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*In This Issue:*

**REPAIRING THE BOUNDARIES  
OF THE SELF**

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Psychotherapy &  
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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

## Repairing the Boundaries of the Self

Imagine, if you will, a world in which all boundaries to which we are accustomed gradually break down. One by one living cells merge together until a fingernail cannot be distinguished from a finger, a flower from the stem. Coffee and its cup become the same substance. The car and the highway blend together. People all begin to look the same. The rocky coastline of Maine becomes indistinguishable from the ocean. In time our world has no boundaries at all, and is just one undefinable mass.

From a psychological perspective, this is how we humans start our existence. Only gradually in infancy do we develop the sense of our own separateness, and most people never have the opportunity to complete the process. A cursory look at our world shows how serious are the personal boundary difficulties. Note the trend in young men and women in their twenties who return to live at home with parents. Overidentification leads juries to award vast sums of money to victims. Painful relationships are everywhere around us—some are distant and lonely to protect from further hurt, others volatile and caustic to fend off perceived attacks, and still others desperate and clinging—all leading to a loss of self-respect and dignity.

The growth and development of essentially intact, flexible, and strong personal boundaries can be accomplished through psychotherapy which provides a recognizable sense of safety and a firm hand with which to face the fear of non-being, that sense of having no boundaries which we all experience but usually know only on a physiologic level. To reach this fear, the defenses which protect against feeling it must be addressed and eventually abandoned in the safety of the therapeutic relationship. When patients feel safe enough to experience their boundary deficits, they feel panic, their bodies perspire as if their very survival is at stake, and they describe sensations like being in outer space or in deep water with no connection to anyone or anything. As terrifying as the experience is, one emerges from it alive, one's body eventually settles down, and each time a small gap in one's deficient personal boundaries closes up. Repeating this process many times is the heart of personal boundary repair.

An as yet inexact but critical aspect of psychotherapy, personal boundary repair requires relatively healthy boundaries in the therapist as well as a sound theoretical basis for interventions. The objective of this issue of the *Journal* is to help in clarifying our understanding of these concepts.

The Editors

# EGO BOUNDARIES AND THEIR ROLE IN EMOTIONAL SURVIVAL

Pamela Torracco, M.S.W.

*(This paper is based on a presentation given at the Bar-Levav Educational Association's October, 1993 Conference entitled "Growing into Competence: The Making of a Psychotherapist.")*

Each of us is a person physically separate from all others. We have been separate since we were born. But physical separation is not the same as psychological and emotional separation, which come only with individuation, the ultimate goal of psychotherapy. What defines us psychologically are our ego boundaries, our psychological skin. They serve many of the same purposes as our physical skin, containing us as individual beings. They separate what is "me" from what is "not me." They are how I know that I am me and not you, how I know that I am me and not a chair. Like actual skin, ego boundaries provide needed protection from the outside world and help us regulate what happens between us and our external environment.

These seemingly simplistic concepts are basic and essential to our understanding of human development and behavior. We were all powerless, boundaryless infants once, and it took us a long time to discover that we were even physically separate from others. The more difficult discovery of our emotional separateness continues more or less throughout life. The only way we become psychologically separate is by really clarifying the boundaries of our "self." Individuation is the acceptance of the fact that we really are separate beings and that, nonetheless, we can live in relative safety. Having begun our existence attached to someone else and having remained completely dependent on Mother for an extended period of time, the prospect of giving this up is naturally fraught with fear, and traces of this old fear remain in each of us.

The condition and quality of the boundaries of the adult reflect the sense of safety he or she has in the world. The quality of our fears and of our boundaries unconsciously affects many of our attitudes and overdetermines much of our outlook: how we think, how we vote, how we evaluate and relate to other people, how close we allow ourselves to get or how distant we stay in relationships. Although we cannot see ego boundaries, we can know a great deal about them by observing how a person relates to others and to the world.

Federn was a pioneer in the development of the concept of ego boundaries. He recognized the importance of their being flexible and he understood hallucinations, delusions and experiences of depersonalization as being directly related to weakness in the boundaries. He differentiated between reality-testing and maintaining a "sense of reality," which he believed was an ego boundary function (Weiss, 1966, pp. 154-155).

Hartmann (1950) and Jacobson (1953) described the concept of self-representations. Jacobson further notes that in the absence of ego boundaries, the early infantile self-image is "fused and confused" (p. 54) with object images. It is only later as the capacity for reality-testing develops, that the infant can begin to distinguish between self and others. It is then possible to develop a more realistic concept of the existence of "self" as a separate object. While the sensations of one's own body aid in delineating ego boundaries, body boundaries and ego boundaries are not the same (Eidelberg, 1968, p. 121).

Bick (1968) describes clearly how the mother functions as an initial "containing object...in the infantile unintegrated state" (p. 484) and is, therefore, experienced as a kind of skin, a precursor to its own psychological boundary which the infant must develop.

Kernberg (1975) focuses on early ego boundary development and its effects on character organization. "When self and object images are relatively well differentiated from each other...then the differentiation of ego boundaries develops relatively undisturbed..." (p. 28). In psychosis, self and object images are never adequately differentiated and "therefore, ego boundaries do not develop properly" (p. 34). In borderline personality organization more stable ego boundaries have developed but they tend to break down in the transference regression. Borderline patients, then, tend to develop a transference psychosis instead of a transference neurosis.

Bar-Levav's work (1988) concentrates on the behavioral and personality characteristics which give clues about the quality of the "boundaries of the self" and the repair of defective boundaries in psychotherapy. Boundaries develop in the presence of the early fears of abandonment and engulfment and, therefore, "the type and magnitude of a person's typical fears...convey useful information about the state of his or her boundaries" (p. 333).

While still very, very young, each human being must adjust to whatever physical, emotional, cultural and social situation it was born into. We do the best we can to minimize our fears and our sense of being small and powerless. We make the best possible adjustment we can using our basic genetic equipment and unconsciously "choosing" from our rapidly developing physiologic and behavioral repertoire. These "choices" become patterns, a few basic patterns become character traits and a unique individual with his own idiosyncratic personality begins to emerge. If we are fortunate, these adaptations are healthy and serve us well throughout life. But for everyone at least a few of their original adjustment patterns are pathological. Though they helped the child survive emotionally early in life, they do not always fit the real situation of the adult. Since ego boundaries and other aspects of basic character structure are not changeable by conscious will, the adult is "stuck" with habitual ways of being which now interfere with healthy rational, adult living.

Most people's ego boundaries tend to be one of two types: rigid or diffuse. Those who develop rigid boundaries are usually tense in their musculature with a tight jaw and a fairly high level of general muscular tension. They tend not to trust people much and not to let anyone come very close. They may be paranoid to a greater or lesser degree. Tightly organized in everything they do and highly routinized in their lifestyle, they are neat and orderly, sometimes in the extreme. They tend to be narrow in their thinking and in their ability to fantasize. They have difficulty experiencing a full range of emotions since feelings do not seem safe to these people and they fear losing control. A tendency to underidentify with others characterizes those with rigid boundaries so they tend to be judgmental and intolerant and are commonly referred to as "thick-skinned." Eye contact is avoided and speech may have a monotone quality. There is little variation in behavior because walking a narrow road and trying to hold oneself together are of paramount importance.

Those with weak or diffuse ego boundaries, on the other hand, are soft in their musculature with little general bodily tension. They may be slightly or severely overweight. They tend to over-identify with others, becoming easily confused about where they begin and end. They become overly involved with people, animals, causes, cults. They tend to be too trusting and easy to deceive. They may invite inappropriate involvement with others by being seductive and flirtatious. Unlike rigid people who feel a need to keep distance, those with diffuse boundaries feel a need to be close to others, almost attached. They have no difficulty fantasizing or feeling. In fact they are "spilling over" because the container of the self, the psychologic skin, is insufficient. They have difficulty thinking clearly and taking firm stands since considerable confusion exists between thinking and feeling. Such people are rarely openly angry because it feels unsafe to take the chance of pushing anybody away.

Obviously no one is a pure type. Deficiencies in the psychological skin are present to a greater or lesser degree in all people. Most people have some areas in which their boundaries are competent and work well but other areas in which their psychological skin is deficient due to the presence of weak spots or even holes. When the weak spots are stressed, the inadequacy of the psychologic skin shows in the person's behavior. For instance, many people are very competent in their work but have serious difficulties in maintaining intimate relationships or in getting involved with people on any more than a superficial level. Others are able to be socially active but have difficulty settling down to solitary activity which requires concentration and clear thinking.

What is meant by well-defined or competent boundaries? Ideally each person ought to be a competent vessel that can adequately hold whatever is within as a competent bottle contains the liquid inside. No one ever achieves this fully. "The boundaries between the self and object-representations within the ego may remain somewhat fluid and interchangeable even into adult life. Although they may achieve a relative stability, they are not static" (Rose, 1972, p. 182). It is possible, however, to repair and correct damaged, deficient and underdeveloped ego

boundaries in properly conducted psychotherapy. People in this process are then more inner-directed than outer-directed and their sense of safety in the world is not dependent on whether they are close enough to or distant enough from others. Instead, they have a basic sense of security within themselves, a sense of being safely contained in their own skin. They don't tend to puff themselves up to appear bigger than they actually are and they also don't tend to put themselves down. They know essentially who they are and where they stand, areas in which they are competent and those in which they have limitations. While their relationships are important, they neither need to hold onto others nor do they need to push them away. They tend to mother themselves well and attend properly to their own real needs. Such people can also father themselves reasonably well, attending properly to self-discipline and living essentially according to reality. Such people experience fewer extremes in their emotional reactions and their reactions tend to make sense in light of current reality with little overreaction and few distortions. When we really know who we are, we are not easily threatened by what happens outside of us. Our sense of well-being is not dependent on how others see us.

Since ego boundaries develop in infancy, their rudimentary edges take shape essentially in the relationship with the mother or the mothering person. Therefore, the quality of early mothering is a major determinant in boundary formation. If a mother holds her baby too tightly because she is afraid herself, if she is too attentive, too worried, too doting, the baby will feel smothered and unsafe. The baby is then likely to develop rather rigid boundaries in an effort to "protect" itself from its well-meaning mother and all others who come close. If, on the other hand, the mother does not hold her baby firmly enough, if she herself fears closeness and keeps distance from others she will inadvertently deny her baby's real needs to be properly held. This baby will experience a desperate wish to be held and its boundaries are likely to remain underdeveloped and soft as it attempts to cling to and bond with others as mother-substitutes.

The only way to repair damaged boundaries is in "long-term relationships that are deeply involving and truly reliable. They must be sturdy enough to withstand even repeated tests under the most intense stresses that can occur between people....Character change is at least as difficult a process and almost as time-consuming as character formation was in the first place" (Bar-Levav, 1988, pp. 335-336). In order to do this kind of boundary repair work the therapist must be able to be emotionally involved with the patient without getting confused, without over- or under-identifying. The therapist himself needs competent boundaries to be able to establish and maintain the kind of relationship which must touch on deep-seated fears in the patient. When frightened the patient will tend to either hold on too tightly or to push away. The therapist must be able to respond then based on the patient's needs, not on the therapist's comfort. The therapist is the tool of therapy and must do whatever work is necessary with him- or herself to achieve flexible, competent, well-functioning boundaries.

We therapists have only ourselves to use in our work. It is not important for patients to know reality details of our lives but whatever we are as people shows. We can try to say all the "right" words to the patient and utilize a variety of sophisticated techniques; but it is our actual presence as a real person that counts. The burden is on us, more than on those in other professions, to fix, adjust and repair ourselves so that we do not abuse those who come to us for help.

All human beings operate according to the same principles. We all came from the same place originally and experienced the same helplessness and dependency. We all had to live with fear and panic early in life and each of us made the very best adjustment we could. We are all survivors of a difficult period and our psychological skin, the boundary which defines our "self," is a reflection of our own unique history. The achievement of competent boundaries allows us to move beyond the characterologic limitations of early life to a freer existence as adults.

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Pamela Torracco, M.S.W., is a psychotherapist in Southfield, Michigan where she practices and teaches long-term, intensive individual and group psychotherapy, the aim of which is individuation through the repair and restoration of damaged and underdeveloped ego boundaries.

## Background Points of Theory

### DEFINING THE BOUNDARIES OF THE SELF

■ 32. The boundaries of the self are only symbolic concepts, existing psychologically without physical representation. They cannot be observed directly, but their nature can easily be deduced from the ways a person typically relates to other people and things. Such external attributes as educational achievements, financial status, political position and power, and physical attractiveness are all irrelevant in judging the integrity of personal boundaries.

■ 36. No real intimacy or closeness is possible without a sense of clear boundaries. Close contacts without tension are best maintained between individuals or states that are stable and secure within their boundaries and more or less equally matched in terms of power. Disturbances in the balance of power typically precipitate turmoil and unrest. When the psychologic or geographic borders are not clearly demarcated, the person or state is in constant uncertainty and flux, and closeness is commonly experienced as a dangerous encroachment.

■ 38. Open borders of states or people are often sensed as openings through which one's "life substance" might ooze out. Totalitarian regimes cannot prevent their populations from escaping except by coercive barriers, as the Berlin Wall and the Iron Curtain illustrate well. People lacking an intact psychologic skin also put up barriers to keep others from coming too close, lest they be sucked dry by them. The fear of losing all of one's strength, vitality, and even identity causes many people to continually maintain great distances from others. Intimacy can only be achieved after the boundary defect of the self is repaired.

*From A Unified Theory of General Human Motivation and Behavior  
Chapter 8 of  
Thinking in the Shadow of Feelings.*

## 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.

There is now 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 concepts of ego boundary repair. 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 December 15, 1994.

# BLEA TUESDAY SEMINAR

## Focusing on Method: How to Repair the Boundaries of the Self

### ASSIGNMENT FOR AUGUST 4, 1992

In simple terms and without jargon, please answer the following questions:

1. What are the boundaries of the self?
2. How is their condition assessed or evaluated?
3. What defects are commonly present in these boundaries? Give brief examples, clinical or otherwise.
4. Pick one example of No. 3 and briefly outline your recommended therapeutic approach.

The total of your answers is not to exceed 250 words.

### ASSIGNMENT FOR AUGUST 11, 1992

Based on the most reliable information available to you, pick any three of the following and answer these questions:

Moses, Jesus, Hitler, Jackson Pollack, Van Gogh, Picasso,  
Freud, Truman, Ben-Gurion, McGovern, McCarthy, Jesse Jackson

1. What is your diagnostic impression of the essential quality of the personal boundaries of each person you picked?
2. List two or more generally known facts on the basis of which you reached your diagnostic impression.

### ASSIGNMENT FOR AUGUST 18, 1992

Outline the two or three steps that in your experience are required and most important in the repair of boundaries that are too thin or too thick, rigid, brittle, or porous. Use a clinical example as an illustration.

Please be brief. You're asked only to outline what you would do. You may use as many as 250 words.

## TUESDAY SEMINAR RESPONSES

1. What are the boundaries of the self?
2. How is their condition assessed or evaluated?
3. What defects are commonly present in these boundaries? Give brief examples, clinical or otherwise.
4. Pick one example of No. 3 and briefly outline your recommended therapeutic approach.

1. "Boundaries of the self" is a figurative term for the degree of realistic emotional clarity and separation from others a person has achieved. To have effective boundaries means a person has access to the full range of his emotions while knowing they are his alone, not those of others. Healthy boundaries are also marked by a rich capacity for intimacy with others without confusion or unrealistic fear of such involvement.

2. Their condition is assessed by observing a person's interactions with others, particularly during times of strong feelings. A person's boundaries are effective when he remains essentially clear on who he is, while he stays in a relationship without attacking or withdrawing.

3. Common ego boundary defects:

- a. Incomplete boundaries allow a person limited intimacy but also steady though superficial relationships.
- b. Thin, porous boundaries allow a person a sense of "blissful" merging followed by intense disappointment when it becomes clear that no two people can become one.
- c. Rigid boundaries push one to a regimented life minimizing the risk of emotional injury. Such a person appears self-sufficient, but generally pushes others away, and is slow to trust.

4. Paul has a distraught, non-involved presentation, is highly intellectualized, and sees his therapy as "all business." Real intimacy scares him and he idealizes women he dates, only to become "bored" with them. My plan is to intrude on his thinking, show and demonstrate myself as a real person to him, and challenge his efforts to keep the relationship distant.

David A. Baker, M.S.W.

1. Independent of changing situations or attitudes of others, the boundaries of the self are psychological contact points between a person and the external world. They determine the type, quality, and range of one's emotional life. They also regulate the emotional distance that a person maintains between himself and others.

2. A person's boundaries can be assessed by observing:

- a. Outward appearance—how one looks, sounds, dresses.
- b. Quality of interactions with others—capacity for intimate involvement without confusion.
- c. Degree of self-sufficiency combined with the ability to ask for and accept help.
- d. Tendency to over- or under-identify with people, animals, or causes.

3. Common characteristics of boundary defects:

- a. Rigid—L. dresses his stiff, angular body neatly. He rarely displays his emotions, speaks sparsely and in a monotone, and is socially isolated. Task-oriented, he is at a loss when faced with open-ended questions.
- b. Loose—R. is a middle-aged bohemian-looking social worker who lives with two cats, which are "like her children." Exquisitely sensitive to her clients, she frequently gets "overinvolved" with their problems, and is often hurt and frustrated.
- c. Porous—M. functions well at work and in structured or intimate social settings, but panics in a large group he cannot control. When he senses a lack of control or external disorder, he overcompensates in a driven manner to restore order.

Ilna Bar-Levav, M.D.

1. Using myself as an example, my skin defines the physical boundaries of my body and shows where I stop and others begin. How I am and how I behave define the boundaries of my self. These boundaries, influenced by earliest relationships, determine my separateness from others and my ability to be with others but not attached to them.

2. Using myself again as an example, the condition of my boundaries and those of others is assessed in three ways:

- a. How much I am able to be firm in my own thoughts and ideas but flexible when necessary.
- b. How much I can be just with myself, self-nurturing, self-satisfying and content.
- c. How much I can be with others, giving and receiving in reasonable amounts, not clinging and not pushing away.

Victor R. Stoeffler, M.S.W.

1. From an emotional perspective the boundaries of the self enclose the individual and help to define his individuality and his separateness from all others.

2. Their condition is best evaluated by careful observation of how the person relates to others and to reality.

3. Boundary defects:

- a. Boundaries are thin. An individual cannot experience the self as separate from others, confuses thoughts and feelings of others with his own, cannot take firm stands. Barbara lived in a family conglomerate composed of Mother and six sisters. Several of them lived and traveled together and embraced the same, narrow world view. Only after years of therapy did Barbara begin to separate.

- b. Boundaries are rigid. An individual who maintains distance, cannot be emotionally involved for fear of merging, is constantly on guard. Allan's body is tense and tight, eyes scan the group like radar. Suspicious of all who approach him, he is often critical and argumentative.
  - c. Boundaries are incomplete. Areas of competence are interspersed with "holes" of irresponsibility. Paula, age 27, was a competent professional but lived with her parents without charge, had no plans to move out and experienced no anxiety about the arrangement.
4. I expressed serious concern regarding Paula's living arrangements, frequently questioning her about her plans to move out. Her anxiety level rose but not enough to lead to action. I finally insisted that she rent her own apartment within six months or I would not continue as her therapist. She complied but only much later did she understand the rationale for my intervention.

Pamela Torracco, M.S.W.

1. Boundaries of the self refer to the psychological separateness a person has achieved. An individuated person has the capacity to have intimate relationships with ease, to set appropriate limits, to be self-sufficient and self-reliant while retaining the flexibility to depend on others as the need arises.
2. Their condition is assessed by observing the ways a person typically relates to other people and situations. Effective boundaries allow for the experience and expression of feelings without the confusion that results in-clinging or distancing, over-identifying or exhibiting a limited ability for empathy. Their condition is also assessed as a person is observed in interaction with others, especially at times of intense emotional experience.
3. Common boundary defects:
  - a. Those with blurred, incomplete (fuzzy) boundaries tend to experience themselves as merged with others.
  - b. People with thin boundaries tend to over-identify with others. Bleeding-heart liberals, vehement animal rights advocates or right-to-lifers are dramatic examples of the same.
  - c. Those with rigid boundaries have limited ability for empathy, difficulty experiencing others as important emotional beings, tend to compartmentalize areas of their lives and live in a regimented fashion.
4. Rigid boundaries: Treatment must be provided within the parameters of a non-acting-out contract presented and agreed upon. The therapist must be a genuine, non-intellectualized person who can provide a sense of safety that allows this rigidly bound patient to experience closeness. The therapist must intrude in a carefully measured fashion on the limits of the patient's ability for involvement and increase the degree of intimacy in relationships.

Marcia B. Stein, M.S.W.

## A note to our readers

Can we make a diagnostic statement about someone we have not met? The seminar participants were challenged to test their conceptual understanding of the boundaries of the self as evidenced in the lives of well-known people. We invite you to answer this question as you read these responses.

Based on the most reliable information available to you, pick any three of the following and answer these questions:

Moses, Jesus, Hitler, Jackson Pollack, Van Gogh, Picasso, Freud, Truman, Ben-Gurion, McGovern, McCarthy, Jesse Jackson.

1. What is your diagnostic impression of the essential quality of the personal boundaries of each person you picked?
2. List two or more generally known facts on the basis of which you reached your diagnostic impression.

1. Moses' personal boundaries were basically rigid with some degree of flexibility. Truman's boundaries were flexible, with a tendency toward rigidity. Van Gogh's boundaries were severely underdeveloped and porous.

2. Moses' rigid boundaries were evident in his isolative character (being alone in the desert for many years) and his impulsivity in killing the Egyptian and hitting the rock for water in a burst of impatience.

Truman's healthy boundaries were shown in his firm dealings on reality issues such as the Truman Committee and the atomic bombing of Japan. The flexibility of his boundaries is clear from his numerous humanitarian efforts in the "New Deal" proposal after the war.

Van Gogh's efforts to find a cause with which to connect early in his life (including a self-sacrificing religious life), his haunting appearance in many self-portraits, and his self-destructive behavior all indicate porous boundaries.

David A. Baker, M.S.W.

1. Van Gogh apparently had diffuse boundaries with a tendency or wish to merge. Truman demonstrated porous boundaries, allowing for clear and decisive action on the one hand, while explaining abandonment fears and difficulty with separation in circumscribed areas of life on the other. McCarthy showed rigid boundaries, poor ability for empathy or involvement with others.

2. Van Gogh: Had a symbiotic relationship with his brother Theo. Psychotic episodes during which he mutilated himself. Significant difficulty expressing himself except through his painting.

Truman: Used the atomic bomb as a painful means of saving lives with the full realization of the devastation that would occur without this action. Fired General MacArthur, upheld the principal of civilian control over the military. Over-involved with the women in his life. His mother's son, lived for an extended period in his mother-in-law's house, regretted that his presidency was an inconvenience to his sister and mother.

McCarthy: Brought reckless and unfounded charges against others for the purpose of self-promotion.

Marcia B. Stein, M.S.W.

1. Jesse Jackson: Thin boundaries.

2. The Rainbow Coalition is evidence of the magnitude of his overidentification with those he perceives to be powerless and underprivileged. Religious fervor to his speech and behavior reflect the intensity of attachment to his cause.

1. Moses: Porous boundaries as a young man, became more complete after integrating his experiences with father-like God.

2. Initially reluctant, he grew to be a great military and civil leader in the face of severe external adversity, i.e. held himself and childlike Israelites to strict adherence to moral codes of ten commandments despite the barbaric environment. Respected and identified with God's higher authority, although he did not follow unquestioningly, i.e., compassionately intervened on behalf of contentious Israelites several times.

1. Hitler: Rigid boundaries

2. Clipped, stiff appearance, walk, and behavior. Built hatred and terror machine to fortify personal and political boundaries against all whom he feared dangerous. All non-Aryans were evil enemies to be eliminated.

Ilana Bar-Levav, M.D.

Outline the two or three steps that in your experience are required and most important in the repair of boundaries that are too thin or too thick, rigid, brittle, or porous. Use a clinical example as an illustration.

The most important steps in the repair of boundaries of the self are: 1) firm holding; 2) the use of therapeutic force, confrontations and intrusion; 3) reality observation, separating feelings and thinking. The intensity, dosage, and timing of these three functions should vary in each case. Boundaries of the self which are too thick require forceful confrontations like "dermabrasion" or surgical incisions, followed by holding and observation. Boundaries which are too thin require much more firm holding mixed with careful, small intrusions since

everything is experienced as painful. Porous boundaries require first a great deal of reality observation and work on separation of feelings and thinking before forceful confrontations and intrusions can be integrated.

A patient Dan has been in therapy for several years and because of porous boundaries quickly adapts to whatever he believes others want him to feel and be. His labile mood swings follow his perceptions of what therapists and patients express about him. He has developed a keen perception of others but has not integrated his own sense of self. Therapy consists of firm holding and repeated confrontation of his adaptive swings from one feeling to another and from person to person. The patient is constantly forced to interrupt his feeling expressions, to assess reality, and to evaluate his thoughts and feelings at the moment.

Natan HarPaz, M.S.W.

Required steps for the repair of boundaries of the self:

1. The work must always be done within a solid real and therapeutic relationship which will withstand turmoil, emotional tirades, and the re-experiencing of intense emotions previously denied or repressed.
2. The therapist must be a solid person who will not fade, weaken, or tremble when a patient pushes against or pulls away from him.
3. When pushing or pulling happens within the relationship, the therapist must consistently and continuously engage the patient's observing part in testing the reality of the process.

Example: Allison has thin boundaries, is sensitive and hesitant to becoming involved and does not want to risk the pain of rejection and hurt. When she withdraws or keeps her distance, I pull her into the relationship, close to me emotionally and sometimes physically, and after the fear subsides, we reality-test to help her reflect on the process that she just safely experienced.

Victor R. Stoeffler, A.C.S.W.

The following are necessary for ego boundary repair:

1. Real emotional involvement
2. Firm holding
3. Appropriate use of force to stress boundaries
4. Reality intrusions

The above should be used in varying degrees and combinations based on a dynamic diagnosis, with consideration always for the quality of the real relationship between the patient and therapist, the vicissitudes of the transference, the degree of experienced fear and the ego boundary deficits in evidence.

Carol shored up thin ego boundaries by using withdrawal. She lived apart from others as much as possible, coming to treatment with ulcers and complaints of contained rage. I provided holding through months of silent or quiet sessions. Entrance into group and later involvement in a marathon session were experienced as frightful intrusions that threatened her tolerance for treatment. Her significant involvement with me held her when she wanted to run. I applied gentle but steady therapeutic force, holding her to the reality principle of no action even in the face of strong fear, and eventually insisting that she participate in the sessions which were indicated for her.

Marcia B. Stein, M.S.W.

### 1. Work in the real-relationship from the first contact.

Therapist is a person, ready and able to use himself as the main tool in the healing process. Therapist presents as confident, competent, compassionate; the clarity of his own ego boundaries are reflected in his personality.

### 2. Establish therapeutic relationship, defining clearly by words and behavior the freedom and limitations existing in it.

Define the contract clearly, repeating, reinforcing and enforcing parts of it as the need arises. Encourage patient to use the full range and free expression of feelings and thoughts available within the confines of the therapeutic setting and contract.

### 3. Exercise firm and sensitive fathering.

Pull the patient toward exploration of frightening territory. Provide opportunities for patient to push against the therapist. Set and adhere to firm limits when feelings are expressed as actions and whenever patient oversteps the boundaries of the therapeutic and real-relationships.

Catherine, age 25, had a long history of impulsive acting out. Anxious and distractible in initial sessions, she nonetheless adhered to my requirement that she not leave her seat during sessions, nor pace in the waiting room. She tested the limits further with clever attempts to extend sessions, frequent phone calls, and protestations that she was too sick for a group. My availability *within limits* was apparently different from her previous therapy experience. She accepted the non-acting-out contract I required, seeming to be reassured that my insistence on it meant she was healthy enough to live differently.

Pamela Torracco, M.S.W.

Required and most important steps in the repair of ego boundaries are as follows:

1. Patients with all types of boundaries require a sensitivity to their internal process, helping them to identify it and to build their sense of inner life.

2. All types require a sense of firm but pliable external limits from the therapist as a brace for their defective personal boundaries. This provides therapists with the optimal chance of entering their internal system as it plays itself out especially in the group. The goal is that sensitively placed but firm external limits will be "borrowed" and eventually adopted consciously as a new boundary. This builds confidence in the process of self-containment and the optimal channeling of emotional energy.

3. For thick or rigid boundaries, measured intrusion counteracts the tendency to lose the boundaries while adding new, more flexible capacity for self-containment.

4. For all types maintain deep emotional involvement over time, promoting emotional dependency while discouraging actual dependency, thus reconstructing the boundary damaged by the mother-infant dyad. Continue to help the person separate his inner emotional life from other aspects of real life.

Ronald Hook, M.S.W.

1. A sound therapeutic alliance based on the real-relationship must first be in place. Then, conditions must be created which render the patient's usual defenses ineffective. This gives rise to anxiety. The patient then needs carefully titrated, yet firm pressure to mobilize his health in the face of this anxiety.

2. Patients with thin boundaries may need little else than the therapeutic setting itself to loosen their defenses, while patients with thick boundaries may require major confrontations to go beyond their usual stance.

Due to her thin boundaries, J. becomes panicky and confused when asked about simple details of her life. Gently but firmly the therapist must hold her to reality by insisting that she maintain eye contact, breathe deeply, and ask herself if she is actually under attack. Her observing capacity and her ability to tolerate her emotions without acting out strengthen her boundaries.

Paul Shultz, M.S.W.

## Background Points of Theory

### SYMPTOMS OF POORLY DEFINED BOUNDARIES

■ 39. People with ill-defined boundaries therefore shun real love and friendship; their predominant fear is of engulfment. They usually seek romantic "love," the security pact of the non-individuated, while rejecting the gifts of true love. Conflicts, divorce, and even violence are common in romantic "love," because the closeness eventually exceeds the tolerance for it by one of the partners while insufficient for the other. Discord often results for no other reason than one partner's wish to maintain a safe distance.

■ 48. People with well-defined boundaries also identify with others, but they do not overidentify. Since their psychologic skin is more intact, they are generally less fearful, and they tend to identify with those who are perceived as more powerful. They often espouse conservative positions even if they are economically not so well off, since their subjective experience is one of greater safety in the world. They are not so eager to change things as to conserve and preserve them.

■ 49. Those with diffuse personal boundaries, on the other hand, usually experience themselves subjectively as powerless, and this colors their "choice" of values. Such people commonly identify with the have-nots, and they tend to become liberal or even revolutionary in their politics or economics, even if very wealthy. The paradox of the Kennedys or Patty Hearst is often described in terms of guilt, but it probably is better explained in terms of diffuse boundaries. Although such people usually insist on holding on to the many objective advantages that they have, they often support those who wish to destroy the existing order. In spite of their riches, they are looking for a better world in which they too would feel safer. Wealth obviously does not insure safety, and it is not the key to real power.

■ 51. People with ill-defined boundaries tend to be "other-directed." The greater their boundary confusion, the more they are dependent upon outside influences to define who they are, what they stand for or against, and what they must do. Their antennae are always acutely attuned to the outside to make sure that they either please or displease others, depending on which of their fears is predominant. Such a state of unrest and agitation eventually leads to premature physical or emotional collapse.

*From A Unified Theory of General Human Motivation and Behavior.  
Chapter 8 of  
Thinking in the Shadow of Feelings.*

## CASE PRESENTATION

*Clinical observation and experience have always been the way knowledge in medicine was transmitted to the next generation of practitioners. Physicians were mainly taught by apprenticeship in the past, and even now observing experienced clinicians is still the backbone of medical education. Though many of us are psychologists and social workers and not psychiatrists, this is an effective way to teach psychotherapy, which is one main goal of this Journal.*

*The clinical case presentation is therefore a regular feature in each of our issues. The primary therapist summarizes his or her diagnostic impressions and major clinical interventions, and this is followed by comments from other experienced psychotherapists; each giving his/her own clinical observations and ideas. We invite and publish responses from all readers, regardless of their theoretical bent, and unless clinically contraindicated also offer the patient an opportunity to anonymously express his or her reactions to the presentation and discussions.*

*This time the presentation and initial discussion is by Paul Shultz, M.S.W. You, the reader, are invited to actively participate in this clinical dialogue by sending in your own clinical observations and plan. Briefly indicate your theoretical assumptions and give a specific rationale for your recommendations. Clearly written presentations will be published essentially without editing, but must be no longer than 250 words. All responses for inclusion in our next issue must be received no later than December 15, 1994.*

### THE CASE OF FRANK

#### HISTORY AND COURSE OF TREATMENT

First-born of five in a family marked by suicide, psychiatric hospitalizations, and schizophrenia, Frank, 48, is only marginally successful professionally and exclusively dates woman after woman, each usually idealized as the "right one" to marry. Father was too ill emotionally to provide adequately, so the family lived in the basement of the maternal grandparent's home. Frank took on the role of family provider, a role he still plays in employing his father, brother and mother in his business. Apparently, mother was a kind-hearted but simple woman to whom Frank has been pathologically devoted up to the present. Driven by a harsh superego, Frank tends to the "needs" of helpless women in a self-effacing, self-absorbed manner.

Frank began treatment in combined individual and group psychotherapy over eight years ago. Serious ego boundary deficits were apparent from the beginning. In the group, he tended either to overidentify with female patients who presented helplessness; or to speak in a self-absorbed, non-contactful fashion about issues outside the room, usually his current love. Presenting himself as intellectualized and affect-isolated, he would become wooden and make little eye contact. Fellow group members would be impatient with him since he wasn't really "speaking to" them, but was "lost in his own world." He typically brought up real life problems, but at times when others were busy and unavailable to hear him.

Over the course of treatment Frank progressed steadily. Often with minimal help from his therapists (e.g. "Stop, Frank. Think!") he was able to make a correction and exercise his growing ability to identify accurately with others and successfully relate his own struggles to theirs. However, despite his ability to understand the roots of his affliction, and his difficulty with relationships, he rarely took responsibility for stopping himself, and continued to slip into the old character presentation rather than exercising his growing ability to comment thoughtfully upon his difficulty with remaining emotionally present with others. Many were the confrontations, but the tendency seemed intractable. This is obvious in the following group session.

Early in the session, one of the patients wondered whether a brief course of Valium might help him make better use of therapy. As the group progressed, others began to speak about their experiences with using medications. George, who like Frank tended to connect poorly with others, spoke. "I feel very scared right now." Maintaining steady eye contact, he spoke of how frightening the issue of drug use was to him, and told the group for the first time of his use of alcohol. Such openness for George was unusual. Almost everyone in the group was deeply involved, their eyes and attention riveted on George. Recently, Frank had been able to identify with George's difficulty in making contact, and had seen him as a "brother" in this regard. Now, however he was fidgeting, looking away, and obviously preoccupied. Suddenly he announced, "Polly and I had a fight last night." This sort of ill-timed comment by Frank was familiar to others in the group. The content was out of context and the timing was insensitive and sure to invite impatience from others since it was an intrusion into this sensitive moment that others were sharing with George. Speaking in a monotone, with no eye contact and with wooden posture, Frank was again in his "own little world." One of the therapists firmly cautioned Frank not to speak at this time, hoping he would focus on others; Frank took a few deep breaths. However, a few minutes later he again tried to interrupt the process saying, "I want to talk about this problem with Polly!" He had not taken the cue, and the others continued, trying to not be distracted. Frank then sat forward and tried to engage one of the therapists in a side conversation. Loudly, George exclaimed, "Frank, you haven't done a damn thing to be involved with other people here! You're so involved with your own bellyache about some woman that you don't even make any effort to be with us!" Despite the fact that Frank had been sensitively involved with George in many previous sessions Frank immediately shouted back, "You goddam bastard! Go to hell!" George reacted immediately. Back and forth the exchange went, quickly getting louder and more angry with each interchange. What to do next?

### INTERVENTION

Central to Frank's work in the group has been his preoccupation with his thoughts and feelings at the expense of real involvement with other human beings. Preoccupied with his idealization of Polly, his real involvement with her is actually as poor as his involvement with others in today's group setting. Confronted by George, the shell that protects Frank from real involvement cracks and he panics, reacting with defensive anger like a cornered animal. A corrective

emotional experience would be possible if Frank's outburst could be quelled and his anxiety ameliorated enough for him to make solid human contact before the end of the session.

Loudly and firmly, Mr. P. (the therapist) instructed Frank to stop and breathe. Based on an alliance-built over many years of similar incidents, Frank was willing to comply. Asked for permission to touch him, Frank agreed and Mr. P. patted his shoulder firmly, saying "Frank, settle down and breathe. Look in my eyes. You are very anxious, and there is nothing for you to do at this moment except breathe." He took a deep breath, but his eyes wandered. "Frank, stay with my eyes. Keep in contact with me." Mr. P. slapped him on the back, like one might slap a friend who is having a hard time. His eyes returned to Mr. P. who continued. "George is doing what he needs to do for himself, and you owe him nothing in response. You feel a need to protect yourself, but you don't really need to. You will be OK, and there is no need to fight at this time."

Once or twice, Frank again tried to hurl invectives at George, but Mr. P. repeatedly stopped him and brought him back into contact. Since the session was due to stop within ten minutes, Mr. P. decided to review previous occasions when Frank had seen George like a "brother" with a similar difficulty being really involved with others. "Usually, George likes you. But I think he finds it hard to be with you when you become preoccupied." Frank's eyes wandered from Mr. P.'s and he started to mutter to himself. "Frank, look at me. You're doing it right now. You'd rather be in your own belly than with me. Dammit, look in my eyes." Frank looked at Mr. P. and tears filled his eyes as his posture slumped. "Here, Frank, take my hand," said Mr. P. Frank reached out and took the hand, gripping it limply. "Squeeze, I'm *right here* with you." He squeezed hard, looked Mr. P. in the eye, and shed a few more tears. Then his eyes drifted away and his hand became limp.

"Dammit, Frank, I'm trying to help you." Frank's eyes drifted. "Stay with me. Polly's not here. But I am, and so are the others. Squeeze my hand." He squeezed and looked Mr. P. in the eye tearfully. "Sit up taller, Frank," Mr. P. said firmly, but gently. "You did nothing to be ashamed of." Tears rolled down his face, and soon he was sobbing deeply as he looked Mr. P. in the eye. Relieved to find someone truly present with him, he felt the deep pain of his isolated existence.

By now it was time for the session to stop. Frank was "in contact" now, but could easily drift away immediately after the session. To minimize the possibility of such damage, Mr. P. asked Frank to agree to telephone him later that evening. During that brief telephone conversation, it was clear that Frank wanted to stay outside of his shell, and was glad to have someone to contact who understood his struggle. Later, in his individual session, he would reflect on this experience and on his difficult struggle to leave "my own little world."

## DISCUSSION

This work was based on several theoretical principles. Boundaries of the self can be thought of as a psychological fence, clearly separating feelings and fantasies which originate inside the organism from stimuli which originate outside the organism. The mature "self" is defined as it relates accurately to the real world outside the organism, while the pathological, narcissistic and ersatz "self" defines itself in terms of feelings and fantasies originating solely within the organism. Over the years that Frank has known Mr. P., a progressively stronger alliance has developed based upon a real relationship between the two of them. Frank knows "in his bones" that Mr. P. really likes him and is truly on his side. Only within the framework of such a relationship can damaged boundaries be repaired. This alliance, not fantasy or transference, makes it possible to bring personal force to bear in speaking loudly to him as one might yell at a small child toddling into a busy street. Even as Mr. P. spoke loudly, he was reasonably sure that Frank would know that he was not pushing him away, but was trying instead to break through Frank's narcissistic bubble.

Human contact is another fundamental principle which is important in ego boundary repair. First and foremost, there must be eye contact. This literally means that eyes must be focused on another human being and that two people actually see each other. Sometimes this is difficult to determine, as when the eyes are pointed in the direction of another but there is no focusing and the other person remains obscure. This is why Mr. P. yelled "Look into my eyes." Human contact also is based at its most primitive level on human touch. This is why Mr. P. reached out his hand to Frank, and why it was important that Frank took it.

The patient's sense of his own physical power involves another fundamental principle. What therapy ought to be developing and encouraging is an adult-adult relationship, not a relationship between a regressed patient and a parental but ineffectual therapist. Only with an adult-adult real-relationship firmly in place can regression be useful to the patient. When Mr. P. insisted that Frank squeeze his hand forcefully, this was meant both to help Frank be aware of Mr. P.'s physical presence, and to be aware of his own physical presence and power. When faced with true intimacy, Frank became frightened and tended to push away. Mr. P. encouraged him to hold on tightly. Having done this, he was more in contact with reality, therefore less anxious, and able to experience the underlying pain of his loneliness and isolation. Since this work happened just before it was time for the group to stop, Frank was in danger of sliding into a regressed, self-coupled position following the group if further measures were not taken. To generalize the real contact of this intervention beyond the therapy session, he was asked, and he agreed, to call Mr. P. later in the evening just to say hello. This he did, moving beyond his characterologic limitations, and strengthening his boundaries in a new way.

Paul Shultz, M.S.W.

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Mr. Shultz practices combined individual and group psychotherapy in Southfield, Michigan. An officer of the Michigan Group Psychotherapy Society for many years, he regularly conducts presentations both locally and nationally. He has also been a training supervisor with BLEA for the past 15 years.

## COMMENTS IN RESPONSE TO THE CASE OF FRANK

We are offered a segment of interaction in one group psychotherapy session, with a focus on the clash between Frank and George. We are asked "What to do next?" The answer, basically, is to use the group to work this through.

Frank's family and group history indicates that he has a severe borderline personality defense organization. This is arrayed against an inchoate sense of annihilation and abandonment. Persons with such a degree of character dysfunction usually do require very long-term combined group and individual therapy. The therapist must continually and patiently identify the presence of these primordial fears in each inappropriate interaction. Until the person has gained safety by identification and affiliation with a developmental series of subgroups, confrontation is useless. It is also typical of such patients to regress after showing gains, and to manifest very uneven contactfulness.

Now let us look at the sub-group interaction process. When medication was being discussed, Frank was not included. George (sometimes viewed by Frank as a brother) suddenly gained the group's "riveted" attention. By now, Frank was again abandoned by his sibling-surrogate and the sub-group. He showed signs of anxiety and regression. Neither therapist, to this point, interpreted what Frank could be experiencing, nor tried to include him in a sub-group of members with similar feelings. Instead, he was "cautioned . . . not to speak" by one of the therapists. This again isolated Frank and increased a sense of abandonment and impending annihilation, especially as a replay of a much-used "Stop Frank. Think!" interaction with the therapists. Frank was desperate to be let into a sub-group. He then tried to reach one of the therapists in a side conversation, as an alternative. That apparently was not consummated. At this point, George aligned himself with the group as a whole and attacked Frank for uninvolvement with others. Now Frank was truly alone with no likelihood of useful closure.

The two therapists could choose to label the panic in both men and its origins both immediate and familial. They could then facilitate expression of different levels of empathy from the other group members, and thereby re-open the doors of sub-group inclusion to Frank as well as to George. At a later time, the therapists could disclose their impatience with Frank and their need to restrain him, as part of their own sense of helplessness. As the group process continues, severely dysfunctional members can find safety and containment in different sub-groups. Then, like a series of steps, they can venture out, try new behavior, and gradually affiliate with a higher-functioning sub-group.

Isaiah M. Zimmerman, Ph.D.

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Isaiah Zimmerman, Ph.D. is a psychologist in private practice in Washington, D.C., and is on the faculty of the Washington School of Psychiatry's group psychotherapy training institute, and the George Washington School of Medicine's clinical faculty.

## LETTERS FROM OUR READERS

To the Editor:

Thank you for covering an important, but difficult to grasp subject in your second issue of the Journal. Making the distinction between appropriate self-care, self-indulgence, self-indulgence which presents as self-disciplined behavior, and fear-driven self-soothing is difficult enough. Determining and properly executing the appropriate therapeutic intervention requires even greater precision, precision which calls for a level of awareness, settledness, and clarity within the person of the therapist that could be heard in the words of the writers. While distinguishing between healthy and pathologic self-care is certainly an important aspect of the therapeutic process to be understood conceptually by any competent therapist, it was clear that this concept can only be truly understood to the extent that these issues are repeatedly challenged and worked through in the person of the therapist. For me, these articles gave light to a frequently cloudy issue and left me wanting greater sustained clarity at a personal level.

Beyond the personal level, this topic (and I assume forthcoming topics) have much broader implications, implications regarding public policy as the United States emphasizes the need for a strong crime bill and the American public expresses a variety of strong feelings regarding Singapore's approach to deterring crime. Implications can also be anticipated regarding the movement of mainstream psychotherapy to shorter, crisis-oriented approaches, acute symptom stabilization and the popularization of Prozac as the "mood-drug" of the 1990's. I believe it would be a valuable addition to include articles addressing broader issues such as these as well as articles expressing the perspectives from fields of study outside that of psychotherapy.

Thank you for your thoughtful and diligent work.

Daniel G. Rooks, Psy.D.

To the Editor:

The topic in the Summer 1994 issue, "Self-mothering vs. Self-indulgence, was thought-provoking. For several years I have conducted a support group for women in varying stages of breast cancer. In the absence of scientific research, but years of observation, there appears to be a common thread in the personality of these patients. All of the women have not mothered themselves well.

These are women who do not have a solid, well-defined identity. They live as though their 'personhood' is dependant upon others, their husbands or children. They live their lives based on what they can, and "should" do for others. They rarely take time for themselves and thoughtfully pursue individual interests or goals. They feel a tremendous amount of guilt when they do take a moment for themselves or put the needs of others behind their own. In short, they do not reach out or strive to meet their emotional or physical needs.

I believe that in these women the development of breast cancer creates a legitimate reason or excuse for them to self-mother. It is when this tragedy occurs that these women finally put their lives first. This does not mean that they selfishly neglect their families and friends. There is simply a healthier balance that allows them the freedom to express and satisfy their own needs. Many women state that breast cancer, though a tragedy, changes their lives and rearranges priorities. There is a gift in the cancer, the gift of self and self-mothering.

Claudia LaFayette, M.S.W.

To the Editors:

Self-indulgence versus self-mothering is a social as well as psycho-emotional issue.

I read with interest and much agreement the writings on self-mothering versus self-indulgence in the Summer 1994 *International Journal of Psychotherapy and Critical Thought*. It is clear that we are confronted by unparalleled self-indulgence in contemporary American society. The definition and discussion of self-indulgence was thoughtful and provocative.

What may be the most challenging aspect of this phenomenon is its universality. It is clear that poor mothering begets self-indulgence. It is also clear that self-indulgence begets poor mothering. In primitive societies, where mothering cannot be assured because of health and mortality issues, mores dictate that all assume responsibility for mothering (and fathering) each child. Hence, we hear the oft-repeated proverb, "It takes a whole village to raise a child." We, however, have no village. The self-indulgent have neither the time nor inclination for the sacrifice of village.

Self-indulgence, in our society, is consequently an issue much larger than can be resolved psychotherapeutically. It is an issue which those who understand the psychopathology must join to confront. They must provide the leadership to create a "village" of opportunity for psycho-emotional health for the coming generations. This may confront them with the conundrum of working to achieve a "conservative" social model by institutionalizing a "liberal" educational response. Without giving access to both mothering and fathering to those children among us who are most needy, however, the opportunity for healthy adult self-parenting is diminished for all.

Michael R. Williamson, Ed.D.

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Please direct your inquiries regarding the training program or conferences to Natan HarPaz, Dean, The Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI 48075.

### Coming in the Winter 1994 Issue

## *The Use of Power and Authority in Psychotherapy*

During a recent BLEA conference on power and authority one repeatedly heard the comment, "I would not feel comfortable using that kind of power with my patients." Many therapists are unclear and confused about the proper use of power and authority in their work with patients. Yet patients cannot resolve their difficulties about authority and power without therapists who go beyond an intellectual understanding of these issues. Therapists themselves must know the experience of pulling hard against patients' pathology and for their health in order to help them grow. The next issue will discuss why power and authority are necessary aspects of psychotherapy, and how therapists can develop their skills in this important area.