

INTERNATIONAL JOURNAL

OF

**Psychotherapy &
Critical Thought**

VOLUME III NUMBER 2

FALL 1995

In This Issue:

THE THERAPEUTIC CONTRACT:
A NEW LOOK

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 on-going 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 with diverse points of view to participate in the discussion of topics presented in the *Journal*. Subject to the availability of space, we will publish all thoughtful comments.

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INTRODUCTION TO THIS ISSUE THE "PERSON" OF THE CONTRACT

Ronald J. Hook, M.S.W.

The therapeutic relationship requires a reparative framework where appropriate boundaries help to channel the underlying affect of the patient in ways that are constructive to his or her maturational process. Therapy is a matter of repair more than insight. This requires that appropriate force of personality is brought to bear to help order the patient's disordered personality. The person of the therapist must enforce suitable limits and parameters to optimize a healthy outcome.

As a supervisor I have repeatedly come upon weaknesses in the capacity of the therapist to introduce and to properly sustain a contractual relationship with the patient. Every aspect of the therapist's personality seems to be involved in this difficulty. A therapist with a self-image of weakness may rigidly use a contract to reinforce him or herself, thus sending a signal to the patient that there is not really a solid human being there to be relied upon, but a rigid and formal "cast" around a person. A therapist who has the self-image of a child (which is a widespread ailment) might simply introduce the terms of the contract because their teachers told them to. This effectively sends the same signal to the patient, no one to count on if trouble gets deep. Therapists with a dominant fear of abandonment may wrongly use a contract to protect themselves from being left by their patient. Therapists with a dominant fear of engulfment may use a contract as something to stand between them and their patient.

With all this in mind you can see how many aspects of the therapist's personality impinge upon effectiveness in this critical area. Why critical? Simply because the patient needs a constructed framework, different from his everyday life, where his disturbing emotions can be invited into the relationship without oozing, in damaging ways, all over his or her life. The therapist's personal sensitivity and stability provides some sense of security to the patient which allows trust to build enough to let the more intense feelings come to the surface. But it is not truly safe (and patients can sense it) unless there is a defined limit for these emotions and their expression. The patients also need a real and reliable force behind those stated limits, since words alone carry no weight.

Therefore, the struggle with the contract is, in fact, a struggle with the therapist's self. There simply is no way around this fact, again. It is not what we say, but how we relate.

This issue of the Journal highlights struggles of therapists with this matter and with the self as the one who applies the therapeutic contract.

There are many ideas in this journal that can be taken usefully outside of the field of psychotherapy. There are implications for fathering, for organizational leadership, for political leadership, for classroom leadership, for mentoring, or simply for being an older brother or sister. Any of these relationships also requires a careful look at the self as the one who applies the rule.

Our editorial staff hopes that you find this matter, as it is elaborated in these pages, to be of great interest inside and outside of the clinic.

Ronald J. Hook, A.C.S.W.

Background Point of Theory

The attainment of well-defined ego boundaries is the ultimate goal of maturation, and it is not achievable through formal learning or by gaining insight. The self is only defined by repeated testing of one's size and strength in relation to other humans and things. This yields reliable and useful lessons only if those with whom the testing is done are predictable, consistent, and emotionally stable.

Damaged or incomplete boundaries of the self can be repaired provided that the same conditions exist; the work can be done only 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. Formal, superficial, or essentially intellectual relationships do not provide the setting needed for reaching this difficult goal. Most current attempts to repair boundaries in psychotherapy fail because the relationship is not real enough and the mutual involvement only tenuous and insubstantial. Character change is at least as difficult a process and almost as time-consuming as character formation was in the first place.

From R. Bar-Levav, M.D. (1988)
Thinking in the Shadow of Feelings, New York:
Simon and Schuster, p. 333.

THE THERAPEUTIC CONTRACT: PAST AND PRESENT

Leora Bar-Levav, M.D.

As stated in the title, this journal issue is concerned with the therapeutic contract; its content, its application and its "enforcement" in the treatment setting. While the use of some form of contract between therapist and patient is common to most clinicians, the particulars that make up the therapeutic contract across treatment modalities and the relative importance of the contract to the overall treatment process varies considerably. Many current texts that focus on psychotherapeutic practice make only a cursory reference to the therapeutic contract or omit addressing it altogether.

Historically, the term "contract" referred largely to the ground rules structuring the therapeutic setting. Only more recently is there recognition of the need for more binding, specific parameters for the therapeutic relationship, namely a therapeutic contract. The following provides a brief review of ideas that led to modifications in how the ground rules for treatment have come to be viewed and employed since their inception in the early 1900's. As will be described, the changes were due in part to a refinement in understanding of the parallel "real" and transference relationships that develop between patients and therapists. Second, the developments that led to the use of a therapeutic contract which is more binding than ground rules alone will be addressed. These resulted, in part, from basic shifts in the understanding of what elements of treatment are critical to the curative process itself.

From the earliest days of psychoanalytic practice, frameworks for the treatment setting and therapeutic relationship were recognized as necessary to enable therapeutic work to proceed. The ground rules, defined by Freud (1912b, 1913, 1914, 1915), including the setting of fixed fees, time and frequency of sessions, the maintenance of the analyst's anonymity, the analyst's restriction to interpretive comments as well as the use of the analytic couch and specific positioning of the analyst were all designed to optimize conditions for analytic work - particularly the unfolding of the transference.

Marked modifications of these rules have developed over the last 80 years. Some argue that this is due to the dilution of a standard which is difficult to maintain by virtue of the strain it places on the analyst/therapist to renounce the pathological gratifications that deviations in a sound framework afford. (Langs, 1976) Such practitioners, represented in the literature by clinicians such as Menninger, Langs or Greenacre, hold that any deviations made in the ground rules ultimately lead to a therapeutic rela-

tionship experienced by the patient as unstable, and introduce elements in the treatment that immutably interfere with the resolution of transference, sometimes referred to as "contamination".

A majority of other authors dating back to Ferenczi (1921) have, in contrast, made a point of the need to modify these ground rules. Sterba (1941) and Menaker (1942) advised the analyst to expose his personality and allow for limited gratifications which, as Alexander described (1954), provide a "corrective emotional experience". Berman (1949) and Zetzel (1956) similarly made allowances for realistic anxieties related to treatment and the need to make modifications in teaching to help convey the analyst's genuine interest in the patient. These and other works likely reflected a growing recognition of the real-relationship (Greenson) between patient and therapist.

Both S. Freud and A. Freud (1954), among others had made references to the real, direct and healthy portion of the relationship between therapist and patient which exists independent of the transference. But it was not until the late 1960's with the writings of Greenson (1967), Roland (1967) and Stone (1967) that the real-relationship was more fully examined. This relationship makes room for realistic emotional and human responses of the therapist and patient.

A movement followed this period in the late 1950's and 1960's that attempted to "humanize" the therapeutic relationship. While many rejected loosening of the parameters previously required for the treatment setting, the notion that the real human qualities of the therapist need to be experienced by patients had taken hold. Thus, the classical guidelines for the treatment setting introduced (but not uniformly adhered to) by S. Freud 50 years earlier became lastingly altered. For that reason, today, the overwhelming majority of clinicians, even of orthodox psychoanalytic training find reason to make exceptions to the original ground rules.

Still greater deviations from the original guidelines for treatment were introduced in the 1950's and 1960's as attempts were made to apply the analytic model to more profoundly disturbed patients. In working with schizophrenia, character disorders, anorexia and perversions, qualitative modifications of technique, termed "parameters" by Eissler (1953), became necessary. These changes included variations in the type of interpretations and degree of the therapist's activity in treatment (Bouvet), the occasional abandonment of therapeutic neutrality (Reich and Nacht), the use of directives (Rappaport), and even the setting of therapeutic limits (Hoedemaker).

Central to the basis for these modifications was the appreciation that the ego function of more severely disturbed patients was relatively weak. Their capacity, therefore, to tolerate anxiety, to inhibit impulsive action

and to stand back and observe themselves and their experience was limited. The intensity of the primitive transferences often led such patients to lose their hold on reality and their capacity to reality-test their experience.

In his work with patients in the "borderline-narcissistic spectrum" Kernberg (1979) wrote, "At times the psychotherapist has to spell out certain conditions which the patient must meet in order for outpatient psychotherapy to proceed...The setting up of such conditions for treatment represents, of course, an abandonment of the position of neutrality on the part of the psychotherapist and the setting up of parameters of technique". (p. 189).

Kernberg goes on to describe instances in which he believes parameters of technique need to be employed and in the process mentions features of a therapeutic contract he employs with patients. At the heart of this contract is a commitment made by the patient to "carry out full responsibility for himself" and his actions. By example, Kernberg describes how, in treating a patient who has historically cut himself, a therapist must discuss his expectation at the outset of treatment that the patient talk about his wish to cut himself while assuming responsibility to not act on that wish. Furthermore, the patient is expected to request hospitalization if he believes he is truly unable to control his impulses. Kernberg concludes that this parameter of technique "will eventually require resolution through interpretation" (p. 193) suggesting that its impact on the transferences is a necessary but unwanted by-product of the need to set specific limits on the therapeutic relationship.

A more recent theoretical orientation, in contrast, does not recognize the introduction of this type of "conditional" status to the therapeutic relationship as an interference but rather as a necessary and desirable framework for treatment. Indeed, it holds such a non-acting out agreement central to the therapeutic work, as part of a larger, explicit contract that the therapist and patient conduct their relationship in a realistic way. Here the therapist is not "neutral". At times he must insist that the patient correct destructive actions before the relationship can continue. At other times he pointedly makes no room for transference distortions to be freely expressed when a minimum of the patient's observing ego is not evident.

Unlike the classical analytic model, this new model called Crisis Mobilization Therapy does not hold that such activity interferes with the unfolding of the transference neurosis. On the contrary, it suggests that such activity of the therapist fosters the development of a relationship based on reality—a "real-relationship". When realistic limits are held firmly in place, the therapist has the freedom to safely expose his personality and express genuine interest in the patient (see above). It is the strength of the real-relationship that taps developmentally early material

in the patient and allows the primitive transference to unfold. As Bar-Levav (1988) noted, "Constructing a safe setting begins by making real contact with the patient...The therapist must touch and welcome the patient's 'soul'. The hidden and denied fears and hurt must be recognized, verbalized and sensitively addressed. The patient's confusion and silence must be listened to, and heard. An immediate sense of relief follows when this is properly done, and contact is thus established. This is a solid base for the beginning of a solid real-relationship." (p. 232) He continues to note, however, that such exquisite understanding gives rise to magical expectations based in life-long yearnings to be perfectly heard and people tend to idealize those who relieve their fear.

The greater the sense of safety, the more primitive material and defenses tend to surface. As Kernberg (1976) noted, not only in severely disturbed patients but also in neurotic and "normal" individuals, "past object relations with a primitive self- and object-representation linked by a primitive affect can be observed at points of deep regression". (p. 66)

The therapeutic involvement stimulates these regressions which have a physical template in physiologic pathways. (Bar-Levav, pp. 88-93) These pathways, laid down in the first weeks and months of life are the residues of preverbal experiences and provide the psychic fuel that drives transference. When the contact between patient and therapist is as described, such regressions become typical. But such regressions can be therapeutically useful only when a sound therapeutic contract is in place from the outset of treatment. A contract which includes at its core that therapist and patient alike agree to conduct themselves according to the reality principle binds these parties to living by what makes sense objectively rather than by the dictates of feelings influenced by distortions of the past. It provides a standard against which not only transference but also countertransference must be assessed. The contract secures the therapeutic purpose by immediately calling upon the adult part of the patient to reality test the situation and momentarily curb impulsive behavior even as strong feelings flare.

It is at such moments when patients' primitive feelings are juxtaposed against the reality of current living that opportunities for real characterologic change are made possible. Such crises productively stress patients' ego boundaries. The patient's capacity to distinguish between past and present, to separate thinking and feeling, and emotional reactions from immediate action is more limited at such times. Typical characterologic defenses and adjustments to the experience of powerful surges of fear, hurt, and anger threaten to be acted out as they always had been during the course of a patient's life. It is the contract that serves as added weight to the temporarily strained ego and helps to anchor the patient to reality and his adult living. By helping the patient delay gratification, impulse regulation is improved. So, too, is the patient's reality testing improved

as the actual source of strong feelings is examined. Here the adage "where id was, there shall ego be" is particularly apt. Ego boundaries repeatedly challenged in this way become more competent and flexible as archaic feelings lose their strength. Establishing that the relationship between patient and therapist always be based on reality provides the backdrop against which such a curative process can occur.

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Background Point of Theory

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.

From R. Bar-Levav, M.D. (1988)
Thinking in the Shadow of Feelings, New York:
 Simon and Schuster, p. 331.

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 issue of contracts in psychotherapy and in relationships in general. What follows are the assignments and some of the answers which were presented over a three week period. Your thoughtful responses are welcome and, if suitable, will be published in a future issue. The deadline for responses (in 250 words or less) to this issue is December 30, 1995.

BLEA TUESDAY SEMINAR

ASSIGNMENT FOR MARCH 28, 1995

First Week

1. Is the contract between you and your patients clear? Why or why not?
2. Give up to four examples of difficulties you have or have had in enforcing an appropriate and realistic contract.
3. Have you left items out that should be in your contract? Why? For example, does it include charges for missed sessions, groups and marathons?

This write-up will be used anonymously (do not put your name on it), so be as candid as possible. Focus on yourself and your difficulties. The objective is to get as many personal difficulties as possible out in the open.*

Ronald J. Hook, A.C.S.W.
Iveta Houser, A.C.S.W.

*The anonymous responses were circulated at random and discussed openly in the seminar. Only later did participants affix their names to material published here.

TUESDAY SEMINAR MARCH 28, 1995

1. My written contract and my verbal delivery of it are essentially clear. I do not typically address confidentiality or extra-therapeutic contacts initially but do outline the guidelines and working rules of the therapy. The cornerstone of the contract goes beyond administrative points, however, since it involves an agreement to separate feelings from action. The essence of the contract, therefore, is made "clear" in process as failures to meet the non-acting out agreement arise. My shortcomings in enforcing this part of the contract limit the clarity of it.

2. My greatest difficulty in enforcing the contract lies in my failure to effectively enough challenge various forms of acting out and acting in, as well as a tendency to rely on my co-therapist to intervene.

Examples:

- a. Addressing lateness to sessions.
- b. Allowing silent temper tantrums to continue.

Example: One patient refused to remove her coat, but with no adequate rationale.

c. Not firmly challenging patients' withdrawal.

Example: One patient typically broke contact with people as they spoke to her. My co-therapist repeatedly insisted she be in charge of her eye contact.

In all such examples my tendency has been more to cajole patients or encourage them rather than to forcibly insist they shift their behavior according to their contractual agreement not to act on feelings.

Leora Bar-Levav, M.D.

1. The contract between me and my patients is clearly stated and agreed to in words and in writing early in treatment. However, it is an agreement in words only since the nuances of what the contract really means become clear only in the process. As minor and gross infractions of the reality principle are repeated opportunities arise for the patient to agree anew to living according to that principle.

2. a. As my own character has loosened I have found it harder to start my sessions on time, and this plays into the character resistance of patients who arrive late.

b. L. came to me following 20 years of being in and out of hospitals, and presented sometimes gross failures to attend to reality professionally and personally. I was not consistently firm with her, making unrealistic allowances for her anxiety.

c. Telling a patient he has the freedom to say whatever is on his mind as long as he makes no threats, implies that blatantly defiant mindlessness is acceptable in the therapeutic setting.

d. In starting a new practice, I made too many allowances for financial difficulties people presented, without clear and firm limits. Later, the issue was extremely difficult to correct.

3. My contract is very specific regarding charges, the cancellation policy, and other concrete issues. However, the issue of the reality principle (see #1 above) has not been clearly enough spelled out and worked with until fairly recently.

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

1. No. Initially my patients often "agree" to or accept the terms of the contract without clear understanding, or wanting to please me, or just to get this unpleasant thing over with. I fail to work with them to clarify the contract until it is clear. I also want the patient to like me, and want "this unpleasant thing" to get done quickly.

2. I have difficulty charging for missed sessions, especially if the circumstances were difficult or unclear. I fail to enforce the "non-acting out contract". I explain and talk about it but often leave it as an intellectual exchange rather than working through patients' resistance by expecting a behavioral correction.

3. Initially, I often do not mention that I will on occasion expect the patient to attend all-day group therapy sessions.

Annikki Kurvi, A.C.S.W.

1. The contract is as clear as any written contract might be. The problems lie in how attentive I am to upholding its terms and to clearly addressing breaches on the part of either party with my patients.

2. a. Mary is but one of many patients with whom I overidentify and protect. She called my home Sunday afternoon and left a message saying she couldn't be in group on Tuesday because she has a test on Wednesday. There is boundary confusion which I have fostered in the past by taking calls at home for other than appropriate matters. There was no questioning or reflection in her message; from her tone it was a "fait accompli". I'm her therapist, not her mother. But I foster too much of the latter.

b. I often collude with my patients by not addressing lateness, unconsciously I think, as a way to leave room for my own acting-out.

c. Regarding timeliness of payment, I am generally too loose. While I can't stand owing money, I allow others to owe me. This gives me and the patient a way to act-out feelings about authority, responsibility, control, and power. Money brings the relationship into the real and practical world. It positions me as the authority who is paid for my time and skill and who must be capable and competent in return. Characterologically, I have often "controlled" others; I am angry now about having to be in control. It is not that I don't feel competent or worthy in terms of self-image; it is more an issue of self-indulgence.

Elaine Minkin, M.S.W.

1. Usually the contract between my patients and me is clear. Sometimes in my attempt not to overload a new patient, I don't address contract issues early enough. But I try to put new patients in a group sooner rather than later and I always introduce the written contract before the first group session. This written contract (actually a summary of issues comprising the therapeutic contract, not intended as a legal instrument) forces me to bring important aspects of the therapy relationship into the here and now. Having the printed word in front of me helps me talk about and expand on the issues in a way that addresses the individual patient's needs and enhances the therapeutic alliance.

2. a. I get angry at the narcissistic temper tantrums of a patient who wants his or her own way and defies contract items. When angry I can't work properly.

b. I get hurt by patients who complain, seemingly endlessly, about the existence of a contract. Their "refusal" to appreciate the fact that it is largely because of the clarity of our contract that their therapy is as good as it hurts me.

3. Yes. It is frustrating to me that not everything can be spelled out in writing. For example, although technically all feelings are welcome in therapy, one of my groups still struggles with the issue of hate over which a group member left. When he was "in hate" his observing ego did not function properly and so his expressions of strong feelings had to be curbed. He claimed this was not what the contract stated. Hate is still a difficult area for me to deal with and also for many members of this group.

Pamela Torracco, A.C.S.W.

1. The contract is not clear enough because I fear patients' reactions to my firmness; I soft-pedal the more difficult aspects of the contract.

2. a. I have tried to use the contract as a substitute for a therapeutic relationship, e.g. mechanically insisting that a scared patient in crisis take three sessions before leaving treatment. Such technicalities are no substitute for a solid alliance.

b. I have been rigid with the contract (such as charging for a missed session when a measure of human concern was called for) and missed the opportunity to strengthen the therapy relationship.

c. I have poorly timed my patients' entry into the group, contributing to their resistance and adding to their fear. I have overidentified with their fear and also unconsciously wanted to keep the patients "to myself" rather than allow my co-therapist to become involved with them.

d. I have ignored a patient's real financial difficulties rather than helping him or her work these through as part of the illness.

3. The one aspect left out involves helping patients accept my role in both their physical and emotional health right from the start rather than waiting until some physical problems arise.

David A. Baker, A.C.S.W.

1. Confidentiality, no spontaneous touching in sessions, and incurring charges for missed group sessions and individual sessions cancelled less than 24 hours in advance are clearly stated and enforced by me. But, I have been less clear with patients about speaking to me directly when cancelling sessions. I have at times accepted phone messages from

patients cancelling their sessions without further inquiry. Avoiding confrontations and yielding to others has characteristically been a struggle for me.

2. Not surprisingly, my lack of clarity sent a confusing message to my patients and contributed to their acting-out. B., who was detained out-of-town, had her husband call to cancel her individual session. It wasn't until I had informed her of the late cancellation fee and I refused to accept messages from her husband that I realized the problems I created in our relationship by being vague about cancellations. I had been acting out my own difficulty sustaining involvement and holding a firm line. Typically, I err on the side of being too accommodating rather than holding firmly to a position. I have agreed to partial payment for services too quickly at times and neglect to confront a patient's poor management of money early on in treatment.

3. I now stress in the contract any adjustment in the payment schedule must be discussed with me prior to receiving the monthly statement.

Joann Coleman, A.C.S.W.

ASSIGNMENT FOR APRIL 2, 1995

1. Are you too rigid or too loose with your contract? (Consider both positions as problematic.) Why?
2. If you have other difficulty enforcing your contract or if you believe your contract is inadequate, why do you think that is so?
3. What do you think is the key element in creating and enforcing a realistic contract?

Use no more than 250 words in response.

Ronald J. Hook, A.C.S.W.
Iveta Houser, A.C.S.W.

TUESDAY SEMINAR APRIL 2, 1995

1. When I was more rigid characterologically, I was too rigid with my contract. As my character has loosened, so has my manner of handling the contract. Sometimes I have difficulty with the contract when I am too loose, as opposed to flexible.
2. In the past, when limits needed to be set I tended to do so harshly, as an acting-out of my own harsh superego. I have come a long way since then and am usually firm yet kind and even-handed in my firmness.

There are occasions when it becomes obvious flexibility is called for, but anxiety interferes with my ability to make a quick, clear judgment about what is appropriate to do. Sometimes I revert to my harsh superego as a way of covering up my difficulty. Obviously, this is always harmful and can be difficult to correct.

3. The key element in creating and enforcing a realistic contract is the clarity and firmness of the therapist's ego boundaries. The ability to test reality accurately in the presence of strong feelings is crucial to creating and enforcing a realistic contract.

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

1. Of the two, my tendency was to be too loose and forgiving in enforcing the contract. This stems from an overidentification with the infantile wishes of the patient.

2. I am not aware of other difficulties enforcing the contract.

3. The key element in creating and enforcing a realistic contract is the therapist's ability to identify with the patient while at the same time recognizing the realistic parameters of the therapeutic relationship. Intact ego boundaries of the therapist allow for such identification and the ability to live with the patient within realistic parameters.

Natan HarPaz, Ph.D.

Background Point of Theory

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.

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

Thinking in the Shadow of Feelings, New York: Simon and Schuster, p. 328.

CASE PRESENTATION

A 35 year-old attorney with a large corporation, Frank has been my patient for two years. Referred by his wife, herself a patient elsewhere, he had originally come to therapy reluctantly, and in part to please his wife who saw their marriage as doomed unless he got help for himself. While he had regarded himself as "emotionally pretty healthy and well-adjusted", it quickly became apparent that his friendliness and sociability were merely superficial. He kept himself emotionally aloof, and was always careful to maintain the upper hand in his relationships. Essentially self-centered, he resisted from the beginning the commitment his therapy required in terms of time, money, and emotional investment. Nonetheless, he accepted my strong recommendation that he combine his weekly individual sessions with twice-weekly group sessions.

As a condition of entering treatment with me, all patients must agree to a simple but critically important contract that includes more than the details of time, money, cancellation policy, and confidentiality. They must also agree that while any and all thoughts and feelings are appropriate to express verbally or vocally in therapy sessions, actions are not an appropriate way to express feelings. Spontaneous touching, moving about the room, and other obvious forms of acting out are prohibited. Furthermore, the many subtler forms of acting-out such as chronic tardiness are also breaches of the contract. Likewise, any major decisions in living must be examined, lest unconscious forces unlocked in therapy be acted out in daily life. In short, patient and therapist must agree that they will live together according to the reality principle. This condition is meant not only to insure the safety of all concerned, but to maximize the usefulness of the therapeutic process. Frank agreed to this, and began attending groups, albeit reluctantly.

While his fellow group members found him likable from the beginning, they nonetheless found him essentially aloof. Several group members pointed out that this was obviously what his wife complained of, but he had great difficulty understanding what they meant. When it came to light that his wife had been having an affair with a co-worker, he still could not understand why she would "do this to me". He welcomed my support and that of his group as he sobbed with pain, but nonetheless had difficulty looking at himself and how he had contributed to the difficulties in the marriage. Much of the therapeutic work involved confronting Frank with the many ways he pushed others away, or tried to maintain control over others in order to have things "his way". He tended to immediately deny what others tried to show him, and frequently complained about how inconvenient the meeting times were for therapy.

Youngest of three, Frank had been the favorite of his mother, described as "a typical housewife who always tended well to her family". Father, a

second-generation German, was seen as "unreasonably demanding" and "emotionally tight". Mother had been Frank's ally in trying to defeat Father's attempts to set limits. Frank became professionally successful as a way of pleasing Mother, but had never fully accepted that his wish to be comfortable must take second place to the demands of reality. What he heard about himself from other patients was often painful to hear, but rather than trying to make use of it, he typically complained that therapy wasn't worth the unpleasantness. "Why talk about my past, since all it does is bring up painful feelings!" As this difficulty played out in therapy, there were many crises and major confrontations.

For example, challenged that he lived like a "spoiled brat", he responded with, "Go to Hell! I don't have time to sit here and listen to this!" As was typical, he began his next session with a plan to leave therapy. But he didn't.

Slowly, Frank began to become more self-reflective, albeit reluctantly. He was beginning to trust the safety of the therapeutic setting, the value of letting his guard down, and his ability to make use of the process. However, this was very frightening to him. His opening up in one session was often followed by a closing off in the next. Sometimes he would provoke a crisis to create distance. For example, during one particular group session Frank was much more open, vulnerable and sensitively involved with others than ever before. Late in the session he sobbed with pain at his realization of how his characteristic aloofness had doomed him to a lonely existence much of his life. He spoke openly of how this tendency had damaged his marriage and contributed to his wife's taking a lover. At the end of the session, he spoke of how useful the experience had been and thanked the therapists for offering him such an opportunity.

The next group meeting was the first session of a new month, the day patients had previously agreed to regularly bring their monthly payment. As usual I passed out the statements in group and collected the checks. This face-to-face collection system not only makes the money exchange part of therapy, but also encourages patients to openly express their feelings about the payment. When Frank got his statement, which amounted to close to a thousand dollars, he exclaimed, "This is too much money! This is not worth it!" Holding his checkbook in hand, he refused to write a check when I came around to him:

What is clinically appropriate for the therapist to do next?

Diagnostically it was clear that the figures shown on the statement, which he certainly could have computed in advance, stimulated hurt and anger and an underlying fear of engulfment. He had complained in the past about being afraid that he was being "sucked into a cult" or being "hooked by a hooker", and now was reacting strongly to these feelings, not by talking about and reflecting upon them, but with the action of

refusing to pay. Therefore, the underlying meanings had to be treated as secondary to the fact that he was violating the contract, and attempting to distort reality. He had agreed to pay his bill in full on the first of the month, and was now unilaterally refusing to abide by that agreement.

I told him quite simply and plainly, "Frank, you agreed to pay me in full today, the first of the month, and I expect you to honor that agreement."

"I just can't!" Frank responded. "I can't justify so much money!"

Perhaps there was some financial difficulty. I made clear to him that if there were such a problem he owed it to me and to himself to discuss the issue in an open way regardless of any embarrassment in order to work out some mutually agreeable payment plan. "That's not it at all! It's just too goddam much money!"

I knew that I would have to bring more force to bear in insisting he live up to his agreement. Clarifying reality cognitively had not gotten through, and I was faced with a choice: either give up the reality principle and live by Frank's dictates, or refuse to go along with his defiance.

"Frank, I insist on your giving me a check now or I will refuse to work with you."

"Well then, work with the others!" he shot back.

"No, I won't allow you to sit here and blatantly violate an agreement that you made in good faith, and act as if nothing serious is going on here." Not only was I emphasizing the reality of the contract that he had agreed to, but I was adding to it the force of my personal presence with an emphatic manner and raised voice. I wanted him to know that I really meant what I said. This was not just as an intellectual game.

I stood in front of him with my hand held out and waited a few seconds. He did nothing. "Frank, I'll have to ask you to leave if you don't pay me what you agreed to pay me on time!"

As I took this position, I was well aware that he might get up and walk out of the room and I might never see him again. Based on the relationship we had built over the last two years, I suspected that this would not happen, but I really didn't know whether that relationship was strong enough. Nonetheless, I was forced to take that risk because therapy could not proceed unless our relationship was firmly based on the reality principle embodied in the contract. Regardless of feelings, our work necessitated that he attend meticulously to reality. To compromise on this issue would be to invite further acting out on Frank's part, and to inadvertently encourage acting out on the part of other patients.

I continued to stand in front of him with my hand out, waiting for the check. A very long 30 seconds of silence passed. Finally, he made a look of disgust, wrote the check, and delivered it with a glare of fury. I thanked him, and as usual, collected checks from the other people and sat down. He continued to glare. "Say what's on your mind, Frank", I said.

He immediately exploded, red in the face. "You bastard!" My co-therapist encouraged him to yell this several more times, which he did. In this room, in this relationship with his therapist, there was ample room for his protests, but only vocally, and only after properly attending to reality.

As a youngster Frank had been fathered poorly. Mother had used her affection as a tool to manipulate Frank, and his successes in life were essentially a result of trying to please her. Father, on the other hand, harshly intimidated Frank into an "as if" compliance, and Frank's suppressed anger was acted out self-destructively. Now in this psychotherapeutic setting, a therapist was insisting he attend to reality and allowing him then to express his anger openly. Thus he could feel his own power even as he "gave in" on the issue, rather than act out self-destructively. He did not walk out of the session because he had learned enough in the previous two years to know that he had paid a big price for that gap in his upbringing.

When he was finished yelling, he settled down a bit and spoke about how hurt he was that others always seemed to demand of him and he didn't seem to get much in return. He cried softly a bit, and by the end of the session recognized the inappropriateness of his action. The real maternal deprivation he had experienced as a child had left deep hurt and anger, but obviously was not justification for shirking adult responsibilities. In the next session, however, he was able to speak with begrudging gratitude in favor of my having held the line. It had helped him to appreciate the value of maintaining relationships based on realistic living, not feelings of the moment.

Few personal relationships are based on a clear mutual understanding of the parameters defining that relationship. Marriage vows to love unconditionally until parted by death are based on wishful thinking and can lead to confusion and abuse. Business contracts, on the other hand, tend to specify clearly what each party agrees to do for or give to the other. A sound therapeutic contract must be more than simply a clear business agreement since the relationship it governs is emotionally loaded, like a personal relationship. Only if both parties agree to steadfastly abide by the reality principle can the work of therapy go beyond the many inevitable emotional crises. Such an approach in marriage, in the business world, and in government would go a long way toward creating a saner world.

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

DISCUSSION

As with any individual personality and developmental history, every issue is multidetermined and can correctly be viewed from different perspectives. For example, every communication—verbal and nonverbal—in a psychotherapy session represents at the least a genetic (childhood), a current and a transference issue, and the therapist makes a choice of which issue to respond to (including non-response), to highlight, or to direct the patient's attention. Likewise, within this same framework and utilizing combinations of ego, object relations and self-psychology concepts, one has many additional options from which to select an intervention; for example, towards defense and resistance or affect related to self and/or others, or to drives and wishes, the internal world of self and object representations or external reality.

The case in point here, of necessity, of course, abbreviated and simplified, is viewed as a man who remains aloof from feelings, defends against introspection, and is in therapy essentially to please his wife—much as he tried always to please his mother who favored him against his father and who "spoiled him", as it were. The core transaction and focus of the presentation is a confrontation over the agreed-upon payment, wherein the patient refuses to pay because the therapy isn't worth the price (or the gain is not worth the pain). The focus is on the importance of firmly insisting that reality comes first and must be respected and the patient must be held to the reality principle above all else. I have no serious brief with this position, but I do see opportunities to consider alternative or additional perspectives, perhaps to deepen and broaden an understanding of the patient's psychodynamics, conflicts and actions.

The patient is a 35-year-old already relatively successful attorney (he works for a large corporation, both he and his wife are in therapy, and he writes a check for \$1000). He is clearly focused on achievement, performance, and control over his feelings, actions and relationships. He is able to be friendly and sociable, but maintains interactions at a shallow or superficial level.

His mother is described as favoring him as her youngest, indulging him, protecting him from his father's demands and limits, but expecting compliance with her expectations as a condition. His father emerges—less clearly—but basically as demanding, setting limits, and having expectations for performance. I would propose, then, that Frank long ago learned that to have needs, feelings and wishes could be dangerous—most specifically dependency needs and feelings such as anger and affection. So from this point of view dependency needs would be repressed and leave him fearful of anything which would represent dependency as a weakness; similarly the experience and/or expression of genuine and deep feeling would represent weakness, vulnerability or related dangers and be suppressed and controlled. So he is defensively aloof, guarded, controlled;

efficient, productive and successful, yet also isolated, lonely and yearning for greater intimacy, of which he is also frightened.

In the session before the confrontation he reveals his sense of isolation and depression and pain—he exposes his dependency yearnings and subsequently feels exposed, vulnerable and threatened. He makes it up in the next session by reestablishing his aloofness, devaluation of the therapist and group, refusing to pay and expressing his anger—all of which are reconstitutive defenses. This perspective allows also a consideration of various options for responding to the behavior instead of, or in addition to, the firm insistence on his “compliance” with the contract or with what the therapist (maternal transference) insisted he do, and with which he then had no real choice (psychodynamically) but to comply. One might have suggested a transference construction, a developmental-genetic connection, a defensive relationship to the previous session, etc., while at the same time remaining firm about the payment. For me, what is right is understanding one’s therapeutic options and then choosing a reasoned course of action; what is wrong is choosing a course of action—even the same one—without the understanding.

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Background Point of Theory

Those with unclear personal boundaries also tend to overidentify with others with whom they have an emotional affinity, even when they do not see that similarities exist.

The more extensive the boundary defect, the greater the confusion that results from overidentification. The fears, hurt, and rage of others are experienced by those who overidentify as if they were their own. Such overidentification always interferes with the ability to assess the real interests of those with whom one overidentifies. This is a common difficulty among those who enter the so-called helping and teaching professions.

From R. Bar-Levav, M.D. (1988).
Thinking in the Shadow of Feelings, New York:
Simon and Schuster, p. 328.

LETTERS TO THE EDITOR

In the Spring issue of the Journal, I read Dr. Aledort's response to the case of Tim with mixed reactions. I agree with Dr. Aledort's emphasis on the developmental model to understand, interpret, and intervene with character pathology. His noting of Pine's crucial moments was particularly useful to highlight and reminded me of Balint's earlier writings on the consequences of lack of "fit" between the child and the people of his environment.

Since Balint's (1968) writing relates so directly to the issue of disdain, allow me to quote him directly: "If we bear in mind that the ongoing harmonious relationship...between subject and object or expanse is as important as the ongoing supply of air, we understand that loud, vehement, and aggressive symptoms appear when the harmony between the subject and its primary object or substance is disturbed. This primary relationship is so important to the subject that he cannot tolerate any interference with it from outside, and if anything contrary to his needs or wishes happens, he simply must resort to desperate methods." (page 71)

As Aledort so correctly states, desperate moments such as disdain are "powerful re-enactments" "driven by repetition compulsion". (page 29) They are also an attempt to communicate both an internal experience while diminishing a sense of helplessness by attempting to inflict similar experiences onto the therapist, i.e., the archaic transference.

Aledort is right again when he states these feelings need to be put into words. Since they are essentially pre-verbal experiences, the patient must rely upon the therapist if the patient does not possess the necessary resources to complete the process on his own.

I believe Dr. Aledort, however, underestimates the usefulness of a therapeutic contract in facilitating this process of developing verbal communication. The therapeutic contract serves, in fact, as a container for intense, at times, desperate affect. The intent for Tim, in the case presented is not as Dr. Aledort infers, to make Tim "a good little boy", rather, the contract is to provide a corrective emotional experience where the patient is held emotionally and contained behaviorally while he struggles to relate in a healthier, more adaptive fashion.

The therapeutic contract does work for the benefit of both the patient and the therapist (again as Aledort notes) and for that reason, must be carefully scrutinized. With a patient as disdainful as Tim, the risk would be a legalistic, rigid application of the contract where the intent is either to obtain compliance or administer punishment. Two precautions serve as a check on such therapist's disdain: (1) The use of a co-therapist to serve as an additional observing ego (as noted in the case presentation) and (2)

The necessity of exploration of the patient's feeling states following confrontations (which unfortunately was not given proper emphasis in this case):

The contract is not necessarily a precursor to the real relationship as Aledort states. Rather, at its best, the contract is a living expression of mutuality. Both patient and therapist agree to work together in a relationship based on the application of reality principles. Within such a primary relationship, disdain would naturally wither.

Richard R. Raubolt, Ph.D.

Reference

Balint, M. (1968). *Primary Love*. The Basic Fault, 71.

Richard R. Raubolt, Ph.D. is President of the Michigan Group Psychotherapy Society and a Board Member at the Sandor Ferenczi Institute, New York City.

Disdain has become so normalized in the media it's almost not noticed anymore. Popular shows like *The Simpsons*, *Beavis and Butthead*, and *Married With Children*, applaud disdain. And it sells well on prime time TV. Why has disdain found its way onto the airwaves more and more? Beyond Ms. Torracco's recognition that, indeed it is everywhere, what do people find so vitally attractive about it?

The answer is deceptive because the face of disdain has the appearance of power while, in fact, it stems from a feeling of powerlessness. To dismiss someone as if they are worthless gives one a sense of control over what they find undesirable. "If I don't like you, and I can't control you, at least I can cancel you in my own feelings."

Viewing disdain on TV, feeds in the viewer this vicarious sense of power. It is food for an audience hungry to feel in more control of their lives. Anyone perceived as having more power, or authority is a potential target for disdain. Add to that the anger and hurt that most people have experienced at some time in their lives regarding the unjust use of power and the equation is complete. The media has found an irresponsible, yet effective formula to exploit the public's hurt, anger, and especially fear while feeding itself in the process. Ms. Torracco accurately addresses the effects of disdain in the media but doesn't go far enough in identifying why it is such an attractive and economic mass media vehicle.

David B. Fogel, M.D.
Private Practice
Washington, D.C.

In light of Pamela Torracó's comments on disdain in the media, a correction to a misstatement she makes will provide for a more fruitful discussion of her concerns.

Resolution to the problem of the public expression of disdain visible in the media requires that one situate agency properly. This is true in addressing the expression of any feeling, but with the introduction of the media and other public players, agency (that is, the consciousness of the power to act), does become too difficult to ascribe. Yet the medium of television has no agency; it does not independently "encourage" disdain, as Pamela Torracó writes. The televised presence of disdainful behavior is simply a more evident symptom of illness. Whether in the interpersonal or public domain, agency remains with individuals to learn to act respectfully and rationally in spite of their feelings, and as well in spite of the strong presence of those feelings in the televised media. Appropriate actions are possible—and continue to be mandated—in spite of strong feelings, or strong technology. The discussion of disdain in the public arena must remain as focused on the agency of individuals to act rationally as does the individual therapeutic discussion.

Cynthia Duquette
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Political Science
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Ed. note: The medium of television has multiple agencies, each of which is responsible for his or her part of what comes out, and shares participatory responsibility for the whole and its consequences. There is no escape.

The Editors

My comments are in reference to Dr. Reuven Bar-Levav's "Disdain in the Political Process" in your most recent issue on disdain (Vol. III, No. 1). Unlike Dr. Bar-Levav, I do not find disdain to be "common" in academia. More commonly academicians refuse new ideas to keep themselves comfortable as a protection from feeling vulnerable. Being closed to different ideas is not in and of itself destructive whereas disdain is.

With respect to openness to new ideas, I am struck by the similarity of thinking in this journal. Although different topics have been selected for the journal, the phraseology, commonly held ideas, and general approach to the subject matter is so similar among the different respondents it is as if one person wrote it. Is this convergence the product of critical thinking or the result of a training program that is too narrow? Can this program be open to new and different ideas without greater divergence of

thinking? How can the faculty and fellows make such definitive statements about disdain, touch, self-indulgence, and the use of power and at the same time remain open to different ideas? Therefore, I challenge and encourage BLEA to nurture openness to new ideas.

Kirk L. Brink, Ph.D.
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In my recent article, "Working with Hate and Disdain in Group Therapy" (Fall 1995), is misleading on one point. I state that disdain is a first cousin of hate. But, in fact, the two are categorically different. Hate is a psychotic break in the relationship; disdain is a dismissal of the relationship, but not psychotic. To call them "first cousins" blurs the significant differences in the diagnosis and treatment of these two conditions. Each of these important topics deserves the attention of a separate article in the Journal.

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Background Point of Theory

Whatever anyone does is subjectively experienced at that moment as the best one is capable of doing. Even the most dastardly, stupid, and self-destructive deeds must be regarded as such. This does not imply that illegal or immoral acts should therefore be tolerated or excused by others. Deeds that may be objectively damaging or even destructive to the doer are often not recognized until much later. Everyone would surely act more wisely if only they could. Why does anyone ever do anything that is not really in his best interest? Because the urgent push to avoid fear commonly distorts perception, often in a surprisingly gross fashion.

From R. Bar-Levav, M.D. (1988)
Thinking in the Shadow of Feelings, New York:
Simon and Schuster, p. 324.

The *International Journal of Psychotherapy & Critical Thought* is published by the Bar-Levav Educational Association. Published three times per year - Spring, Summer and Fall. Subscription is \$20.00 for one year, \$35.00 for two years, and \$8.00 per individual copy.

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