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*In This Issue:*

SELF-MOTHERING VERSUS SELF-INDULGENCE:

HEALTHY VERSUS PATHOLOGIC SELF-CARE

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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

## Self-Mothering Versus Self-Indulgence: Healthy Versus Pathologic Self-Care

Although common in daily usage, self-indulgence is rarely mentioned in the literature of psychotherapy, and the concept of self-mothering is generally still almost unknown. The basic meaning of both concepts can be easily deduced, but beyond that we intend now to examine their clinical value and their place in the psychotherapeutic treatment of patients.

Most clinicians agree theoretically that appropriate self-care is a healthy adult objective, while regressive gratification is a sign of emotional immaturity. Confusion abounds, however, when such theoretical agreement is translated into actual recommendations about the procedures and steps needed to help patients learn to care for themselves well. It is very difficult to wean growing children from being self-indulgent, and the task with patients is much harder yet. We intend here to lessen the lack of clarity on these issues and thus to help clinicians do this aspect of their work better.

In our permissive societies proper and desirable self-mothering is often confused with harmful self-indulgence. So much is given, promised and available to so many of us in our affluence that there is too little understanding of every person's need to still care for him- or herself. People now expect quick and easy solutions to every problem, and many have become accustomed to seeking comfort and solace in any form, as long as only little time and effort are required. This is why alcoholism and drugs are a serious national problem, and why shoplifting is so common among kids. Taking aspirin is a ubiquitous solution to a headache, even if the pain is due to fatigue, thirst, a missed meal, or anxious tension. The frustration tolerance of many youngsters is much too low for the same reason; they shoot and kill each other for minor slights, or for no reason at all. The gun is king when reason is not.

In the absence of sensible self-mothering young and old satisfy themselves with the help of pathologic self-indulgence. Few among us sleep, eat, read, relax, work and play enough, but not too much. What is behind the push to do things that we ourselves recognize as bad for us? Anxiety? Habit? A willful refusal to stop?

Much ignorance and confusion exist about the meaning of healthy self-care and self-concern. "Self-praise" and "self-satisfaction" often carry with them negative connotations, while being "self-less" is considered a good thing. Contradictions are common and they interfere with good child-rearing no less than they do with the work of the psychotherapist.

Discussions that follow thus are of the greatest importance in childrearing, but our emphasis is on clinical relevance. Learning to successfully battle self-indulgence requires that we become competent in self-mothering as therapists, friends and citizens. Our success or failure in these has a powerful impact, one way or the other, on virtually every aspect of our personal and professional lives. The topic of this issue would therefore be of interest to thoughtful parents and citizens also, but for psychotherapists it has an even greater significance. In a real sense it determines whether our efforts are crowned with success. Patients often improve in psychotherapy but they only get well if they win not only the narcissistic battles against self-indulgence but also become competent in mothering themselves lovingly without guilt or shame.

The Editors

# SELF-MOTHERING VERSUS SELF-INDULGENCE: HEALTHY VERSUS PATHOLOGIC SELF-CARE

Reuven Bar-Levav, M.D.

Self-mothering and self-indulgence are opposites that have much in common: both concepts are of central importance in the raising of children and in psychotherapy, and yet neither is as yet well-known. Poorly understood and inadequately described, both are hardly ever even mentioned in the psychiatric literature. Self-mothering is a relatively new concept introduced by this author (Bar-Levav, 1988) and no other references to it were found, except for Blanck's discussion of "self-soothing" as an interim goal in the management of anxiety (Blanck, 1979). Wiggins (1990) discusses self-indulgence as a problem that society must recognize so that it would not become "the helpless victim of alcohol and narcotics." Walters and White (1988) see self-indulgence as one of four characteristics responsible for criminality, while Grieger (1986) relates it to dysfunctional relationships. This author has previously defined self-indulgence as consisting of acts "that provide regressive gratification in an area already freed from fear" (Bar-Levav, 1988). When moralists speak of self-indulgence they condemn it, while "progressive" educators sometimes come to its defense.

What is self-mothering? Simply, it is the same as good mothering, except that all the needed supplies and services are provided to the person by the self. The well-mothered baby has all its physical and emotional needs satisfied at about the right time and in the proper dosages by a loving, supportive, responsible and consistent outside caretaker. The result is an inner sense of safety and well-being which lasts throughout life, provided however that the same supplies continue to be available on a regular and steady basis as time goes on. But since maturation is impossible without separation from mother, someone else must become the reliable supplier of these essential needs. To become emotionally self-sufficient we ourselves must learn to be that supplier, and self-mothering is thus the basic ability which makes individuation possible.

Most people do not acquire enough of the skills of self-mothering, and they attach themselves instead to another person when they grow up. They hope and magically even expect a spouse or someone else to take mother's place as the source of solace and of other needs. Since both marriage partners often have these same expectations, many marriages fail. Normally, even very loving spouses tire sooner or later of one-sided giving.

Not only babies but adults too need for their physical well-being regular well-balanced meals, rest, recreation and emotional support. But many people clearly fail to take good care even of their basic needs, and stocking up on emotional supplies is much more difficult. To do so we need clear and flexible personal boundaries that demarcate our identity, emotional ties and roots to sustain our sense of belonging, and privacy as well as enough anxiety-free time to attend to ourselves thoughtfully.

But nowadays, both actually and metaphorically, too few people sit down at a table to dine in the company of others even once in awhile, and instead it is common to take meals on the run. Most people eat, sleep, work and play too much or too little. Our busy hustle and bustle lives, TV and the personal computer are constant distractions that make it too easy to forget our real needs. Generally, people take more time to exercise their bodies than they do to replenish needed emotional supplies.

In an effort to vanquish narcissism among the young, most civilizations have always emphasized the importance of humility. No one wants his children to become braggarts. Self-praise was thus condemned, even as children were taught to praise the desirable traits of others. The Judeo-Christian tradition has underscored the importance of respecting and loving others, but not the self. Yet the commandment to "Love thy neighbor as thyself" is meaningless before one learns to love oneself.

Even so, we still look upon self-love with suspicion and do not teach our youngsters to attend to themselves with appropriate self-concern, nor do we encourage them to take pride in their realistic achievements. Hence the enormous and widespread hunger to be seen, recognized and praised by others, and the almost universal wish to be caught in the spotlight for even a passing moment. This is why people wish to become VIP's, and why they do grossly bizarre things for a little attention. Anything to be lifted out of the gray anonymity that envelops those who have not learned to observe, to see and to love themselves.

Loneliness is especially oppressive for people who are poor in self-mothering. Disappointment commonly results when practically everything must be gotten from the outside, and people then typically protect themselves by allowing no one to come close, even as they also refuse to leave their isolated shells to make contact. They are hopelessly caught in this double trap from which there often is no escape.

Adults who have not been adequately mothered by others do not usually mother themselves well even later on because:

1. Resignation or hopelessness is often built into the core of such people's personality. Expecting nothing but disappointment, those who are resigned never reach out to supply their physical and emotional needs. The possibility of being well-satisfied and lovingly cared for is unknown to them. They fill themselves instead with self-destructive indulgences such as over-working, over-eating, alcohol or drugs. Hopeless people know at least that hope exists, though they lack it. Since they were not mothered well they expect even less from others, and they have neither a wish nor the strength to do so for themselves.
2. Such people also do not know how to mother themselves, since they have not experienced it enough. They commonly neglect their realistic needs for food, for rest, and for human companionship. The triggering mechanisms that cause others to be alerted to their unsatisfied real needs are stunted or underdeveloped. Thus, they provide for themselves poorly.

Sensible and appropriate self-care, self-recognition and self-praise, tempered by moderation and by good taste, are scarce and urgently needed in our society. To make up for this deficiency kids stare into TV cameras and scream that they and their team are number one. This is the closest our advertising culture comes to promoting self-mothering. Very few people dare to describe themselves seriously as a valuable human being.

Self-indulgence is common in the absence of self-mothering. Without balanced and regular meals people have no choice but to satisfy their hunger by eating popcorn and candy all day long. When this normal hunger for mothering is expressed pathologically it often involves orality. Alcoholism and over-eating, smoking and endless chewing of gum are all common. But such people typically live the life of "noshers" in a myriad of other ways also. To make up for what they really lack and need, many such people tend to always grab, demand and expect "more" from everyone. Not feeding themselves properly, they nonetheless remain emotionally always hungry.

Self-indulgence is ours by nature. Since we all slip into it after infancy. At the beginning of life there is no moderation or judgment, and everyone wants whatever they want when they want it, immediately and without delay. Without enough fathering these traits continue to govern at least some behavior throughout life. But with sufficient good fathering children eventually learn to tolerate the discomforts of not always getting their way, though not before many crises, struggles and disappointments have been overcome.

The threshold of tolerance for discomfort and for disappointments is raised to proper levels when success is achieved. This makes planning ahead and the pursuit of important but distant goals possible, and it enables the person to have stable human relationships. Such living provides the means and the conditions for rational and satisfying self-care. It also reduces the anxiety that springs from the constant search for someone outside ourselves to mother us.

Self-indulgence is related not only to the absence of good mothering and fathering, but it sometimes results from the presence of harsh fathering. Adults raised this way have no model to help them develop self-respect and self-love, even if obedience out of fear is achieved. Such people tend to be harsh with themselves and with others, and they often mortify their flesh and their soul by driving themselves mercilessly till they burn out. To compensate they go on binges of self-indulgent living which endangers the internal dam. Even self-starvation fits in with this scenario.

The development of self-mothering thus requires both good mothering and good fathering. Good mothering supplies the physical and emotional needs of the child, while good fathering directs the struggle against the natural tendency to seek instant gratification. Neither function is gender related. Most early mothering and fathering is done by mothers since they are the ones who are usually responsible for most of the baby's care. With good early mothering the baby:

1. Learns physiologically that it can count on a steady and consistent supply of its real needs, which protects it from the need to hoard piggishly. Enough is usually quite enough.
2. Such babies also "learn" that disappointment and frustration are compatible with life.

Both these lessons must be incorporated for the eventual process of separation-individuation to be completed. Children and adults with such inner "knowledge" are less dependent on approval from others; and they have less of a need to always please in order to get what they need from the outside.

Individuated people are self-contained, and they do not usually even wish to indulge themselves. Like a competent vessel, they too can hold their emotional supplies for relatively long periods of time, which lessens their need for frequent refueling. Besides, self-indulgence always exacts a price in dignity and in self-respect, qualities which such people are eager not to lose.

Self-mothering feeds the adult needs of the person while self-indulgence is an attempt to satisfy the inner infant's pre-verbal hunger, which is in fact unsatisfiable. This is why self-mothering fills, and no amount of self-indulgence is ever enough. Self-mothered individuals are typically satisfied with their lot and willing to share of their riches with others, while self-indulgent people tend to remain emotionally in turmoil no matter what their real achievements (Bar-Levav, 1994).

One goal of effective psychotherapy is to convert patients from the pathological mode of self-indulgence to the healthy way of self-care defined as self-mothering. In the process, chronic depression is lifted, hopelessness and helplessness are essentially eliminated and core anxiety is lowered at least to the point where it no longer produces symptoms.

The intensive work involved is based on eight principles described elsewhere (Bar-Levav, 1988) that aim to basically alter physiologic responses. Interpretations or explanations to the intellect are not relevant to this process. Since self-indulgence is a defense against anxiety, it is not given up without repeated struggles within the therapeutic setting in a process that in many ways replicates the healthy maturation of children. Emotional dependency and the Real-relationship keep the patient from bolting even when massive anxiety, hurt and anger are mobilized (Bar-Levav, 1988). These are expected and common by-products whenever self-indulgence is confronted and challenged.

Narcissistic "injuries" are unavoidable, and patients must physiologically come to realize that they are in fact not real injuries at all. Those who first coined the term could not have foreseen the current developments in psychotherapy that go beyond "character analysis." With the patient's self-observant capacity and a strict non acting-out contract well in place, powerful storms of intense affect are welcomed, encouraged and given open expression. This is the essence of work-

ing-through that alters physiologic pathways and habits. The increasingly powerful observing ego of the patient joins the therapist in repeatedly repulsing the push to inappropriately gratify the self with self-indulgences, even under the pressure of such forceful stimuli.

To survive, everyone needs satisfaction of their basic needs. When good nourishment is scarce, surviving organisms always find pathologic ways to feed themselves. This is true among plants as it also is in the animal kingdom, of which we are part. Most people marvel at the rich and amazing variety of adaptations found in nature, but they usually overlook the fact that many of these result in stunted growth. This is what we try to change in the lives of the patients who seek our help.

But plants, animals and people are alike in their stubborn refusal to give up that which helped them survive, even when better options become available. The worm that lives inside the horseradish will not switch over to make its home inside the sweeter carrot. The same for humans. The compulsion to repeat our pathologic ways is rooted in unconscious fear that the new alternatives may not be life-sustaining. This fear must be physiologically overcome before any real changes become possible. "The push away from fear and dread supersedes everything" (Bar-Levav, 1988).

Self-indulgence is thus defined as the insistence on following tested, pathologic adaptations even after enough of the relevant fear has been eliminated. It indeed requires much courage to venture for the first time into deep water over our head, which is why people normally claim the continued presence of fear to avoid taking such risks, even when it is no longer present. This is the self-indulgence that must be replaced by self-mothering. Otherwise we are condemned to never swim but to always wade at the edge of the pool.

To succeed in this task therapists must therefore be able and willing to not only serve in the mothering mode but also to "father" their patients (Bar-Levav, 1988). This need is not yet widely recognized. But self-indulgence is not given up without it. Upon close examination many failures of psychotherapy and psychoanalysis will prove to have occurred on this basis.

More specifically, appropriate self-praise which may have previously been defined as arrogance must become legitimate, and its use encouraged by patient mothering. But chronic lateness or self-medication to lessen anxiety must be confronted by firm fathering. The patient's needs for rest, recreation and human companionship, as well as the necessity to make a decent living, must all be stimulated if they have been stunted. But these same things must also be curbed and limited by fathering interventions if they are being pursued self-indulgently and in excess. This is an intrusive, active and on-going process since none of these changes occur spontaneously.

The inability to self-mother is a very common disability, as is evident wherever we look. Many millions of people have never learned to care for themselves in a

healthy way, and they experience guilt or even shame when they mother themselves lovingly. This is why self-indulgence and the lack of self-restraint are so widespread.

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Reuven Bar-Levav, M.D., is a psychotherapist, teacher and author of *Thinking in the Shadow of Feelings,* Simon and Schuster, 1988 and of over two hundred other articles. He is also the father of Crisis Mobilization Therapy, the founder of the Michigan Group Psychotherapy Society, and a contributing editor of *VOICES.*

# WHAT IS THE BLEA TUESDAY SEMINAR?

A BLEA post-graduate 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 others' opinions and statements. We have grown together in our expertise 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 on-going 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 handed out 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 self-mothering and self-indulgence. What follows are the assignments and some of the answers which were presented over a four-week period. Your thoughtful responses are welcome and, if suitable, will be published in a future issue. The deadline for responses (250 words or less) to this issue is October 1, 1994.

# BLEA TUESDAY SEMINAR

## Self-Mothering Versus Self-Indulgence: Healthy Versus Unhealthy Self-Care

**ASSIGNMENT FOR OCTOBER 6 and OCTOBER 13, 1993**

I. Define self-indulgence.

II. Review your patients and in no more than 100 words describe the self-indulgent features of one in whom they are prominent.

III. Review the patient's history and early development. Explain why the patient has become self-indulgent.

The total of your answers should not exceed 250 words.

**ASSIGNMENT FOR OCTOBER 20 and OCTOBER 27, 1993**

IV. How are you helping the patient with prominent self-indulgent features (about whom you wrote last week) overcome his or her difficulty?

V. How successful have you been, in percentages? Why have you not been more successful?

The total of your answers should not exceed 250 words.

# TUESDAY SEMINAR RESPONSES

I. Define self-indulgence.

Self-indulgence is the failure to use one's internal control and self-discipline. Due in part to a deficiency of appropriate limit-setting during childhood, it is pathological in that it is a conscious or preconscious refusal to respond to the demands of reality in favor of gratifying regressive wishes. It is not fear-driven behavior; it is alterable by will.

The nature of self-indulgent behavior depends in part on how the person was mothered. An individual who was overly tended to and indulged, emotionally if not materially, is likely to behave in a more overtly spoiled way. By contrast, one who was deprived physically or emotionally as a child may habitually deprive him- or herself by refusing to take care of realistic needs. In this way, overworking, overexercising or overly tending to others at one's own expense may be examples of self-indulgence even if they appear as self-disciplined behavior at first blush.

Ilana Bar-Levav, M.D.

Self-indulgence is a giving way to one's desires or impulses despite the dangers or inappropriateness of the behavior. It provides regressive gratification in an area in which one has repeatedly displayed the capacity to live otherwise. It is the refusal to use self-restraint and exercise individual responsibility.

William J. Yochim, M.S.W.

Self-indulgence is the process of yielding to the push against progressing by one capable of functioning in an adult, age-appropriate fashion. The self-indulgent person behaves in a regressed, infantile manner, motivated not by fear but by a pleasure/comfort-seeking process.

Natan HarPaz, M.S.W.

Self-indulgence occurs when one does not attend to significant but difficult realities because one does not want to, but could do so. One goes "the easy way" regardless of what makes sense. Unused capacity for good judgement, self-discipline, and self-nurturing, particularly in the face of realistic needs, is a major indicator of self-indulgence.

Joseph Gluski, M.D.

II. Review your patients and in no more than 100 words describe the self-indulgent features of one in whom they are prominent.

III. Review the patient's history and early development. Explain why the patient has become self-indulgent.

Mark, a 28-year-old honors graduate, chose employment far beneath his capabilities because it was less demanding and required he work only 32 hours a week. Although he complained he could not support himself on his meager salary, he resisted any pressure to accept or pursue employment suitably more challenging. Any challenge to his comfort level was met with angry outbursts and complaints of unfair treatment. He complained it was unfair to pay for his therapy when his insurance benefits ended. Mark is obese and binges on alcohol when hurt or angry.

Mark is the youngest in a sibship of four. His mother recognized his intellectual abilities and considered him "special." She pampered and overprotected Mark, demanding less of him than of his siblings. Labeled as a "mommie's boy" by his father, Mother came to Mark's rescue when he refused to work part-time in high school and college. Mark's father, who was away from home most of the time, made feeble and unsuccessful attempts to intervene in the relationship between Mark and his mother. As a result, Mark was not pressured to go beyond his comfort level and assume responsibility for himself.

Joann Coleman, M.S.W

During sessions when Kelly does not get her way she often sticks her chin out like a defiant two-year-old. She never balances her checkbook and has not cooked a meal for herself in years. Her desks at home and at work are piled high with papers. She lies on her couch for hours despite not being tired, and often says she cannot do things that she is clearly capable of doing.

Neither of her parents set limits for her. Even as a small child she had no set bedtime and ate whatever and wherever she chose. In addition she was not pushed or supported in developing mastery in most areas. By the time she was five years old her self-image was that of a child with something so wrong with her that she could never compete with her peers.

Joseph Gluski, M.D.

Susan, after four years in therapy, often greets even mild confrontation from therapists or group members with a pout and complains that therapy is too hard or too painful. She tends to withdraw when others receive the attention she would like, as if she is being mistreated. Her body language and facial expressions silently announce, "I'm suffering!". Bright, competent, and a gifted English teacher, she remains as yet an unpublished writer, claiming an unwillingness to tolerate the likely rejection that goes with submitting her work for publication.

Susan's mother, at times harsh and often emotionally unavailable, idealized Susan's intellectual capacity and over-identified with her hurt. She looked down on Susan's father and interrupted his honest attempts to set appropriate limits with his two daughters. Susan's father, when frustrated, resorted to temper tantrums.

Marcia B. Stein, M.S.W.

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NOTE: Answers to questions II through V are presented here by Paul Shultz, Leora Bar-Levav, and Pamela Torraco in consecutive paragraphs for continuity and clarity.

II. Review your patients and in no more than 100 words describe the self-indulgent features of one in whom they are prominent.

III. Review the patient's history and early development. Explain why the patient has become self-indulgent.

IV. How are you helping the patient with prominent self-indulgent features (of last week's assignment) overcome his or her difficulty?

V. How successful have you been, in percentages? Why have you not been more successful?

Nick, a 35-year-old married professional with two children, and a patient for eight years, has essentially overcome irrational fears. Able to reflect upon the motivation for his self-destructive behaviors, he rarely does so outside of the treatment setting. Without a therapist pressing him to mobilize his strengths, he often allows himself to follow his feelings, avoiding the unpleasant, and seeking whatever at the time seems to be a source of comfort: excessive eating, masturbation, alcohol use. Disregarding the demands of reality, he rationalizes: "I'm having a hard time; I deserve a little pleasure."

Second-born of four, Nick was the first boy, and was raised as his mother's "prince." Father, a businessman, was absent most of the time, and was seen as an "easygoing guy, too nice for his own good." Mother was hysterical, "running hot and cold." As the mother of the infant Nick, she probably was equally inconsistent, unable to provide enough holding for an infant to feel safe. When she enforced her high standards, she did so harshly, by rule of fear in hysterical outbursts. At other times she was unrealistically permissive, allowing regressive behavior to continue unchecked. It seems likely that as Nick grew, the major source of comfort was to be found in regressive behavior. Since neither mother nor father provided consistent limit-setting, Nick never developed enough self-discipline to find a sense of safety by living competently in the world.

Co-therapy makes it possible for a "fathering" group therapist to confront Nick's self-indulgence and enforce limits with him, while I make individual sessions "mothering" enough to provide a consistent place for his pain and anxiety. Extreme transference reactions to the "fathering" co-therapist probably would have compromised the alliance without this arrangement. "Mothering," however, clearly does not mean joining forces against the "father," since I also confront his self-indulgence, only less forcefully.

Individual sessions should be experienced consistently as a particularly safe place for Nick to become observant of his self-indulgence, rather than hide in shame and guilt. His ideals are high enough that he worries about his tendency to regress in such ways as leaving his office for lunch, then spending the whole

afternoon drinking beer and playing pin-ball. When he speaks of himself as a "piece of shit" for being so irresponsible, I interrupt to help him see how unloving he is to himself to use such harsh language. More and more often he goes beyond shame and guilt to cry with self-loving sadness.

Success score: 55%.

Like Nick, I at times enforce high values with shame and guilt rather than with loving self-discipline. Sometimes I realize that my interventions with Nick sound blaming or shaming; at other times I catch myself indulging him, rather than modeling good self-mothering. I am not helpful to him when I lose sight of the difference between good self-mothering and the ersatz "mothering" of self-indulgence.

Paul P. Shultz, M.S.W.

Carol is a 43-year-old physical therapist who has historically exercised little self-discipline against impulsive living. In response to twinges of anxiety, Carol has routinely eaten or smoked, given up on tasks and withdrawn from contact with others. She has lived as if her feelings were of central importance in the world, causing much damage in her relationships with others. Though quite bright, she has often become confused when letting her feelings overwhelm her and portraying herself as silly and thoughtless. She has allowed disarray in her home, typically not keeping up with housework, particularly in her bedroom, which she claims is a "pigsty".

Carol's mother was rigid and frightened by the open expression of feelings, including anger and protest. Consequently Carol learned to protest through a multitude of quieter, self-damaging means, mostly by withdrawal. Carol's father was immature and at best playfully nurturing to Carol while she was very young. However, he was childlike himself and could not demand much of Carol interpersonally. He did not actively squelch her disdain and dismissal nor limit her freedom to withdraw.

I have helped Carol by: a) being unsympathetic to her apparent helplessness and unamused by her silly, childlike or thoughtless behavior, b) interrupting her when she speaks in a non-observant way, and c) challenging her withdrawal and hysterical exaggerations. She generally opts to distance herself from these behaviors when I help her recognize these features as damaging, not self-respectful and diminishing of her stature.

I have been 55% successful. I err by seeing her as observant when she is not, or more helpless than she is. Sometimes I cannot challenge her silly, childlike manner because I am charmed by it. In addition, Carol is often dismissing and occasionally even disdainful. Such disrespect of our relationship should have no place in therapy and calls for firm, incisive correction. Yet at times I too quickly assume my anger is inappropriate and often block my realistic response. In doing so I miss the opportunity to challenge her disdain and to intervene forcefully when it is therapeutically necessary.

Leora Bar-Levav, M.D.

Diane is 36 years old and has been in therapy for about 2-1/2 years. Her momentary emotional state is usually written on her face and demonstrated in her posture and walk. She dresses more according to how she feels than by what is appropriate to the situation. She has a history of overusing alcohol and drugs, is habitually late, oversleeps and skips her college classes when she "feels like it." She complains that her therapists don't understand her and that this therapy may not be "right" for her. Pouting and righteous indignation are her typical reactions to not getting her own way.

An only child until age ten, Diane felt unsafe with her overprotective and insecure mother. Her father's extreme rigidity prevented him from being able to allay his daughter's fears. Diane had few realistic limits set for her as Mother was permissive and Father, although he tried to intervene, was harsh. As the frightened child grew older, she tried to solace herself through indulgent behavior. By the time she was a teenager she was openly defiant and when Father confronted her, Mother took Diane's side and sabotaged his efforts.

I continually work to strengthen the therapeutic alliance. In every session at least some work with the Real-relationship occurs. I point out self-indulgent behavior whenever I see or hear it, sometimes focusing on it firmly, sometimes just matter-of-factly as when I suggest she adjust her voice or chin. She is often able to make such adjustments, even thanking me occasionally. When she becomes defensive or openly fights with me or others about such interventions, I focus on the defensiveness itself as the self-indulgent expression. When she is genuinely afraid, I try to help her go beyond her usual anger or withdrawal while fully experiencing her fear in the safety of the relationship with me.

I have been 60% successful. I had thought my success rate higher but Diane arrived at a recent group session "high" on drugs, thus forcing a confrontation of her willingness and/or ability to remain in therapy by renewing her commitment to a no-acting-out contract.

I have not been more successful because:

a. This condition is extremely difficult to treat. The self-gratification possibility of substance abuse is an ever-available method by which self-coupled people can seek relief.
b. I am the opposite of Diane in terms of self-indulgence in my history. Although not often actually angry at her, I am sure that my frustration and sense of powerlessness are evident from time to time, interfering with my ability to stick with her and her ability to trust me. I am sometimes jealous of her "freedom" to abandon reality and live by feelings.

Pamela Torraco, M.S.W.

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# SELF-INDULGENCE OR RESISTANCE: A BRIEF REVIEW

Sharon Banks, M.S.W.

The term self-indulgence rarely appears in the psychiatric literature. Even when the term is used, the concept seems to be misunderstood. In a transcript of an analytic session written by Winnicott (1986), the patient describes his continued smoking as "self-indulgent" despite his commitment and periodic resolve to stop. Repeatedly, he refers to himself as an undisciplined person, one who shuns challenges. No notable intervention is made by the therapist, who apparently missed an opportunity to work with the patient's lack of self-discipline and self-restraint.

The therapy situation just described brings an important point into focus: Patients and therapists alike seldom differentiate between acting out of some inner conflict, and acting out in an area that is essentially worked through but remains a habitual pattern. However, making a clear distinction between resistant behavior and self-indulgent behavior should prove useful in our clinical work.

The concept of unchanging, intractable behavior that is not beneficial to the therapeutic process is historically known as resistance. The term was initially used by Freud in 1892. Later (1895) he observed that patients would "forget" that which was made clear and understandable in their previous session, due to the unconscious emotions interfering with and stifling the memory.

> Every step of the treatment is accompanied by resistance; every single thought, every mental act of the patient's must pay toll to the resistance and represents a compromise between the forces urging toward cure and those gathered to oppose it...the patient must himself get to know his particular defenses and maneuvers in an effort to overcome the psychic force with which he fights what he strives to attain. (Freud, 1938)

Working through resistance continues to be the bulwark of the analytic work. It is approached in many ways: cognitively, affectively, behaviorally and in more intense work, physiologically. Any defense against change or interference that exists within the psyche of the patient and deters his progress in the direction of health, maturation and eventual cure falls into the category of resistance.

Wilhelm Reich stated that the neurotic character holds onto the ego-syntonic habits, attitudes and modes of behavior that serve as an armor against external stimuli and instinctual uprisings (Greenson, 1967). Menninger (1958) used a broader definition: "Resistance is anything that gets in the way of change...[such

as refusing] to maintain contact, live in reality and grow to maturity." Pierre Janet (1973) concluded that defense structures which dissociate certain traumatic memories are intractable and organized affectively, cognitively and viscerally. They are split off from conscious awareness and resistant to change. Greenson (1967) adds that "resistance defies the patient's reasonable ego...defends the neurosis, the old, the familiar, and the infantile from exposure and change."

The definition of resistance becomes even more diverse in the group treatment literature. The list is long, but an overview of the subject can be gleaned by reviewing the works of Sponitz (1952), Slavson (1964), Bry (1951), Rosenthal (1985 and 1991), Ormont (1969 and 1992) and many others. Yet none of these writers distinguish between conscious refusal to change and unconscious resistance.

Only in the last decade have a few psychologists mentioned the term self-indulgence. Those clinicians use the term in reference to extremely aberrant or impulsive behavior in addicts, adolescents or people with severe personality disorders. It is not used in reference to an unwillingness to change after the resolution of internal conflicts has occurred.

Aurora-Saroj (1986) states that "psychic retardation is marked by a lack of emotional maturity and discipline, dry and flat affect, a loosely integrated personality, self-indulgence and aggression." Grieger (1986) also infers that self-indulgence interferes with personal relationships. More recently, Wiggins (1990) argues that "psychology has not been in the forefront of prevention and treatment of addictive behaviors and this must change. Psychologists must help shape public opinion to be actively opposed to self-indulgence so that society is not the helpless victim of alcohol and narcotics." Funder and Block (1991) use the term self-indulgent as a characteristic of delinquent adolescents who are impulsive, rebellious, and hostile.

Bar-Levav (1988) distinguishes between intractable behavior motivated by fear and behavior motivated by willful choice. A persistent refusal to adapt to reality and to take responsibility for one's life he calls the pathologic "push against progressing." Although initially such behavior provides solace in the face of fear, eventually it becomes an entrenched and habitual refusal to grow up.

As indicated in the literature we are clearly just at the frontier of understanding the concept of self-indulgence. Additional knowledge is urgently needed for treatment of this aspect of emotional illness.


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Sharon Banks, M.S.W, practices combined individual and group psychotherapy in Birmingham and Southfield, Michigan. She has presented nationally and locally and is a Fellow of BLEA.

# Background Points of Theory

SELF-INDULGENCE

■ **91.** Affluence and relative security enable individuals and societies to exist in the feeling mode for a while and therefore unrealistically. This is a luxury of questionable merit, since it encourages delusional living. Self-indulgence in the pursuit of "more" is possible only when actual survival is not an immediate concern. Having more obviously does not satisfy the yearnings for more, which are irrational.

■ **96.** The mistaken notion that adulthood is related to maturity has had disastrous consequences in modern permissive societies. The raising of children by adults who are still emotionally in childhood is responsible for societies with childish mores. Having fun and seeking thrills or distractions are not solid bases for building character. The self-indulgence that typifies much public and private behavior in such societies could not have been so prominent before the age of waste and affluence, when self-restraint and individual responsibility were needed for survival...

■ **97.** The family is among the first victims of self-indulgent living. Proper parenting is especially crucial when children are raised in nuclear families without grandparents, uncles, aunts, and other family members. Many such children have only one parent to help them accept the constraints of reality. An increasing percentage of the population in many advanced societies lives under the delusion that such constraints can be avoided, with tragic consequences both to the individual and to society.

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 to anyone, 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 of other experienced psychotherapists, each giving his/her own clinical observations and treatment plan. 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 Joseph Gluski, M.D. 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 October 1, 1994.*

# THE CASE OF AARON

## HISTORY AND COURSE OF TREATMENT

A 39-year-old married man, Aaron is a successful lawyer and father of a three-year-old daughter and a one-year-old son. He came to therapy eight years ago, badly shaken after staying away from home until very late at night to avoid being seen by neighbors who had invited him to a party. He was suspicious and often paranoid with fixed ideas of reference. Terrified of being closely involved with anyone, he at least realized that he could not make a good life for himself as long as he was limited by such powerful irrational fears. His initial surly, obnoxious presentation was a protective cover that hid his fears and pushed others away.

Second-born in a sibship of four, Aaron was the first boy and was raised as his mother's "prince." Mother was hysterical, "running hot and cold." When she enforced her high standards, she did so harshly by rule of fear, in unpredictable outbursts. At other times she was unrealistically permissive, allowing regressive behavior to continue unchecked. It was deduced in the course of treatment that she must also have been inconsistent and unable to hold the infant steadily and securely. It seems likely that the only safety Aaron knew was found in regressive behavior.

Aaron's father ran two businesses and was driven to accumulate more money than he would ever need. Rarely home, father's minimal involvement with his children was not enough to help them give up their regressive self-solacing. Since neither mother nor father provided consistent limit-setting, Aaron never developed enough self-discipline to find a sense of safety. His harsh superego enabled him to become an attorney, but he tended to deal with emotional crises even in adulthood by regressing. This pattern became second nature to him.

The patient reports that his older sister is the most successful of his siblings. She married and has a family. But the sister who was two years his junior was withdrawn, bitter, and harsh; with years of therapy she had softened some and finally married in her mid-thirties. A brother, the youngest, was the most indulged by mother. She encouraged him to stay at home, and at age 30 he still lives with her and remains unemployed.

Treated in combined individual, group, and marathon group therapy, Aaron initially felt welcomed as he was helped to see that his obnoxious behavior was a cover for irrational fears. He was grateful for being helped to restrain himself from pushing others away, and to reality-test his fears of involvement. Slowly, over a period of several years, his fears decreased and his sense of reality improved.

Aaron's tendency to withdraw was most pronounced in the group. Typically he would feel frightened or hurt by somebody or something and become silent. A pouting look would then come over his face. His individual and group therapists repeatedly pointed this out for him to see, and invited him out of his withdrawal.

Sometimes he became quickly reinvolved, and gradually developed skill and comfort in doing so. But he retained his basic pattern of withdrawal. With time it became ever more obvious that his silences were often not due to fear, but represented a stubborn refusal to speak. His therapists then challenged his self-indulgence with increasing firmness.

Since his therapists aimed to help Aaron overcome character defenses, many were the confrontations, and many were the times Aaron wanted to quit therapy. But he did not. He was not willing to give up the Real-relationships with his therapists, even under some duress, because the bond was powerful. The therapists had repeatedly helped him avoid self-damaging behavior such as overeating, taking excessively long lunch breaks, mismanaging his money, and smoking. Slowly and reluctantly, Aaron faced his fears and his wish to indulge himself, making major changes in his personal and professional life.

By this point, much of Aaron's anxiety, isolation, silence and confusion were behind him. He had made major advances professionally, socially and financially. Married for several years, he was sexually satisfied and emotionally involved with his wife. When he purchased his new house he was conscious of its finished basement, but he no longer saw it as a refuge in which to regress.

A few months prior to the following episode, Aaron had been transferred from his original therapy group into another one in the same practice, more fitting for his needs. During a session with his new group it somehow became known that all of his old group members would be present at a marathon group psychotherapy session that he also would attend. Aaron was very pleased.

The following vignette is drawn from that 28-hour group psychotherapy session led by a team of seven therapists. All 24 patients at the marathon were being seen in twice-weekly group sessions and once-weekly in individual sessions.

## CLINICAL VIGNETTE

Shortly after the beginning of the marathon Aaron commented poignantly on how he felt about being with his old group: "I don't know if I've ever looked forward to a marathon the way I was looking forward to this one," he said. "I went to a wedding of a childhood friend a few weeks ago and was glad to see my former chums. But we'd been only superficially involved as kids and my contact with them was limited. Not so here. I bring this up to highlight how much it means to me to have my old group here. I've never had friends like these." At this point Aaron addressed the members of his old group one by one and spoke sensitively of his unique relationship with each. The contrast with how he had been when he started therapy eight years before was striking to all who knew him.

Seven hours into the marathon session, Aaron sat forward and began to speak

again. "I have been agitated since the beginning of the marathon, when Mr. Van Horn [a therapist] told the smokers to talk about their wish to smoke during the marathon, rather than doing it. In past marathons I simply did not smoke to avoid the issue. I don't want to involve you therapists in it. I would rather handle this whole matter on my own, but consider it wrong to sit here and not say anything."

Dr. Singer, another therapist, challenged Aaron by saying, "I don't understand your dilemma. Why not just stop smoking for good right now and that would be it. After all, you've already stopped for 28 hours on many previous occasions and know that this makes sense for you. So if you agree, do it, but not merely as a compliance."

"I'm planning on quitting soon," Aaron replied.

Dr. Singer persisted by suggesting again that Aaron grab the opportunity to commit himself to quitting right then and there. Aaron declined again. Hoping to help him limit himself and mobilize his health, Dr. Singer finally said, "I suggest that you either quit smoking for good right now, or else that you agree to smoke a cigarette every half-hour for the rest of the marathon." The risk of lasting harm to Aaron from not facing the issue of self-indulgence was judged to be far greater than possible damage from smoking during the marathon. Aaron struggled for an hour to consider his course, and finally decided to smoke every half-hour. One of the therapists agreed to go to purchase a few packs, though not of Aaron's favorite kind, as he requested.

As the marathon continued, Aaron walked out of the house every half-hour to smoke, even when he did not want to do so in the worst possible way. (No smoking is allowed in the room). He "confided" in another therapist, saying, "Usually I like to smoke, but every one of these has been a pain." His emotional struggle was also evident on his face. He looked ashen.

Near the end of the marathon Aaron said, "I'm disappointed that I have struggled so hard without winning the battle; but I think I have been doing something important for myself. I don't want some of you newer people here to get discouraged by my struggle."

## DISCUSSION

Despite Aaron's ability to stop smoking, he refused to do so because of self-indulgence. He was no longer so anxious but reached for cigarettes all the time out of habit to comfort himself. Other explanations for his not stopping are improbable. When Aaron said, "I don't want to involve you therapists in it...," he did not even claim that he was anxious, and his demeanor supported this. The fact that he had stopped for 28 hours at each of 12 previous marathons is one of many pieces of supportive evidence which confirm his ability to do so. Furthermore,

his progress in many other areas previously dominated by his self-indulgence suggested that he was capable of tolerating the feelings that might arise once limits on his behavior were set.

Because consistent and realistic limits were not firmly enforced upon him as a child, developing self-control now required a double effort, as well as outside support and pressure. Aaron was not eager to go along with all this, and he reluctantly accepted the easier of the two choices as a diluted way to face the issue. He knew that his therapist said unpleasant things, but that he was right and made sense.

A limit-setting intervention such as this poses the risk that the patient might become lost in shame. Aaron's behavior and words show that this did not happen here because a solid Real-relationship was firmly in place. Because the relationship was well-tested and Aaron had demonstrated considerable health in openly bringing up the issue, the timing of the intervention was right. He had retained the perspective gained earlier when he had helped other patients face their own inner demons.

During subsequent therapy sessions Aaron increasingly recognized his responsibility for his own actions. By openly refusing to comply with the suggestion that he quit smoking then and there, he had proven to himself that he was in charge, not the therapists. It was obvious now that he could prevail even if he acted irrationally, although he had to pay a high price for doing so. This stimulated him to increase his efforts to give up his self-indulgent behavior. Aaron continued to examine his overall poor self-care and genuinely recognized his need to improve it. He actively kept his struggle with smoking in the forefront of his treatment.

Whether he did or did not smoke was not the main concern of his therapists. Living by the reality principle was the core issue. Aaron's refusal to give up smoking indicated that he still refused to embrace fully this principle. Therapy is doomed to fail when patients consciously choose to retain the option of living according to what they feel and if they act any way they want to. To finish therapy successfully the separation-individuation process must be essentially completed. This requires that self-indulgence be given up.

Joseph Gluski, M.D.

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Joseph Gluski, psychiatrist and BLEA Fellow, practices intensive individual and group psychotherapy in Southfield and Birmingham, Michigan.

## COMMENTS IN RESPONSE TO THE CASE OF AARON

As an introduction I must say that I realized that the way this material was collected is a way of indicating which way the therapist wants to see and hear the patient, and how he wants to respond to him and treat him. Similarly the way I listen to the material is important in the way I react and formulate my conceptualizations and interventions for the same patient.

In the beginning I don't think of interventions, but would rather concentrate on a way for the patient and therapist to understand each other. I would slowly try to listen to how he speaks to me and transfers to me. First I notice that he sees me as a person whom he cannot really trust. He is suspicious and paranoid, but still he comes for help even though he keeps his distance from me.

To avoid the clinging mother this patient spent a lot of time in a world he created for himself in the basement. It is to be expected that he would do the same with his therapist. I see his not involving his therapists in important issues as a way of recreating the old distance that he felt was necessary for survival. As his therapist I would have to be different from his mother and provide enough "holding" so he could feel safe and not have to escape into regressive behavior. I would also try to be consistent and stay with him rather than be like his father who was busy accumulating money and only minimally involved with his children.

My preference would be to stay with just individual therapy although I might not discourage his participating in groups or marathon sessions. If he were in groups with other therapists it would be important to have contact with my colleagues so that they would understand the material of the individual sessions and the patient would not keep material away from his therapy. I suspect I would not work with "increasing firmness" for a long time with this patient but rather give plenty of time for him to discover safety and eventually overcome his own wish for destructive behavior. Slowly he would work through his transference dilemma with me and achieve independence.

In conclusion there are many ways in which to reach the soul and the mind of the patient. These ways depend not only on our training, but also by the way the patient teaches us as his helpers.

Slowly a process called intervention unfolds. "Intervention" comes from the Latin, intervenire, meaning a flowing between oneself and the patient. This flowing between, this closeness in which the therapy takes place, is influenced by the therapist's careful listening for how the patient will lead the way. This is a basic assumption which I think leads to a successful outcome of therapy.

Rudolf Ekstein, Ph.D.

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Rudolf Ekstein received his psychoanalytic training at the Psychoanalytic Institute in Vienna. He was a training analyst at the Topeka Psychoanalytic Institute and on the staff of the Menninger Foundation. Presently he is Guest Professor, University of Vienna; Clinical Professor, Medical Psychology, University of California, Los Angeles; Senior Faculty, Los Angeles and Southern California Psychoanalytic Institutes and in private practice, Los Angeles, California.

# LETTERS FROM OUR READERS

To the Editor:
The first issue of your journal addresses a central issue of the practice of psychotherapy in America: touching. American puritanism has struck at the very heart of psychotherapy, and the blow may well be lethal to the soulmaking inherent in the therapeutic process.

I have been practicing psychotherapy for over 20 years in Jerusalem, and have enjoyed the fact that Israeli culture is much more casual about physical contact than its American counterpart. I suspect that this has to do with the greater personal distance of peoples in colder climates in comparison with cultures of warmer climates.

Physical contact does not play a central role in my therapeutic work, but then again, I would not accept into therapy a person whom I had an aversion to touch. With some clients physical contact is a part of our experience together, and with others there is virtually no physical contact. The point is, the potential for contact is a cornerstone of therapy.

The difference between physical contact and sexual contact is real easy, and self-evident to anyone who is sexually satisfied. Clearly, a therapist who is meeting his sexual needs in his personal life will not have to exploit his clients sexually. Therapists who have not graduated from masturbatory sexuality to orgiastic sexuality need more therapy themselves.

Finally, let me restate my central point. The issue of physical contact between therapist and client is culture bound, and the taboo against any and all forms of physical contact is a function of puritanism and contradicts an inherent psychotherapeutic necessity.

John Baumgold, Ph.D.
Jerusalem, Israel

Editors' Response
Cultural differences certainly must affect the nature and meaning of physical touching in the psychotherapy of a particular society. Many of us in America have gone to the extreme by avoiding touch altogether. Additionally, the influence of psychoanalysis forbidding physical contact has had an impact on our field. Our effort in the last issue of the *Journal* was meant to open up the topic for thoughtful questioning beyond cultural and climatic differences. If indeed there is less fear of clinically indicated physical touch in Israel, it would be important for psychotherapists there to report on the results of such pioneering interventions for the advancement of our knowledge. We invite such specific contributions.

In all cultures, however, touching must be used thoughtfully and responsibly as part of a theoretically grounded treatment plan, as illustrated in the last issue of the *Journal*.

The Editors

## Background Points of Theory

SELF-MOTHERING

■ **21.** Mothers who were themselves not mothered properly or not enough find it difficult to mother their children or to wean them appropriately and on time. They are often impatient with the clinging and scared baby, or else they over-identify with its needs and overlook its increasing competence. Babies who are not weaned properly—too early, too late, or too abruptly—tend to remain dependent and to become addicted to helplessness in its many forms. They unconsciously expect that helplessness will assure Mother's presence forever. Weaning in the broadest sense refers to the giving up not only of Mother's breast but also of the possibility that anyone outside the self can forever provide warmth, comforting, assurance, and nutrition.

■ **22.** The "push against progressing" is the persistent refusal to grow up and to acquire mastery, and it may be conscious or unconscious. It is also the persistent refusal to mother oneself appropriately and lovingly. The "push against progressing" is based on the delusion that infantile wishes are fulfillable, and it ignores the basic changes in circumstances that occur with time. Normally, both the wish for mothering by others and the refusal to become self-sufficient are given up only after protracted struggles, when it finally becomes obvious that no other choice exists but to adhere to the unyielding demands of reality.

■ **28.** Healthy maturation consists of overcoming both the regressive pull and the associated push. The satisfaction and pride obtainable from mastery are soon recognized as having far greater value than receiving any handouts. Emotionally mature individuals can mother themselves whenever they need support, although they can also accept solace and help from others. Such "self-mothering" consists of settling down while in the midst of anxiety, without regressing. It requires taking appropriate time away from adult responsibilities and duties for resting, relaxation, and recreation.

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

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Direct editorial correspondence to:

Victor R. Stoeffler, M.S.W., Editor
123 N. Ashley
Suite 202
Ann Arbor, MI 48104

and business correspondence to:

Elaine Minkin, M.S.W.
3000 Town Center, Suite 1275
Southfield, MI 48075.

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## Coming in the Next Issue

# *Repairing the Boundaries of the Self*

Personal boundaries are like a person's "psychologic skin," separating him or her from others. Only when individuation has essentially been completed can people enjoy both being alone and intimacy without undue fear. Widespread difficulties with personal boundaries contribute to untold pain and loneliness, unsatisfactory relationships, and emotional isolation. The result of twenty years of clinical experience in repairing damaged boundaries will be the focus of the upcoming issue of the *Journal.*

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