anger for the therapist, special care must be taken to not act out these reactions with the patient. Sound supervision along with the use of a co-therapist in a team practice provide necessary guidance and objectivity in this difficult task. In addition, developing the ability to recognize and be appropriately firm in the face of disdainful or hateful behavior requires a specific experiential training over time.

Both hate and disdain are malignant to relationships and a threat to civilized society. When the basis of relationships—mutual respect—is broken, nothing else in human affairs should proceed until that is properly resolved.

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Background Point of Theory

To dissolve hate and to change persons afflicted with it require that they first experience the fear underneath it as such; this can only happen in the presence of someone with whom they feel secure. Only then does the frozen hate begin to thaw out slowly, eventually turning into rage. This in turn must be neutralized, not merely talked about or recognized as such. Interpretations about the causes and origins of anger are basically irrelevant in this process, since they have no power: They originate in reason and appeal to reason. The heat of fury and the explosive intensity of rage found at the root of hate must be experienced as such, and expressed verbally or vocally at someone willing and able to stand in as a symbolic target. It requires exquisite skill, inner strength, sensitivity, good timing, and enormous patience on the part of very experienced and courageous therapists. The dangerous task becomes completely safe, and success can be achieved, but only in well-designed and well-constructed therapeutic environments...

From R. Bar-Levav, M.D. (1988)

Thinking in the Shadow of Feelings, New York: Simon and Schuster, p. 170.

WHAT IS THE BLEA TUESDAY SEMINAR?

A BLEA postgraduate clinical psychotherapy seminar has been held in Detroit every week for over fifteen years, from 12:00 noon to 2:00 p.m. Practical issues of patient management have been supplemented by theoretical examinations of the nature of psychotherapy and human behavior in general. The Socratic method of teaching has typically been used. Seminar participants have been challenged to think critically and to examine afresh their own, and everyone else's, opinions and statements. We have grown together in our competence and in our ability to understand and to enunciate the rationale, techniques, and methods of our clinical work. Our patients have also been the beneficiaries of this ongoing effort.

The BLEA Tuesday Seminar has thus been and is a laboratory in which new ideas are spawned and tested. Carefully prepared but brief assignments, no longer than 250 words, are prepared by seminar participants from questions distributed the week before. The answers are read aloud, discussed, critiqued, and sometimes debated.

Now here is a chance for you, the reader, to also benefit from this stimulating experience. Each issue of the Journal, devoted to one Tuesday seminar topic, will bring to you the questions asked and some of the responses. In this issue, we examine the issue of disdain in psychotherapy and in relationships in general. What follows are the assignments and some of the answers which were presented over a three week period. Your thoughtful responses are welcome and, if suitable, will be published in a future issue. The deadline for responses (in 250 words or less) to this issue is August 30, 1995.

BLEA TUESDAY SEMINAR

ASSIGNMENT FOR MAY 21, 1991

1. Define disdain.

Disdain, as defined by Webster, is "...a feeling that something, or someone, is beneath the level of one's own dignity, or is unworthy of one's notice or acceptance..." Synonyms for disdain include contempt, scorn, arrogance and haughtiness. Disdain prohibits relationships based on mutual respect and concern. Actually disdain is not a feeling but an attitude. Inherent in the attitude is an indulgent attention to the self and a failure to empathize with the other. A disdainful attitude may be adopted by a child to defend against fears of powerlessness and low self-esteem. For the sake of the child a parent ought to view disdain with alarm, prohibit its expression, and help the child make an adjustment and express the related feelings appropriately.

Helene S. Lockman, M.S.W.

2. Of the following, which do not belong in a relationship between parent and child?

- Hurt
- Anger
- Disdain
- Love
- Sadness
- Disappointment

All except for disdain belong in the relationship because all are feelings, or expressions of feelings, which really exist. All are best handled by safe and appropriate expression. Disdain is the exception because it adopts a posture of categorical "holier than thou" rejection of the person of the parent, the fathering parent. It is a dangerous declaration of a commitment to the narcissistic position which, if unchallenged, will harden. The damaging consequences to future relationships and to the child will be great.

Ronald J. Hook, M.S.W.

The only one on the list that does not belong in the relationship between parent and child is disdain. Hurt, anger, and love are basic emotions that the child will repeatedly feel toward the people who are most important to him, his parents. They must be allowed some expression within the

relationship or they will either be denied or find distorted means of expression as the child develops and grows.

Temporary rejection and distaste are two paths that the growing child has available to exert his emerging independence. Though he does not have sufficient real power to exist independently, expressing his preferences, even in strong opposition to his parents, is an ego boundary strengthening exercise.

Disdain, however, is not appropriate. It goes beyond preference to a disregard of the actual relationship between child and parent. Rather than ego boundary strengthening, it reflects a distorted self-image of the child due to a deficiency in fathering by the parents. Unchecked, it is damaging to future relationships, as the child fails to learn what violates the rights and boundaries of others and is not forced to accept appropriate authority and rules of order.

Ilana Bar-Levav, M.D.

ASSIGNMENT FOR MAY 4, 1993

1. Identify a situation from your personal life where you acted or were treated in a disdainful manner. Discuss whether the disdainful behavior was dealt with well or poorly and why.

Note to the reader:

Some of the comments which follow are personal. The authors put their need to learn from each other ahead of their personal feelings. We thank them for their openness and invite you to follow their lead and be more openly exploring of yourself.

My daughter had a history of being disrespectful and dismissing of me, of my values, and of all help offered. At college she continued by shirking her responsibilities, refusing contact with me and others, acting out in numerous ways. I finally told her that I would not continue to pay for college and that the burden was on her to work herself back into the family and to make a plan for her future. I also made it clear that I was not abandoning her. Though coming late in her life and mine, this action demonstrated a greater adherence to reality, to the objective goodness and badness of those involved; to reasonable and respectful standards; and to the foiling of irrational expectations.

Name withheld at writer's request

When I confronted my adult son about his personal appearance he reacted in an insolent manner, blaming me for most of his personal difficulties. I handled the situation poorly. Instead of responding firmly to his unacceptable behavior, I took on a reasonable posture and began explaining myself. I overidentified with his hypersensitivity to criticism and hurt. Fearing rejection, I lost sight of the validity of criticizing his appearance and failed to maintain an adult posture.

Sharon Banks, M.S.W.

My daughter was ignoring her mother's requests to put something in its appropriate place. When my wife gave a clear directive, Sarah picked up the object contemptuously, threw it at her mother's feet and began behaving in a dismissing manner. I shouted for Sarah to pick up the object and immediately do what she was told, then apologize to her mother, which she tearfully did.

I believe I handled the situation well. Sarah was obviously operating from a narcissistic position. My wife's insistence on her attending to her chore was experienced as an insult to Sarah's narcissism, to which she responded by attempting to "eliminate" the source through contemptuous dismissal. Immediately stopping this behavior was the only effective response.

David Mikkola, M.S.W.

2. Identify a situation from your practice where a patient acted disdainfully. Discuss whether you treated the situation well or poorly and why.

On my psychiatry rotation, I had an adolescent patient who behaved disdainfully toward many, including my attending physician and myself. She had a smug smile, as if she knew what I was going to say and had dismissed it in advance. She challenged openly, saying: "No way. I'm not going to do what you say. You don't know what you're talking about." She rolled her eyes, walked away, refused to answer, etc.

In general I handled the situation well. I acknowledged her displeasure. I indicated that her manner of expressing it was unacceptable and would not get her what she wanted. I stated on a few occasions, "I can't help you if you act this way. You can tell me differently what you want to say." I also persisted in the relationship with her by coming to see her each day, inviting her to speak about herself and supporting her efforts to further her best interests. I believe I was able to move with the patient

beyond her disdain also because the controlled setting of an inpatient ward helped to limit her acting out. The strictly enforced rules and regulations of the ward enabled both the patient and myself to feel more secure so that I was willing to explore with her underlying issues and feelings, and she was willing to open up to someone who cared about her.

Author unknown

"D" has a long history of dismissing those who challenge and confront her. Sometimes she rolls her eyes or flips her head the other way. At other times she politely dismisses the words of others before she has even heard them. In one such instance my co-therapist and I confronted her solidly about her dismissing behavior. She reacted angrily and defensively at first, but was confronted again without argument. Gradually, she softened and became tearful as she recognized her pattern of rejecting others.

David A. Baker, M.S.W.

Routinely angry but haughty patients come to our crisis center with "entitled" demands, literally spitting at staff. They are stopped with physical restraints, seclusion, and at times medication while they exhibit this behavior. It is impossible and dangerous to reason with such patients at such times.

Lester Potempa, D.O.

After our six years of work together, N. had freely and open-heartedly thanked me on a number of occasions for my help. Nonetheless, there were other times when she entered the group session with eyes averted and a sour look on her face, and had what amounted to a silent temper tantrum. On this occasion, after she had sat with arms and legs tightly folded in snide silence for half the session, staring at the carpet, I asked her to unfold and sit forward. "Leave me alone," she sneered. I was hurt and angry at her and did leave her alone, although I knew I should not allow this to continue. My co-therapist came into the room as expected a few minutes later. He also asked her to unfold and sit forward, and she sneered contemptuously at him as well. He, in turn, directly confronted her disdain as inappropriate and unacceptable "in this relationship". She responded with a look of utter disgust. After one more try, he told her it made no sense for him to continue as her therapist, unless she apologized for her disdainful treatment of him. After three sessions where this had been the sole focus, time had, as hoped, cooled the power of the

emotions. She then apologized in a dignified manner, and reflected sadly on how her disdainful treatment of others had brought her many losses over the years.

In view of how well my co-therapist worked with the issue, it is clear that I had worked poorly with it, following my feelings instead of expert clinical judgement.

Paul P. Shultz, M.S.W.

It was near the end of a 28-hour marathon weekend therapy session when a patient, clearly in a deep transference with me and often angry and sarcastic, directed a line of derisive remarks at me, ending them by calling me a fool. I waited for a few minutes, took a deep breath, and told John that his anger was acceptable, but not his disdain. "As a fool, I could not be your therapist," I said. "Unless you fire me and leave therapy, you will have to retract your statement that I am a fool. We cannot work together under these circumstances." John retracted the statement which was the first step in working through many related issues with him. It was the correct thing to do because it separated his anger, which I could work with, from his disdain which was destructive to our real relationship. It was incisive, but not retaliatory and was respectful of myself, which in turn elicited my patient's respect for me and for himself.

Victor R. Stoeffler, M.S.W.

Background Point of Theory

Disdain is destructive to all relationships. It contains not only disrespect but also dismissal of others, which is why it is ruinous. Disdain ends dialogue and breaks down the possibility of future communications. In the presence of disdain no sensible resolution of conflict is possible. This requires that a genuine correction be made.

We have already seen that anger and disappointment cannot be avoided in relationships. But they must always be expressed from a bedrock of respect. Fixed hate can develop without it, and this often is beyond repair. Disdain, disrespect, dismissal and an open attitude of distaste poison relationships. This is why they must be uprooted from the start.

Even so, such expressions should not be hidden if they exist. It is impossible to eliminate an unseen obstacle. It is best therefore for the disdain to come into the open, but then it must be met head on. Firmly, and without ever allowing it to prevail or to go on.

From R. Bar-Levav, M.D. (1995)
Every Family Needs a C.E.O.,
Detroit: Fathering Inc., Press, p. 180.

SUPPLEMENTAL ASSIGNMENTS

Comment on Disdain in the Media

In the name of "freedom" many facets of the media, but particularly television, are often disdainful. Citizens who feel personally wronged, whether or not there was any actual wrongdoing, are given air time and interviewer support for their self-righteous presentations. In a misguided attempt at "fairness" interviewers challenge all points of view, often putting down guests' remarks with disdainful questions/comments beginning with "But don't you think that...?" rather than asking questions which encourage critical thinking about the issue at hand.

Daytime talk shows which group together people with strong feelings on an issue and then encourage them to sling mud at each other while a voyeuristic audience looks on are disdainful and disrespectful of everyone. They play on our human weakness to be swayed by strong feelings rather than encouraging our human potential to think.

These dangerous subliminal messages sent to passive TV-watchers are eroding our values. Disdain is encouraged by this powerful medium which reaches millions every day.

Pamela Torracco, M.S.W.

Comment on Disdain in Marriage

The expression of disdain toward another person totally dismisses the relationship. It is an announcement: "This relationship is over. I am not interested in working anything out. I'm not interested in resolving any conflicts. I just want you out of my sight." Often there is an additional implied message: "I might be willing to welcome you back, but only on terms that I dictate unilaterally."

This is why disdain is so destructive, and obviously precludes the resolution of difficulties that exist within a marriage. Yet, ironically, it is within a marriage that disdain often finds its most free expression. Why is this?

"I promise to love you till death doth us part." With such an unrealistic promise in place, both parties can live with the delusion that they have the freedom to treat the other party improperly and still be accepted as a partner. Obviously, anyone thinking about this proposition would dis-

claim it immediately. Nonetheless, people unconsciously harbor such wishes for unconditional acceptance, regardless of how unrealistic they are.

For the same reason spouses often feel more free to expose themselves emotionally with each other more than they typically would do. Therefore, they also are more liable to be more deeply hurt or threatened than anywhere else in their life. We know from newspaper reports that such deep hurt, or fears of being left by the other party, have sometimes even led to homicides between intimates. Statistics tell us that most murders do in fact happen between people who are intimately involved. For similar reasons disdainful expressions are more frequent within a marriage. Disdain in a marriage is a kind of psychological "murder" that at least in the short run, "kills off" the other party. If not corrected, it will ultimately lead to the deterioration of the marriage.

Paul P. Shultz, A.C.S.W.

Comment on Disdain in the Political Process

Because disdain is so damaging, even ruinous, to all relationships, it is a potent weapon often used in the political arena. After all, we have here a modified form of warfare among opposing forces, and the purpose is to prevail.

Office holders usually try to dismiss requests by challengers for a public debate. They often do so disdainfully, not even deigning to respond to the request with a proper answer. Negative campaigning, dirty tricks, misleading sound bites, doctored photographs, stabbing commercials and print ads all are meant to defeat the opponent by treating him or her as deserving not respect but disdain.

Such expressions are all distortions of the political process. Critical thinking and objectivity would serve us better, but disdain is more powerful because it often is destructive.

Reuven Bar-Levav, M.D.

Addendum:

Disdain is also common in academia, used to defeat potential competitors. By refusing to admit new ideas some hope that the threat to their position would disappear. Refusal to publish or to promote is the method usually used in such circles. - RBL

CASE PRESENTATION

Tim, a 33-year-old, married, Caucasian, Catholic father of four with a degree in business administration, was referred by his attorney after an arrest for embezzling from his employer. Handsome, tall, and athletic, his eyes conspicuously pierce and dart. Intelligent and charming at will, he carries himself haughtily and often speaks condescendingly.

In the initial interview he reported restlessness, palpitations, poor concentration, and insomnia. At that time he minimized the embezzlement and externalized the responsibility for it. Being left alone to run the business meant to him that the owners did not care, and only got what they deserved. He seemed to be self-righteous and did not show remorse. There was no history of substance abuse.

Tim was the youngest of five children, seven years separating him from the next older sibling. He claims he was an unplanned "surprise package," perhaps unwanted. He described his mother as tired and uninterested, refusing to spend the time or energy to get him to after-school activities.

He describes his father as "a workaholic," mostly absent. His father's alleged only concern for his children was that they obtain good grades and keep busy with chores. Tim reported that when he or his siblings did not finish a chore, his father would unleash a tirade. Otherwise, he claimed his father never disciplined him, leaving this task to his tired, uninterested wife. Apparently the only time she set a firm limit was when Tim brought home a bad report card.

Twelve years ago Tim married his high school girl friend after she became pregnant with their first child. He describes her as a pretty, passive woman, who is unconditionally accepting of his behavior.

I saw Tim initially only in weekly individual psychotherapy as I planned for a once weekly therapy group with a co-therapist. He entered the group after six months. As a condition of his treatment Tim agreed to a non-acting-out contract. This contract declared that he would commit his best effort to take no action in or out of therapy purely on the basis of his emotions.

Early on in his group he was confronted about his haughtiness, denial and externalization of responsibility. He denied any law breaking and

even openly claimed that he was doing me a favor by being in the group. It soon became obvious that he had used his considerable charm and quick mindedness to avoid culpability for his behavior. He eventually spoke proudly of how he could manipulate teachers and other authorities. I once suggested that he would have been better off had he failed at this. To this he immediately became indignant, sarcastically trying to dismiss me. He was surprised and touched while I firmly maintained my position but continued to remain deeply involved with him. Slowly he came to experience these confrontations as beneficial for him. He began to feel a sense of security with another person that he had rarely experienced before.

He was no less surprised and touched when group members confronted his haughtiness and, again to his amazement, continued to want to be with him. He began to discern that his therapists and fellow group members were real people, steady people. This provided him with a framework to look more deeply at himself. Soon he could see beneath his veneer of false pride to his pain of deprivation. Eventually he cried, speaking painfully of how his relationships were with only a few people who "put up with my shit and didn't challenge me." He began to see how his abuse of relationships, his avoidance of emotional involvement and his disdainful behavior cost him true friends and left only a distant relationship with his wife and family.

Clinical Material and Discussion

In a recent individual session just prior to my departure for a vacation, Tim forgot to bring his check to pay for that month's therapy. Timely payment was a contractual expectation. After some negotiation Tim proposed that he drop off a check during the week I was away. I accepted.

At the first group session of the next month, while distributing monthly statements, I noticed Tim had, in fact, not paid. As I handed him his statement I confronted him about it. He glared at me and with a tightly curled lip stated, "Don't you ask me about this in group. I told you I would pay you."

"Then how come you didn't pay as we agreed?" I replied. During a long pause Tim continued to glare. I turned to go back to my seat and as I did, Tim threw his statement to the floor. After I was seated, he spontaneously left his chair, picked up the statement and began walking toward me.

I very firmly told Tim to stop and return to his chair. Looking surprised and hurt he complied. As he sat, he began to speak, "You had no right..." I interrupted him. "Tim, what you did here is unacceptable. You made an agreement not to act out your emotions. Your anger and hurt are not justification for action." Tim began to interrupt, "But..."

"I'm not finished, Tim," I insisted. "In order for us to continue working together, you must recommit yourself to the contract not to act based solely on your emotions." Tim began to speak, "But..." Again, I stopped him. "Do you agree to this?" After a reflective silence, he agreed.

He then hurried to speak about how angry and embarrassed he was. My co-therapist gently but firmly intervened, "Tim, I must stop you. What you are saying is obviously very important. However, there is something that is more important." Tim replied with a familiar scowl and haughty tone, "What do you mean?" The co-therapist replied, "You were disrespectful to your relationship with Mr. M. You broke your word by not paying when you agreed. Secondly, you have not addressed what you are going to do to clear that up. Before you proceed with what you feel about what happened, you need to do something about these two issues."

Tim sat with this for several minutes. Then, with appropriate reflection said, "Mr. M, if it is acceptable to you I will bring a check to you tomorrow. I also apologize to you, and to myself, for breaking my promise."

I replied, "I accept your apology and your plan. I also suggest that before the group is over you talk more about what has happened to you here tonight."

Tim did so, speaking about how angry and hurt he was and with help also recognizing how breaking his word, coupled with his impulsive and disdainful actions, affected the real relationship between him and me. By the end of the session and periodically afterwards, Tim talked about how he understood and appreciated what had happened, though he hated it.

Tim unknowingly damaged his relationship with me by breaking his word. In effect he lied. His haughty "How dare you!" attitude also behaviorally devalued and dismissed me as a real person.

The confrontation about nonpayment stimulated his embarrassment and shame. He reacted to his feelings in his characteristic manner. Like a two-year-old he attempted to rid himself of the therapist, the perceived source of his feelings of hurt and anger and humiliation.

His behavior qualifies as disdain, not anger, because of the canceling effect it has on others. My immediate and forceful interruption helped him eventually regain self-control. I and my co-therapist then helped him to see how he violated his contract and how his behavior affected his relationship with me as a real person. We squelched Tim's impulsive interruptions until he settled down enough to see what he had done, and what the consequences of his acts were. Reflecting on our relationship over time, Tim overcame the emotions of the moment and recommitted to his word (the contract). He also restored our relationship to an appropriate footing by sincerely apologizing for his lapse. A securing of these appropriate parameters would afford future opportunities for his anger to be expressed safely.

Sadly for Tim, he had gotten away with acting in this manner for most of his life. His social isolation and impoverished relationships are only some of the tragic results.

His therapy will consist of many more confrontations as his narcissism is brought under control. These confrontations, executed properly, will eventually provide Tim with real safety that will enable him to express and work through the very strong emotional reactions to his early deprivation.

David Mikkola, M.S.W.

David Mikkola, M.S.W., practices combined individual and group psychotherapy in Birmingham, Michigan. He is also a Fellow in the Bar-Levav Educational Association post-graduate training program for psychotherapists.

COMMENTS IN RESPONSE TO THE CASE OF TIM

In Mahler's developmental model, the narcissistic character disorder typically has had trouble negotiating the subphases of separation-individuation. The important moments between the child and the mothering person during these crucial nodal points of increasing individuation and the tasks inherent in them are met by failure in the dyadic relationship. These crucial moments as Pine calls them are either experienced by the dyad as good or bad fits. These fits are heavily invested with narcissistic libido or narcissistic aggression. When the moment is met by the good enough mother, the child can then both retreat and move ahead with ease and love; the primary narcissism gives way to autonomous ego functioning and the thrust for individuation is invested with neutralized aggression. When the moment is met with the character pathology of the

mother, then the primary narcissism is kept in place and becomes more invested with aggressive drives, thus making it that much harder for the child and the mother to progress to the next step in their mutual developmental growth.

These crucial moments or "fits" occur at each developmental step many times over and are the nuts and bolts of our therapeutic task. These powerful re-enactments are driven by the repetition compulsion and the need to put into words feelings that were experienced in the body and before comprehensible words. The patients need to know what went wrong and when and to be able to re-enact the good or bad fits in the transferences in the group with the therapists, or the individual group members, or the group as a whole. All patients with characterological problems that we work with have these narcissistic bad fits that are invested with aggression and entitlements that are not nearly as obvious as the patient Tim. Every good group needs a Tim and a good borderline patient as well if you want to do character analysis. I make it easier on myself in that I run my groups two and three times a week without any other outside individual therapy. As a result the group becomes the only effective space to do the hard work. The therapist is like a pig hunting exquisitely delicious and expensive truffles that the narcissistic injuries and their narcissistic defenses have become. They have been made monuments to be worshipped at and cannot bear to be discovered. Their discovery leads to explosions of anger, anxiety, depression and relief all in one and become crucial moments for the therapists to be there as good enough mothers to hopefully create a new and important holding environment for the patients, and give them a good fit. Each developmental phase has its own unique narcissistic structures and they will vary among the patients and within the group as a whole as it evolves.

From the history Tim clearly suffered in all the developmental phases, with a listless, most likely depressed mother who didn't want him, and therefore wouldn't be able to give him good enough mothering or to be available for the good fits around separation-individuation phases. There was very little refueling or inter-subjectivity and empathy from either father or mother when he failed at a task. No wonder that he has to "embezzle" some goodies for himself. All that was expected of Tim was to create no anxiety for either parent. Therefore he had to look for other people to play out his anxiety and needs to determine the strength and the vicissitudes of his internal demons. It is no coincidence that he recreated the circumstances of his birth with his wife and their first child. He obviously has areas of healthy ego structure as he hasn't seemed to project all his internal rage onto his first-born and he has gone on to perform well professionally and has picked a woman who can heal

might be that he will outgrow his wife. Even with these relatively healthy ego structures he has to maintain a wary distance from all important people, to protect them from his rage and his intense devouring neediness. Therein lies his narcissistic defense of disdain.

The case report is fascinating in that it represents the intense conflicts that the patients put into the therapists. The contract that was insisted upon was both for the patient and the therapists. The contract enabled the therapists to feel narcissistically secure in their outrage toward the patient while it enabled the patient to finally have a parent who cared, noticed him and would battle it out with him. These contracts work for both at the beginning of therapy and then have to be replaced by the real relationships between all parties. The contract had to be broken so Tim could bring his internal life into the group. Many times we have to make contracts so we could live in the group with each other and feel safe. Invariably they are broken to be replaced by reenactment and a chance for analysis.

The confrontation in the group that was reported is a beautiful example of a reenactment with the patient demanding the therapists become the awakened mother yet at the same time the angry father. The therapists need to know what aspect of what developmental phase is being reenacted and confirmed. It could be the need for the awakened mother or the need to be humiliated at the hands of the father. There is great emphasis to talk to his ego strength about responsibility and maybe not enough emphasis about the earlier needs for his mother to contain his anxiety as he took a risk as he did in the group with the bill.

Tim knowingly damaged his contract with the therapists so he could have a relationship with them. He unconsciously wanted them to feel what he felt like when his parents broke their contracts with him. The therapists felt self-righteous indignation and narcissistic outrage around the "how dare you" attitude. The contract must have also felt like another achievement he must do to satisfy his father.

I am particularly curious about where the group is in this, other than watching. Over time the disdain and entitlements of the group and the therapists must be examined. I think it is premature especially in a once-a-week group to expect Tim to express his anger in a safe way. He needs time to let you know how bad the bad fits were and to fail even miserably without humiliation or shame. This is a thin line the therapists must walk. It is important to not let him contain all the entitlements for the group. The therapists have to look at their ability or

inability to tolerate intense affects in Tim and in the group. The therapists need to be applauded for taking the risk they did in telling us about this episode and letting me comment freely upon their work.

The therapists have their work cut out for them but it would be easier if they could spread the narcissistic entitlements and injuries around the room and accept the fact that Tim cannot be a good little boy anymore and will make their life miserable. If he doesn't then they have to look at their own narcissistic disdain and self-satisfaction at his internal life, his impulses, aggression and neediness. Disdain is only one of many bad fits they will have with him and the group.

Stewart Aledort, M.D.

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