CONFERENCE BOOK ISNIP

International Society
for the
New Identity Process
Daniel H. Casriel, M.D. - Founder

INTERNATIONAL CONFERENCE
GRÖNENBACH SEPTEMBER 1993

BONDING IN A THERAPEUTIC COMMUNITY

Possibilities and restrictions of bonding, a psychotherapeutic method in the therapeutic community (TC) De Sleutel
Observations of 15 years of group monitoring.

Lecture on the occasion of the 8th ISNIP conference at Grönenbach (Germany) - September 1993. To be Published in "Psychiatrie en Verpleegkunde" (Phychiatry and Nursing).
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1. History

De Sleutel (The Key) is a TC (therapeutic community) for drug addicts situated near Ghent (in the Flemish part of Belgium). The TC developed from the activities of the student group Y.A.C. (Youth Advice Centre) in 1973 as, as the time, drug addicts were refused in psychiatric hospitals.
Towards the end of the sixties and the beginning of the seventies, we as students believed in an alternative treatment for drug addicts. We rented a farm in the countryside where addicts could live together in drug-free surroundings. The therapy was based on the democratical and non-directive concept of M. Jones. The group therapy we used was the client-centred therapy of C. Rogers. Regularly there were crises caused by acting out, fits of aggression and suicide attempts. The group therapy was manipulated by the informal leaders, the most dominant residents, ...
We were disappointed and looking for new models of treatment when we came into contact with the Day-top model in the Netherlands. After a period of training and supervision we started with a structured TC in 1977. Three times a week an encounter session of two hours was organised based on abreaction or release techniques. Through the confrontation with manifest negative behaviour, often in an aggressive manner, residents grew closer to one another, opened up and listened to each other! The treatment was focused on their behaviour, on their addiction related problems. The treatment was a success. The TC had a rigid structure, rules and regulations and it was free of drugs.
Residents were capable of taking more responsibility, they confronted each other, became more honest, more mature.
Not only the fact that some members of our staff were trained in client-centred psychotherapy, but also our own experience and clinical observations taught us that addiction is a symptom which points to the presence of problems on a deeper level. We started looking for an adapted therapy method. At a conference in Rome in 1978, we met Dan Casriel where he led a workshop about N.I.P. (New Identity Process). We were enthusiastic and invited the Swedish teaching fellow I. Arn to our TC. After theoretical and practical training, we started in 1979 with NIP in our TC. A year later four staff members went to A.R.E.B.A (New York) for further training in this process. Since then, the application and the frequency of the application of the process changed regularly. The motivation was the study of the population of the population of the TC.

2. The population

2.1. Number

- A capacity of 15 beds -sometimes we had 18 to 20 re-sident
- 75% were male and 25% female
- The average age was 25 to 27 years
- The residents were detoxificated by entering the TC.

2.2. The Symptoms

Addiction
- alcohol
- illegal drugs
- medication

Sometimes we had more alcohol problems than drug related problems, less medication problems. During these last five years the drug problems are on the increase.

2.3. The Personality

In addition to their addiction problems, many have psychiatric problems. In some American studies (Mc Lellan) research was carried out on drug addicts proving that 80% of the research

population had encountered at least ONCE in their life psychiatric problems BEFORE their drug dependancy became apparent. Psychiatric disorders can be a result of drug using but psycho pathology is a risk factor for addiction.

We have also found that alcohol abuse and affection disorders frequently go together to diminish pain. Five years ago we investigated 50 patients using the D.I.S. (Diagnostic Interview Schedule). The study lasted one year. We recorded a high percentage of affection disorders among drug and alcohol addicts. 70% of the alcohol addicts showed affection disorders before their pathological use. Among drug addicts, we noted a high percentage of sexual disturbances. For the personality disorders we used the classification schedule of Millon. The conclusion of the investigation was that 60% of the alcohol addicts had an A.S.P. (anti-social-personality) and 40% a dependent personality. Of the drug addicts 70% had an A.S.P., 50% a histrionic personality and 40% a dependent personality.
The high percentage of A.S.P. can be explained by the behaviour criteria for A.S.P. in D.S.M. III R.

For the identity level the system of Kernberg was used.

1. defence system : primitive - projection - self-destructive behaviour - low self-esteem - narcisstic
2. reality testing : aimed at immediate fulfilment oftheir needs
3. identity integration : weak ego - dependent personality
4. object - relations : feelings of depression - fear of losing the love of people fear of attachment

Starting out from his psychoanalytic background Casriel taught us that an addict has a defective guilt mechanism. The absent parent is not fulfilling needs and as a result the reaction is : I don't have needs anymore. The ego becomes weak, the control system is weak and the behaviour is anti-social. The addict only loves himself (narcissism).
The two most important defence systems are fight or flight. In these people Casriel found a third defence system which is to freeze, to withdraw like a turtle. To withdraw within themselves from the pain of reality which becomes the only way to survive. This primitive defence system works well at the beginning but becomes dangerous afterwards.
That is the reason why an addict has no inner motivation to change. He does not feel the pain. He is not like a neurotic who feels the pain of a bad tooth.

2.4. Conclusion

The population of a TC for addicts like De Sleutel in Ghent is made up of a group of young people with, in addition to the problems caused by their addiction, a high percentage of affection disorders and sexual problems as well as a personality which is mainly anti-social (non-conformist) and dependent.

3. The Treatment

To treat these people one needs a residential place in which the residents and the therapists can live together. De Sleutel is a community for 15 to 20 people, living together 24 hours a day. All activities are done in group.

The rules are as follows :
- general rules : no drugs - no aggression - no sexual relations
- house rules no isolation, grow or go ...

There is a hierarchic structure based on a Daytop model :
three groups made up of residents, a person responsible for each group and the co-ordinator. They work, eat and play together. It is a community run on the basis of self-help with a staff who supervises.
Many therapeutic systems and games are used to train the residents. The games are based on five basic values : responsibility - honesty - friendship - respect -authenticity.

The basic frame is a holistic humanitarian concept (vision)
1. everybody can grow
2. we are not born with aggression, with guilt
3. we need other people to grow, not a supernatural power

3.1. The programme

TC : +/- 1 year
re-entry : +/- 1 year :
residential phase : 6 months
non-residential phase : 6 months

TC
1st phase : the aim is - to work on behaviour : to learn to observe the rules - to learn to handle conflict - to control impulses If they can do this, they start to have

deeper feelings.

2nd phase
the aim is - to understand themselves better - to have a cognitive insight into their personal systems, psycho dynamic relations - family systems- to take more res-ponsibility - to interact with other residents - to become more social-minded

3rd phase
the aim is - to be themselves, to make plans for the future, to make new friends, to develop a social conscience - to assume more responsibility in the TC, to be a model for new residents - the integration of new values - t o pre-pare re-entry

Re-entry
- residential phase : 6 months
- non-residential phase : 6 months

3.2. Therapy

Since De Sleutel came into being, there has been a serious evolution in the psychotherapy model.

3.2.1. Between 1975 and 1977 the client-centred therapy (C. Rogers) was used (3 x a week). This method was not lly adapted to the population as already explained.

3.2.2. In 1977 we were trained in encounter techniques in accordance with the Synanon model : a lot of provocation, people aggressively confronting each other (cfr. Daytopsystem). The encounters mirrored the tension within the TC and the personal tension of the residents brought them together. The TC became more secure and closer. Per group there were two-hour sessions three times a week. In the first phase the TC works on the level of the personality : rules, standards, values, defence systems ...

The confrontation with their behaviour : dependent people became more aware of their weak ego. The structure and hierarchic model in which residents who had been in therapy for a longer period act as role models, gave them the possibility to identify. The caring and warm feelings opened them up and they tried to trust people again.
Residents became once again capable of friendship, stopped loving themselves and tried to make friends.

As psychotherapists, we were not always happy with these provocative and hostile confrontation techniques, because to us they often seemed very destructive. We also believed that the deeper problems of these primitive defence systems had to be solved.
One part of the population did not always feel happy either with the methods used and from our observations we knew that a lot of them never opened up and that some of them guarded their feelings as if against danger.

From dr. Casriel we learned the new identity process (NIP) and brought it into our programme.

3.2.3. For about two years we discussed the introduction of the NIP group (place - frequency) into the hierarchic model.
After the training (4 staff members) we were so enthusiastic that we stopped the encounters and replaced them by 3 NIP groups of 3 hours a week. After 6 months there was too much aggressive acting out and so many daily conflicts that we did not have time for own psycho dynamic processes.

The conclusion was 1 encounter group and 2 NIP groups; much later 2 encounters and 1 NIP group and 1 minithon every month or a marathon every 2 months.

The schedule for the last 5 years has been as follows :
1 NIP session of 3 hours a week with 1 therapist and a group of 10 to 12 residents. A minithon (8 hours of therapy) every month led by 2 therapists or a marathon of 2 to 3 days (20 to 24 hours of therapy) with 2 therapists.

One needs a minimum of 2 therapists (1 man and a woman) for a group of 12 participants (with a minimum of 10) in a large room or in 2 adjoining rooms. If one does a marathon of 2 to 3 days, it is necessary to involve all staff members.

In addition to the therapist, the other staff members can organise other activities such as dancing, creative activities, relaxation sessions, sport etc...

My 15 years of experience with NIP in a TC with this particular population has convinced me that this combination is the most

obvious one.

3.2.4. When to start with NIP in the programme !!!

With this kind of population characterised by their obvious primitive defence systems and the high percentage of non-conformist behaviour, it is opportune to start by confronting them with their behaviour which is also the target of the first phase. Keeping this in mind it is better for the residents to start with the NIP groups after having spent some months in the TC (about 3 months).

In the encounters they learn to abreact their tensions, their aggression. They learn to talk about their feelings, their ideas, their needs. They are confronted by their peer-residents. In this way, they begin to realise a hidden agenda, a blind part of their awareness, which is necessary before starting the NIP group.

The procedure to become part of the NIP-group consists of writing a report to the therapist. The therapist and resident then make an appointment to talk about motivation. The result is discussed during the clinical staff meetings.

The criteria to participate in an NIP group are :

- the resident starts to have some feelings : anger, fear, pleasure, pain, love
- the resident feels more responsibility for himself, his feelings and his behaviour, he can stop his projections - the resident starts introspection
- the resident is ready to work on deeper emotions, the deep-seated motives of this addiction, his problems
- the resident controls his acting out
- the resident has spent some time in the TC (at least one month)

the NIP group is part of the programme which means that every resident becomes part of this group at some point in time. The exact moment of participation is determined in accordance with the resident and in keeping with the criteria.

In the early days we let the residents decide for themselves when they were ready to participate in the NIP group, but we soon realised that they were not really capable to take this decision. It would be like giving them the chance to decide whether or not to participate in the encounters. So we decided that NIP would be a part of the whole programme.

The question is whether NIP therapy is always the right answer for every resident? Sometimes we noticed that a resident needed individual therapy on top of his participation in the NIP group. The NIP therapist took care of these individual appointments. This led to good results for the resident, but these individual sessions had a bad effect on group dynamics.

It is my opinion that individual support can be given by their personal staff member.

3.2.5. How can we work psycho therapeutically with people with a primary defence system?
According to me the TC is the basis. The NIP therapy only works with this population as a result of the structure and the whole hierarchic model.I will now describe a working group and some of the techniques used. Residents in a TC use these techniques on a different level than people in an out-patient group.

The session starts with a group discussion. Each member of the group talks for some minutes about how he/she feels, what he/she wants to work on in the group, who he/she wants to work with and how he/she realised what was decided at the last meeting.

Everybody sits down on mats and holds hands. The therapist also talks about his/her feelings.

Group scream : everybody stands up, joins hands, breathes deeply and screams together (Aaa-aaaaaa). Then every resident chooses a partner to work with on the mat.

At the beginning of the therapy (the first period : some weeks, some months) residents have difficulties talking about their feelings. They will say : "I don't know how to feel, I don't know what I feel, I don't feel anything." It is as if their feelings are atrophied. Sometimes they cannot express what it is they feel (alexythemia).

The therapist or other residents have to tell the resident what he feels. This happens by means of trial and error e.g.
A > screams A > no
F > screams F > yes
in this way an intrinsic frame of reference is constructed.

Everybody is on the mats doing a bonding exercise. One resident is down on the mat and another resident is on top of him/her and they hold each other. The one who lies on the mat is working. The other one is the teddy bear (the helping person). Bonding is to be physically and emotionally open.

The residents of a TC are really afraid to do this exercise. Naturally everybody who starts with NIP is afraid to do bonding, but residents in the first period (second and third month) are taking less responsibility. They clearly demonstrate their aversion.

They talk, laugh, sleep, try to seduce each other... they have problems to do the exercise correctly. The therapist has to follow them step by step sometimes feeling like a policeman. One has to push them, to support and trust them, to help them to break through their resistance because they are very much afraid and have little contact with their basic feelings.

Emotions of pain, pleasure and anger are ego-dystoon (they are not part of them). The therapist's expectations should not be too high especially if one is used to work with an out-patient group or if one compares with the training group. The therapist must be aware of his/her counter-transfer: 'they don't want to work or to feel, they don't like me...'.

After some months (depending on the residents), they start to take it more seriously because they start to feel and to experience their emotions.

Residents who have been confronted with incest or who have been sexually abused constitute a specific problem. Bonding exercises will often be identified with sexuality which is why some residents may ask to bond only with a woman ...
We agree with this and monitor their process. Sometimes we suggest to do a nurturing exercise (a mother and child exercise) because the position of the exercise is less related to sexuality.

Scream exercises

During all these exercises we use the scream as a pre-verbal manner in which to express feelings. We often say a lot more in this way than by using words. Especially for this population, the scream AAAAA growing in volume can produce feelings.
At this stage of the therapy it can be observed that there is only a scream, not a content (only music, no meaning/words). The scream is also more aggressively abreacted. This comes from the encounter group where the abreaction technique is used.

The therapist has to teach them to have feelings connected with the scream. As an outsider one is in a better position to hear whether the scream contains feelings. By providing feedback the therapist can help them to identify these feelings and to support them to continue.

The first feelings are usually 'Anger' and 'Pain'. 'Fear' comes later. 'Pleasure' and 'Love' are difficult to feel. 'Love' is often connected to sexuality, 'Pleasure' is generally 'act as if' pleasure.

Attitude training

After the individual work on the mats, the residents form a circle. Those who want to work tell the therapist that they want to do an exercise.
Attitudes are the individual cognitive process of someone. To work on attitudes, one has to withdraw into oneself to come into contact with what one is feeling. During the first months of the therapy, the therapist has to specify the attitude as the resident is not as yet able to do so. Later on the residents know their programme and they are more open and able to identify the attitudes and to alter them from negative to positive attitudes (e.g. 'I'm not good enough' becomes 'I am good enough').

Confrontation techniques

In the circle, residents can confront each other not by saying things that hurt, but by expressing their feelings. For instance they can say "you make me angry" instead of "you're an asshole!".

The difference between the NIP group and the confrontation-encounter-groups is a serious problem. Sometimes residents refuse to take responsibility for their own feelings and they want to hurt someone else.
As a therapist it is necessary to be a firm leader in order to avoid feelings of insecurity.

After the exercises the group members sit together, form a circle and they end with a final group discussion. Everybody tries to formulate a resolve for the next session. A resolve might be : 'the

next time I want to work some more on my anger, or I intend to hug 5 times a day with 5 different persons, ...'.
Afterwards everybody hugs everybody, the therapist included. That is the end of the session.

It is my experience that in a TC a rigid timetable is necessary, for instance
30' : initial group discussion
2 hours : emotional work
30': final group discussion and hugs

In an out-patient group one can freely mix the steps of the process. In a TC a rigid structure is preferred.

Seminars

It is instructive to introduce theoretical information about the process, emotions, attitudes, defence-systems and the formation and development of identity. I prefer to do this before the session or at the beginning of the session.

The therapeutic relation

The position of the therapist is important. Casriel taught us about peer-transfer relations and authoritarian relations.

In my experience, a peer relation is not possible. One can achieve it in an adult out-patient group. Sometimes the therapist has to be very directive and limit the abreact exercises. It is important for the residents that the therapist is also a human being with his or her own feelings and problems. To build up a relation of trust it is important that the therapist also speaks about his or her personal feelings, experiences and to let the others know when one is touched by a strong feeling. Dare to show it !

The residents are characterised by two basic attitudes :
1. A distrust of the therapist. They will test you to see whether you are willing to listen to their stories, whether you won't laugh at them, whether you take them seriously, There is a lot of manipulation.
2. They trust you too much. Residents are too open, they tell you their stories immediately, but they expect an instant solution from you > they want a symbiotic relationship.

The two basic pitfalls for the therapists are :

1. Strong feelings of negative counter-transfer when residents are not open enough.
2. Too strong a counter-transfer because deep down there is a huge cry for help > take away my pain, my suffering. The therapist is confronted with stories which can be very traumatic.

For NIP the therapist needs a lot of energy and training. This powerful method requires therapists to be well trained in fundamental attitudes such as honesty, truthfulness and unconditional positive acceptation of the clients (do not judge them even if they have committed crimes).

4. Conclusion

What is the influence of NIP on a TC ?
Our experience has led us to believe that residents stay longer in a TC. If they run away they generally come back for the closeness, the bonding (if they really feel it), the atmosphere in the group because it is less hard and warmer, more open and less manipulating.
NIP is the place in the programme which can be compared with the uterus of the TC.

Residents can show their emotions and try to become themselves. They are born again and it brings them in real contact with other human beings.

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BONDING IN A THERAPEUTIC COMMUNITY FOR DRUGADDICTS

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A. Introduction

Today four people are going to speak about NIP in the T.C. for drug addicts. This gives us a fantastic opportunity for a rich exchange.

Most people in the audience are familiar with the work in the T.C. Therefore I think it will not be necessary to give an extensive introduction about this work. I guess it would take a separate lecture to do so because the treatment network for drug addicts has become so complex these days.

I intend to give you my personal summary of what seems important to me concerning the themes "drug addiction, T.C. treatment and NIP". I'll be referring accurately to other people who have been thinking and writing about this, so that you can go back to these sources if you are interested.

B. WHAT IS DRUGADDICTION?

1. COMMON DEFINITIONS

Following the chronology of history, I think we have to go back to the definition of addiction as it was written down in the World-Health Organisation - memorandum of august 1980.
In an article of 1982 Edwards, Arif and Hodgson made a summary of the evolution of this definition over the last 30 years and they quote the mentionned WHO-memorandum as following. The word "addiction" has been chang into"dependence". (Edwards e.a., 1982).
They write that "Drugdependence is a socio-, psycho-biological syndrome with a pattern of behaviours, where taking the psychoactive drug has become more important than other behaviours that used to be of much bigger importance before", Later in 1987, in the same way of thinking, we find the descriptive definition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R).
Drugdependence is defined here as : "a disorder with a cluster of cognitive, behavioral and physiological symptoms that indicate that the person has

impaired control of psychoactive substance use and continues the use of the substance despite adverse consequences." A difference is made between drug-dependen and drug-abuse. This is only a matter of the severity of the problem measured by 9 criteria who indicate the loss of control and its consequences. A classification is made of the abused substances (APA, 1987, 165-185).

Of course these descriptive definitions don't say anything about the etiology of drugabuse. The etiology, and therefore the proposed treatment, is seen differently in a collection of theories. For more details about these theories
I want to refer to Martin Kooymans last book "The therapeutic Community for Addicts". There he gives a review of the biological, psychodynamic, behavioral, system oriented and psychiatric theories about this matter (Kooyman, 1993t 24-33). However none of these theories kan explain fully the origin and continuation of drugabuse, says Kooyman. He prefers interactive models where dependence is seen as a psycho-physiological-social syndrome, determined by a complex system of reinforcements (WHO, 1981). He refers to the writings of Van Dijk (1979, 1980) who gave an excellent description of the pharmacological,the psychological, the social and the cerebro disintegrative vicious circles that keep the addict addicted (Kooyman, 1993, 35).

2. CASRIELS IDEA ABOUT DRUGADDICTION

For the purpose of this lecture it is important to look at Casriels view of the problem.
In my knowledge, Casriel gave no systematic description of his ideas about drugaddiction, but he speaks regularly about it here and there in his writings. He was very familiar with it in his work as a psychoanalytical psychiatrist. If I understand well it was exactly his frustrating psychoanalytical experience with young addicts and delinquents that made him look for a better treatment. His search started in Synanon (a selfhelp community for addicts) where he learned about the importance of the behavioral approach (stop the acting-out) and the emotional confrontation (cfr. "games"). In 1963, shortly after this visit, he became one of the founders of one of the first therapeutic communities for addicts. A that moment he introduced the NIP at once as part of the treatment.

So, from the historical point of view, NIP is very connected with the treatment of addicts. I even have the hypothesis that the NIP-method was first made for addicts and showed also to be usefull for other patients later on. To me the general theory of NIP refers very much to the specific treatment of addicts, namely first stop the acting-out behavior and then teach them to handle the emerging emotions and attitudes in cathartic groups.What more does Casriel write about the phenomenon of addiction ? In my review about this matter I'll be referring mainly to Casriels basic book "A scream away from Happiness" (1976) and Janneke Coolens doctoral dissertation (1985).
Casriels classification of psychopathology is very simple. He speaks about three big categories : neurotics, character disorders and psychotics. For him most addicts belong in the category of characterdisorders. (Casriel, 1976, 148).
He considers symptoms as external signs of an internal emotional disturbance. They are the result of specific defense mechanisms of the person against to much pain. People with a characterdisorder cannot handle the pain. Instead of transforming their basic emotions, as the neurotics do, they have no contact with their basic emotions. They disconnect them from their consciousness, "freeze"- them and so don't feel them. At the most they feel a vague tension that they try to canalise temporarily with acting-out behaviour (taking drugs). This acting-out behaviour has a destructive character for others and for themselves and it can also take the form of agression or control (in the case of anger), of flight or withdraw (in the case of fear).
Following Casriels idea, Kooyman explains that their acting-out behaviour can be understood as a defence against being hurt. For the most important fear of addicts is to be rejected. In fact they are the ones who provoke this rejection by their acting-out behavior. But when they cause this rejection themselves, it looks as if they have more control about it and this seems to be more bearable. (Kooyman, 1985).
Their fear of being rejected is connected to their extreme negative selfconcept. They have a very strong conviction that they are "condemned to lose" (failure identity). Kooyman tells from his experience that most of them can't feel that they have the right to exist. And he says that if one

does the necessary research one finds generally that there is a situation during their first year of existence that shows a problem in the relation with the person who is supposed to take care of them. From this experience the child can get the feeling not to be wanted (Kooyman, 1985, 163).

Casriel thinks only a small part of the addicts are neurotics and in that case the addiction is secundary to the neurotic problems. The most frequent addiction in this group is alcohol- and medicine-addiction. Casriel says that neurotics do feel their emotions but have problems to express them. Their defense mechanism is the distortion of their emotions.
Casriel writes that even a smaller group of addicts have a psychotic disorder. With these people the addiction can be seen as a way of selfmedication to control the psychiatric symptoms. These people suffer from uncontrollable emotions and their defense mechanism is to disconnect from the "so painful" reality. The psychodynamics of all forms of character disorder are very similar for Casriel and for this reason he treats them all in a simular way. We'll talk about this later. What I like to Casriels way of thinking is the way he puts it in the social context. He says that it is the social reinforcment that makes certain forms of addiction more socially accepted than others.

He speaks about the same disturbance for "warkoholic, succesfull businessmen, for compulsive housecleaners, mild-mannered bookworms, reckless drivers, long-term underachievers, overeaters, unhappily married people" as for "people that shoot dope, drink heavily or are sexually promiscuous". The common denominator is anaesthization of basic emotions and encapsulation of the feelings behind a defensive shell that is extremely hard to penetrate in traditional psychotherapy situations. (Casriel, 1976, 3).
Other factors such as individual background, social values and rules, knowledge about and attainability of the substance or the behaviour, age, individual preference etc. are the ones that decide how the addiction is going to look (Casriel and Amen, 1971).
Casriel goes on with his social analysis and says that addiction is partly caused by society itself. He points at our society and describes it as going from a neurotic type of society to a character-disorder-type of society. He describes how the change of the structures of society has its influence on the development of new emotional disturbances such as addiction (Casriel, 1976). Important factors for this change, says Casriel, are the disappearence of the big family, the competitive city life and the social mobility. These living conditions have their influence on the fact that it is getting hard to have deep emotional relationships and develop a feeling of belonging. Going away is often easier than fighting for something that is difficult to get.

Casriels socio-cultural analysis and experience (as a disciple of the antropologist Kardiner) brought him to introduce the concept of bonding and to practice bonding during therapy sessions. As you know for Casriel bonding meansemotional openness and physical closeness. And as you can imagine from their already described living-strategy, it is very difficult for character disordered drugaddicts to accept this kind of intimacy. For them fysical closeness is mostly only connected with sex. For this they are not able to have long lasting intimate relationships with others (Kooyman, 1991, 88-89).

3. CONCLUSION

As a conclusion for this search for a NIP-vision about drugaddiction, I can formulate the folowing definition. For this, I'm using the familiar "A-B-C"- concept that refers to "affect-behaviour-cognition". So, a drugaddict is a person whoes behaviour is characterised by acting-out in a way that he or she has lost the control about the use of a psychoactive substance. On an emotional level this person "freezes" his emotions and feels only a vague tension which is discharged through his acting-out behaviour. On the cognitive level there is a deep negative attitude towards life which means that he or she doesn't believe to have the right to exist and be succesfull in life. Addicts have big difficulties to give and to receive tenderness and bonding, and therfore don't have long lasting intimate relationships. From this NIP definition of drugaddiction it is easy to think that the proper
treatment for addicts will consist of : first stop the acting-out, secondly teach the person to manage his emotions and thirdly help him to acquire positive attitudes towards life. Emotional but also fysical closeness will be an important part of the treatment.

C. DRUGADDICTION : HOW CAN IT BE TREATED ?

1. INTRODUCTION

Neurotic drugaddicts can be helped in an outdoor treatment way with individual-, group- and/ or system - oriented psychotherapy. The difficulty here is the control of the use of the drug. For this urine-control has eventually to be part of the treatment. Sometimes these people also need a short or longer hospitalisation. This is the case when they have little social network supporting them.

Drugaddicts with a psychotic personal;ty usually belong in psychiatric hospitals. But these hospitals sometimes have problems to control their drugabuse or other ways of acting out (violence for example), and send these "difficult" clients to the T.C. In fact the T.C. is not the proper place for people with little ego--strength because of the penetrating techniques that are used such as confrontation, stress and intimacy. More and more exceptions are made on this point, specially in the case of borderline patients who are getting a specific treatment in the usual hierarchical structured T.C. This new treatment has been elaborated by people such as the Stauss group here in Gronenbach. We'll be able to learn more about this during this conference in a separate workshop. In other places I heard about discussions about the proper "number" or "kind" of borderline patients that would be welcome in a usual T.G. Janneke Coolen writes about a statement of Casriel who said that he would allow maximum one borderline patient in a group (Coolen, 1985, 25). Myself, I remember a statement of Peter Geerlings (in a NIAD-course of april 1991) saying that the "symbiotic" (vervloeiende) but not the "compulsive-destructive" borderlines would be welcome in a T.C. This because of the big anxiousness that emerges when intimacy or feelings of belonging start to come.

The final treatment for the character disordered drugaddicts usually is the hierarchical structured T.C. It may take a long time before they get treated, because they'll try to avoid it as long as they can. Only when social or personal pressure and suffering is at its maximum, and they still want to choose for life, they will come into the T.C. And many of them will run away severall times during their treatment.

2. THE HIERARCHICAL STRUCTURED T.C.

Most of you are familiar with the work in a T.C. for addicts. And as I told you in my introduction I shall only try to tell you what seems essential to me about this matter. For more details I would like to refer you to Kooymans recent book, which is a real manual about the T.C. (1993), and also to my own writings (Martens, 1989, 1990 c, 1993).
For me a T.C. for drugaddicts is a kind of self-help community with a rather strict supervision by a clinical and/or by experience trained (ex-addicts) staf. The treatment deals with all the aspects of the addiction problem (such as medical, psychological and social) in a well integrated treatment consisting of socio-, psycho-, body- and amilytherapy. The most important acting-out behaviour is stopped at the beginning of the therapeutic program by forbidding drugs, violence and sex with each other. The social reintegration of the addicts is programmed step by step, first inside the T.C., later outside, until the ex-resident is able to manage by himself for his living and social life.

3. NIP IN THE T.C.

Now, where does the NIP appear in this T.C. ?

First it has to be said that the NIP was connected to the T.C. for addicts from the very beginning as Casriel introduced it himself when he founded Daytop. As he was not able to develop the NIP in Daytop with the support of his team, he left Daytop and started his own T.C. for addicts "AREBA" where NIP-groups were part of the therapeutic program.

Not only historically but also theoretically there is a strong tie between T.C. and NIP. The implicit basic work hypothesis of T.C.'s and NIP are identical namely : stop the acting out and teach to deal with emotions and attitudes. This is beautifully illustrated in an outline by Johan Maertens about "De twee T.G.'s" (in dutch) : one "T.G." standing for "T.C." and the other for "therapy group". (cfr. Figure n 1). Personally I would complete the attitude of "I am good enough" with "I have the right to exist and I am good enough the way I am". (Maertens, 21).

NIP-groups fit into the

psychotherapy-part of the T.C. The psychotherapy of the T.C. is mainly grouppsychotherapy. Only during the later phases of the treatment individual psychotherapy is sometimes added.

The groupstherapy usually is the encounter group, the so called "confrontation - encounter" wich was developed after the "Synanon-game". During these encountergroups the residents of the T.C. confront each other about their destructive behaviour here and now in the T.C. This confrontation is made very -intense by the yelling and the screaming of emotions. When there is a connection with the past this is worked through in the here and now situation. The goal is to change the negative ehaviour of the confronted resident and make him understand himself better. From the otherhand the goal is also the full expression of emotions in the people who are confronting others. For more detailed information, again I would like to refer to Kooymans very didactic writings (Kooyman, 1985, 168-169; 1993, 71-79).

The encountergroups are considered to be the most important therapeutic tool of the T.C. Although they have their limits. From the one hand it is necessary to limit the work in these groups to the here and now situation to be able to canalise the tensions and conflicts that emerge from the very demanding community life, but from the other hand the used techniques are not sufficient to allow the full emotional discharge when the connection is made with the past. And here comes the importance of the bonding-group. As you know, NIP group allow and stimulate this emotional regression to the past, not only to discharge but also to work through emotional blocks or traumatic experiences from the past. This working-through seems to be necessary to be able to start a new life. If this is not done, the traumatic experiences from the past can go on having their distorting influence.

4. ADVANTAGES AND DISADVANTAGES (?) OF NIP IN THE T.C.

Having NIP in the T.C. brings more adventages than only giving the opportunity for deep emotional work.
An important one is the theory that is introduced with NIP. This theory makes it explicit that a complete treatment should take care of behaviour and emotions and attitudes. The behaviour correction is mostly done by the sociotherapy. Emotional work happens mostly in the encounter- and bondinggroups. The cognitive change (insight and changing basic attitudes) is growing during the whole treatment but it is especially trained during the last period of the treatment connected to the concrete social reintegration. The theory of NIP is simple and easy to handle as a common language by staff and residents.

A second advantage is that NIP offers the possibility not only of emotional but also physical closeness and intimacy. This part of the treatment would not be available in the T.C. without the NIP-approach. And as said before this is very important to help the residents build up a lasting partnerrelationship in the future (Kooyman, 1991, 89-99; 1993, 57).

The possibility to experience intimacy during the NIP-sessions also brings the residents to touch each other and hug outside the sessions. Hugging can be a way of giving support to someone in a difficult moment, and at other times it is done just for fun. In and outside the T.C. residents hold hands or arms. The typical cool subculture of addicts disappears : showing tears but also laughing is easier.

This makes me think of another advantage. NIP as a theory and as a practice heads not only for a "neutral" but certainly for a "pleasurable" life. Addicts have a big problem taking in pleasure as they are afraid it will disappear soon and that will hurt. So, it is very good that the NIP points clearly to that problem for them. From the technical point of view IP-sessions are very economic : lots of people can work for themselves at the same time.
Also the used technics of bonding and screaming are a safe way to handle very intensive emot-ons who normally would lead to acting-out or splitting from the T.C.

The weekly discharge of emotions certainly has a positive influence on the time in program of most residents. Violence and running away is less frequent. As Johan Maertens writes : "You eventually run away because of a warm transference relationship, but you certainly come back for it!" (Maertens, 23).

Are there any disadventages by introducing NIP in the T.C. ? I don't know if you can call it a disadventage, but working with NIP asks a lot from the staff of the T.C. First of all at least two staffmembers have to go through the process themselves and follow the training which takes minimum 4 years. The rest of the staff is expected to be interested and emotionally open and willing to hug once in a while. To me this change for better is only an advantage for residents and staff, but it asks a lot (from both !). The NIP cannot be used disconnected from the rest of the therapeutic program. For this a good briefing and co-operation between the NIP-therapist and the other members of the staff is very necessary. This integrated way of working is especially important in the treatment of addicts who would take advantage of "any whole in the therapynet to continue their escape" (Martens, 1993, 116-124). Doing all the necessary to have a harmonious team takes time and effort.

A limitation of NIP is that NIP is too scary for residents who have just come to the T.C. The contrast with the way they handled emotions before their intake is to big. A waiting period for at least 6 weeks is indicated.

Another limitation of NIP is that it is not usefull for people with a weak ego strenght, at least when NIP is used in the common way. The risk to be lost within their own emotions is too big. We'll talk more about this further on. Going on the mat together can be problematic for residents who have been sexually abused. The fysical contact can evoke the traumatic experience before they are prepared to deal with it emotionally. Waiting some time and giving them individual psychotherapy can be a solution. For other "tough" boys the physical contact on the mat is not wanted because they make the association with homosexual experiences. This, of course, is only a form of resistance and càn be worked with as a resistance. But NIP can also be abused by residents ! In Deinze I already told you the story of one of our residents who was working on the mat with his fear to be caught for his secret sexual contacts with a female resident. But he was doing this without telling anybody what his fear was about ! Other boys and girls try just to make fun together on the mat without allowing any real intimacy. (Martens, 1986, 61- 62). In this case it is very important to teach the difference tetween intimacy, sensuality and sex.

D. MY PERSONAL EXPERIENCE WITH NIP IN T.C. DE SPIEGEL IN BRUSSELS.

1. INTRODUCING NIP

Shortly after I started to work in T.C. De Spiegel in 1983, I started to talk about introducing NIP into the T.C. Together with another staffmember, who was an ex-addict, we were convinced from our personal experience that the NIP would bring the nessary depth to our therapeutic program, as it was originally thought of by Casriel. My arguments were more or less the ones I just mentionned. The big doubt of my colleagues was if such a "strange" method would not interfere with the other very reality oriented parts of the therapy. We decided that each staffmember would check it from his personal experience and participate in a NIP-workshop. Thls happened during the spring of 1984 and the experience was mostly positive. So we decided to introduce the NIP and I went on with my training. The question remained how we would bring the residents to use the NIP. We finally saw an opportunity during a crisis we had that summer. We had to discharge several residents for a while because of drugabuse. When they decided to re-enter we took advantage of the situation to ask "more" of them. From now on they were expected to express their feelings during groups by screaming and hitting matresses. We were making go-arounds, holding hands screaming and making eye-contact as it is used in our usual attitude groups. At the same time we gave them seminars about the NIP-theory. But we still didn't dare to use the groupscream or propose the full body contact and work on the mat. This finally happend during a five day marathon in february 1985 that was started and supervised by Alix Kremer. Since that time we have been doing our weekly 3-hour session in the familiar way.

As we have only a small T.C. with about 13 residents, we thought we would need all of them to have reasonable good dynamics in the NIP-group. As you can imagine this was very scary to young residents. We respected their fear and handled it by asking them to participate only at a behaviour level : be there, look, listen, eventually start to scream and touch. They were

encouraged to express their fear, respect it and put their limits.

Also borderline residents were accepted in the NIP-groups in the beginning. Mostly they were doing some ego-strenghtening work by practising positive attitudes. I'll tell more about this later in my lecture. To avoid that the NIP would become an isolated part of the treatment, great care was taken for briefing with the other staffmembers before and after the NIP-sessions. Staffmembers who didn't have a training had their turn as a co-therapist. Their role was to observe, take notes and assist the therapist if necessary (for instance to go afer a resident who leaves the group during confrontation). My main preocupation, though, was that all staffmembers would know that was going on during the NIP-sessions and that they would be able to follow the emotional process of the residents.

2. EVOLUTION AND SITUATION TODAY

As the years went by my attention was drawn to what I could call the average NIP-process of the addicts in our T.C. This was definitely different from my experience with neurotic people in my private practice.

In the T.C. the resistance to express and discharge emotions is much bigger. For this my interventions are more active, directive and sometimes provocative. In a way they are simular to my interventions in an encountergroup. But in the NIP-group I show more interest for the inner-world, the "difficult" or better said "painful" emotions, I also ask for connections with important persons from their past. Sometimes I stimulate the regression-atmosphere with my low voice and caresses.

I noticed that one can recognizé a certain chronology in the emotional work of the residents. Most male residents first dare to let out their anger. They already know this from the haircuts and the encountergroups. They experience it as a real relief to be able to discharge this anger fully and use for this not only their voice but also their body by hitting the matress or doing an anger-attack. Female residents usually first start to express their pain and have big difficulties to do so with anger.

For the character disordered male, pain comes second, if it comes at all, because this is very hard for them. It usually happens after a few months in the context of their clean but painful contacts with the outside world. Seeing back the family and the rests of their junklife (social isolation, debts, juridical problems) brings up the pain about what is and what was missing in their lives. At that moment the emotional regression to the infant-period may happen.

Fear is always there during the whole process but it is stronger at the beginning and at the end of the program. In the beginning it is the fear for emotions and the loss of control. At the end it is a deep fear coming from their negative attitude.about the right to exist. This appears when they are trying to build a new living situation by themselves : getting a job, finding a house, eventually having a partner.

The emotions of pleasure and love are the real tough ones to work with. This work only happens a couple of times at the end of the therapy but a year of therapy usually is too short to benefit from this last part. There is a lot of fear to allow these emotions because they are expected to disappear quickly, and missing them will hurt. Negative emotions are more familiar and safe for addicts anyway.
Through my observation of our esidents in the NIP I also noticed a different process in two categories of psychopathology namely the antisocial and the borderline residents.

First the antisocial ones. These residents have a lot of resistance because of their fear for the loss of control and more specifically for their own agression. It is important to help them to understand the difference between agression (against the other) and anger (for themselves) and invite them to trust to express their anger in a direct way without violence. Hitting matresses and screaming makes it easier for them to make the evolution from an expression only "via the body" to an expression only "via the emotion". The next step is letting out the pain and this is very hard but very important for a positive prognosis. Their pain is the pain from early deprivation or rejection in their childhood. They experience the same pain in their conflictuous relationships with authority figures and society. This turningpoint happens about the sixth month of their stay in

the T.C. You usually get an emotional break-through or a splitting away from the T.C. at that time. If they come to the end of the one year treatment they usually have to fight with their paranoid attitudes. They are convinced that there is no place for them in society. It is true that most of them have to deal with big debts to pay or even the possibility to have to go back to jail.
With the borderline residents, on the contrary, emotions come very easily on the mat. But soon you will realise that they don't really work through their emotions. They don't experience any relief as they go on discharging and they feel disappointed. No shift to the past is happening. Some of them get panic stricken by fear. To me the only meaningful thing to do is to let them work with egostrenghtening attitudes such as : "I am I" and "I can control myself". Later we decided to give them individual psychotherapy instead of bonding. This is more helpful for them and it relieves me from a lot of preoccupation during the NIP-session.

As time went by we also decided not to allow the younger residents to the NIP-session during the first six weeks of their stay. I decided they were taking much of my energy at the cost of the ones who can benefit better from it. The result is a smaller but better working group. And as the average occupation level of our T.C. lately is better than it used to be, the NIP group actually has 10 to 12 members.

3. SPECIALS !

Special for our T.C. is that for years the NIP-session has been following a body-therapy session of one hour done by a trained therapist. The goal of this therapy was to make the residents more conscious about their body and teach them how to relax. This was considered a good preparation for the NIP-session. This is not done any more because the therapist has been given another task in the T.C..

Instead we are using dynamic meditations now and then, just before the NIP-session. The residents generally love it except for the antisocial ones who do not like to lose control with their eyes blindfolded. The "Hoo"-meditation seems to bring the residents to express anger and the "Kundalini" to express pain. Our very special experience consists of the two NIP-marathons we did together with the residents of another T.C. Two times in 1990 we had a two-day marathon together with the residents of T.C. "De Sleutel" in Gent. This marathon was directed by the two NIP-therapists of both T.C.'s They were already familiar with each others work outside the T.C. The advantage that we saw is that we would be able to work with a much bigger group with people who do not live together. This could be an opportunity for a bigger variety in the input, more possibilities for confrontation and projection and interesting group dynamics. Our hypothesis was confirmed. The marathons were very productive. The residents were really surprised to see that they could trust "strangers" and be open with them. Important confrontations and emotional break-troughs took placé. The impact of the standing-up attitude group with 25 residents was very powerfull for the ones who were practising positive attitudes in the middle of the circle. At the end there was an exceptionally warm and loving atmosphere.

E. GENERAL CONCLUSION

My general conclusion to this rather long lecture can be very short: just use NIP in the T.C. for addicts ! It's interesting and very useful !

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THE TRADITION OF CATHARSIS IN THERAPY

by Lynn Grodzki, LCSW

I would like to introduce myself. My name is Lynn Grodzki, and I am a New Identity Process (NIP) therapist from Silver Spring, Md., where I run groups, workshops, and lectures on methods of experiential therapy

In today's culture we value the bottom line, so this brief introduction represents what I think you need to know about me, in one sentence. But if I had wandered into this small village of Groenenbach two centuries ago, and we were meeting for the first time, you would demand to know much more. Two hundred years ago, an introduction was expected to include some mention of lineage. My lineage, which means my-direct descent from my family, my kin, or my tribe would place me in the proper perspective and give me legitimacy. My lineage would establish me as part of a continuum and offer us a way to find a connection, so that we might begin a relationship based on mutual trust.

I could trace my lineage for you in several different ways. I could tell you my family history, beginning with many past generations of my father's family, who lived in the village of Bachmut and immigrated from the Ukraine to the United States. I could detail my vocational history, explaining my training and education, and naming my therapist, and her therapist, and his therapist, until you began to have a sense of the influences on my work. I could disclose my personal history, telling you how the New Identity Process helped me recover from both a physical illness and psychological distress. Each approach, whether it focused on my familial, vocational or personal history would identify a different aspect of who I am, and help determine the basis of our relationship now and in the future.

When I started to write this paper, I wanted to establish a definition of the work we do as therapists, and consider our history as well as our future direction. So I began by asking the question : What is the lineage of the New Identity

Process ?

As I first began to research the lineage of the NIP, I felt as though I was examining a tree with no branches or roots. Other than Dan Casriel's three books, no references surfaced when I entered the phrase "New Identity Process" in the computer files of the National Library of Medicine. After an unproductive hour at the computer, randomly putting in words I thought might generate some sources with no success, I typed in the word "catharsis." The screen filled with reference material, including many mentions of the NIP. I decided to read all I could about catharsis.

This research has led me to a perspective on the NtiP that I particularly like. From this angle, the methods of the NIP follow in direct descent from the earliest examples of ancient healing arts and lead to the most advanced discussions of intercellular science. I believe that the way to understand our lineage is to view it through the tradition of catharsis.

The word *catharsis is* Greek in origin, and means to purify or cleanse oneself. In ancient Greece, physicians gave patients cathartics or purgatives to rid them of toxins in the body. Priests and spiritual healers also relied on catharsis, in the form of intense emotional ventilation, to purify people and offer them an experience of renewal during religious ritual. The practices of fasting, prayer, chanting, drumming, and wild dancing created an altered mental state in a person, and as a result of this altered state, emotional arousal and catharsis was commonplace. After the catharsis, a person might undergo a healing of physical or mental symptoms as well as a heightened state of mental awareness (1).

Several significant books on catharsis were published during the last fifteen years. Two of these, *Catharsis in Psychotherapy* and *Emotional Expression in Psychotherapy* both by Michael Nichols have greatly informed this paper. Nichols, a psychologist and researcher, compiled a thorough review of the literature about catharsis and also conducted some important empirical data on the subject. He notes that the method of catharsis has generated either intense criticism or strong advocacy among therapists since its inception. One reason for this is based on multiple meanings of the word, catharsis. In the psychological literature, I have found that anything from shaking in fear, to watching violence on TV, writing about a memory, playing football, screaming in pain, hitting another person, or shedding a polite tear, has been called catharsis. Without a clear definition catharsis presents a problem for therapists trying to advance its worth.

The psychoanalytic definition put forth by Freud and Breuer explains catharsis (or abreaction) as a process, in which a patient recalls a previously forgotten memory and experiences the feelings associated with it, resulting in a release of repressed, psychic energy and a feeling of relief (2). Most therapists agree that stimulating catharsis requires a concerted effort, on the part of both the therapist and the patient. Some method for lowering the defense system is needed, to allow the repressed material to come to consciousness.

The first tool used most consistently by early therapists to alter a patient's psychic state and thereby lower or relax his defenses system was hypnosis. It is important to take the time to understand the association between the first uses of hypnosis and catharsis. This is how the lineage of the NIP begins.

In the late 1700's, Anton Mesmer, a physician, founded a clinic in Paris to study the effect of magnetic forces on the human body. He believed he could heal patients in his clinic by exposing them, under the proper conditions, to the lodestone (a variety of magnetite.) Mesmer created a clinic environment of safety and high drama (1). He would begin his sessions by having his patients sit around a large, magnetized table in a darkened room, holding hands. Mesmer would pass among them, telling them to relax and to sleep. In time, a patient would become agitated, and might begin to moan, scream, shake, or cry violently. Others would join in, until all the patients around the table would be in

the throes of intense emotional release, while still holding hands. The sessions might last hours and could include joyous laughter as well as wailing cries. Afterwards, the patients would be very relaxed and calm, and many of their presenting symptoms would go into remission or disappear.

Mesmer knew that the experience of catharsis in the sessions was essential to the healing, and he searched for a scientific explanation. He determined that the force of the catharsis came from an invisible fluid generated from the lodestone, that entered each person during the session. He called this fluid animal magnetism. The medical community investigated this theory and found it, of course, unsound. So despite the fact that he did cure patients as a result of this treatment, Mesmer was discredited and fell into disrepute. But his techniques continued to interest physicians, throughout France and the rest of the continent, because "mesmerism", the use of induced trance to bring about emotional catharsis, resolved symptoms (3).

In I 860, Jean Charcot, a French neurologist, was experimenting with mesmerism, now renamed "hypnotism" with his hysterical patients The illness of hysteria, at this time, included a host of symptoms : depression, mood swings, extreme excitability, seizures, paralysis and lack of feeling in the body (4). Charcot found that under trance, hysterical patients often verbalized forgotten, traumatic memories that seemed directly related to their symptoms. Sitting in his lectures were Janet, Freud and Breuer, all equally fascinated by his demonstrations of hysterical (neurotic) patients who, under hypnosis, would recall childhood trauma, express intense emotions and then be relieved of hysterical symptoms.

Pierre Janet, Charcot's pupil, began to study the relationship between trance and catharsis. Janet theorized that traumatic memories played a major role in producing hysterical symptoms As a result of the intensity of the childhood trauma, both the memory of the event and the emotions about the event would split off from the rest of the personality. Janet called this act of splitting "dissociation". After a session of catharsis, there was often an integration of the traumatic incident on both an emotional and an intellectual level. Patients understood the old trauma in new ways; their changes in mental functioning seemed durable and lasting.

Prior to the catharsis an aspect of the patient's personality might seem frozen, as if their development had stopped at the time of traumatization (5). Janet wrote "Many of the patients become unrecognizable if we can only make them cry. After a fit of weeping, which is sometimes very difficult to induce, their obsessive ideas of persecution, the airs they put on, their stiffness, their incessant doubts, and their very resistance will disappear, as if by magic" (6).

If a session seemed dull, Janet took it upon himself to incite or provoke fresh anger in a patient and produce emotional discharge, which is an intriguing, early description of a therapist using confrontation to generate catharsis. He believed that hysterical symptoms would reoccur, so cathartic sessions needed repetition. Janet insisted that his work and Charcot's in France were the true starting point for psychoanalysis (1).

In Vienna, at the turn of the century, Joseph Breuer, a successful and eminent physician was, like Janet, experimenting with hypnotherapy and catharsis with his hysterical patients. He related the details of one patient, whom he called Anna 0., to his younger friend and colleague, Sigmund Freud. This case became the founding case of psychoanalysis. Anna 0, an intelligent young woman, actively participated in her treatment and relished the opportunity for uncensored talking, while under hypnosis. She found that these "chats" with Breuer produced forgotten memories and emotional discharge. Afterwards she might have some temporary relief from a variety of symptoms. She called Breurer's method her "talking cure" (7j.

Freud had also witnessed demonstrations of hypnosis and catharsis, as conducted by Charcot, and he considered Charcot to be one of his great

mentors. But Freud had reservations about the use of hypnosis, which Charcot likened to an artificially produced morbid state. Freud became increasingly uncomfortable with a dependency on hypnosis, although it was considered essential in bringing forth catharsis. He saw that the talking cure that Arena 0. found helpful could be achieved without hypnosis, by using the technique of free association. So in *Studies on Hysteria,* Freud expanded the definition of catharsis to include, for the first time, uncensored talking as a form of emotional expression. He wrote "Language serves as a substitute for action; by its help affect can be abreacted almost as effectively (as crying and raging)" (2).

Breuer, the older physician, was more content to use the standard methods of hypnosis and emotional catharsis. Freud, intent on positioning himself apart from Breuer (7), continued to develop more objections to Breuers cathartic method. Cathartic sessions required repetition in order to cure each and every variation of a symptom. Freud preferred to investigate the root causes of the neurosis through talking, in hope of eradicating them all at once and creating fundamental personality change. In this pursuit, the thinking of a patient became key; the symptoms and emotions of the patient could be ignored as inconsequential. In fact, the use of emotional discharge tended to offer such relief that patients did not want to stay in analysis and complete the self-exptoration. Freud began to feel that too much catharsis took his patients away from the intellectual hard work of analysis, and robbed them of their motivation to continue (8). He became increasingly disenchanted with a therapy that focused on symptoms and emotions.

Freud, with his background in neurology, said that although he could theorize about the neurological workings of emotions, it had to remain a vague theory because the science of the day could not verify his concept (4). He defined a "container" model of catharsis : In abnormal situations, emotional energy is created through agitated thinking. If the energy can be expressed immediately, through a form of emotional discharge, the body retains to a level of balance. However, if the energy can't be released, it converts to other symptoms as a way of finding expression. The energy, still in the body, fills up individual neurons, until they become full. Freud clearly saw emotions as concrete things that required some form of container, an inner repository, from which emotion would be ventilated and drained. This necessitates the use of abreaction to drain off emotion and stop the development of symptoms.

Freud eventually abandoned this container model of catharsis in frustration, saying that without knowing more about the nervous system it was not possible to go further in developing an accurate description (9). As he moved away from the use of hypnosis and catharsis to concentrate on cognition and resistance, much of the practice of psychotherapy followed him. But not all therapists abandoned catharsis. With the advent of World War I, it surfaced as an essential method for healing large numbers of traumatized soldiers

William Brown, a neurologist during WWl in France, treated from two to three thousand cases of neuroses of war, using catharsis as his primary method, and documented his results (10). He determined that catharsis alone could produce a lasting evolution of symptomology in the soldiers, who were suffering from what we would now diagnose as PTSD (Post Traumatic Shock Disorder). Brown used the psychoanalytic method of hypnosis, but he did not find talking to be a sufficient form of abreaction to cure these traumas. Soldiers needed to relive the horrors of the battlefield and fully express the emotions of pain, fear and rage by screaming, crying and shaking with fear. Successful treatment required that there be repetition of catharsis, in multiple sessions.

Brown said, "Catharsis accounts for the cures. Catharsis removes the cause of the symptom. Abreaction of repressed emotion sweeps away the repression and frees energy which had been previously needed to hold the

forgotten memories apart from the rest of the mind. .. the freed energy is thus put once more at the general disposal of the personality (11) ". Brown's work confirmed that when the goal of therapy was quickly healing symptoms, not creating fundamental personality change, the logical and expedient method to use was catharsis, not cognitive analysis.

In 1927, Wilhelm Reich, a psychoanalyst and a contemporary of Freud's, was exploring the subject of resistance. He defined the greatest resistance to emotional and sexual health as the resistance present in the physical body, which he termed the body armor. Although Freud had touched patients on some occasions, using his head pressing technique* to break through their resistance to remembering during hypnosis, Reich created an entire model of therapy based primarily on the use of touch that he called orgone therapy.

* The head pressing technique was as follows : Freud applied the back of his hand to a resistant patient's forehead during hypnosis, telling the patient that the memory would surface underneath his hand, for the patient to recall (7).

Organe therapy exemplified what might be called the "conflict" model of catharsis, as opposed to Freud's container model (4). In the conflict model, there are two psychic forces at work, battling each other. One is the force for emotional release and the other is the counter force that seeks to prevent the expression, usually referred to as resistance. Catharsis is created by the weakening of the counter force. As long as the force and the counter force are of equal strength, there will be no expression of emotion. Much of the work of therapy within the conflict model is the focus on overcoming the resistance and upsetting the balance of the two forces, to allow the emotion to spill out.

Under Reich's guidance, patients engaged in a process of first breaking down their defenses, then working through the deeply repressed material with emotional discharge. He encouraged them to regress and re-experience the feelings of infantile genital anxiety. The patient's ability to fully work through genital anxiety and experience pleasure in their body became a hallmark for Reich's definition of a sexually healthy adult. A number of techniques, including touch and massage, were relied upon to lower resistance to catharsis and increase the patient's ability to experience feelings of all kinds, including pleasure.

Interestingly, Reich used orgone therapy and catharsis with psychotics as well as neurotics. He found he could control the level of catharsis and make it manageable by bringing forth emotions one at a time. He described one session with a schizophrenic woman, writing, "I encouraged her crying which blocked the rage, and after some tearful release of sorrow I let her develop her rage by encouraging her to hit the couch... the most important emotion to elicit is rage (hate) and until this is released one cannot allow the softer feelings of longing and love to emerge (12)."

In 1947, an analyst in supervision with Reich named Fritz Perls began to define a Neo-Reichian approach that he called Gestalt Therapy. Perls developed new and powerful techniques of promoting catharsis, often within a group format, although emotional discharge was not his primary goal (13). As the movement of Gestalt Therapy grew, one of the offshoots was the idea that therapy was not only for the sick, but also for the "personal growth" of the well. The encounter group removed the traditional distance between patient and therapist. Anyone in attendance at an encounter group was fair game for confrontation from the group; the group interactions were deliberately left unstructured and uncontrolled to encourage conflict and break through defenses. If catharsis occurred, as a result, it was accepted and acknowledged as a "breakthrough".

With the advent of encounter groups, psychotherapy began to mirror the cultural and political unrest of the 1960's. Other aggressively cathartic therapies quickly emerged, perhaps as a protest against the mainstream, cognitive

psychoanalysis. Three of these therapies appeared independently, yet they all relied almost exclusively on emotional discharge as their major intervention. The first two, Jackin's Reevaluation Counseling, and Janov's Primal Therapy are important to review for their linkage to the third, Casriel's New identity Process.

Harvey Jackin, a behavioural scientist, designed a framework of therapy that he hoped would address social change as well as personal growth. Untrained as a therapist himself, he fashioned a simple process whereby lay therapists would assist their peers to engage in sessions of emotional discharge. The therapy was conducted with the participants taking turns, mutually counseling each other. Jackins believed that the use of catharsis alone could reduce tension, help people to cope with traumatic experience, alter patters of dysfunctional behaviour and aid in a cognitive reevaluation of life (1). His emphasis on lay counselors in Reevaluation Counseling may have been, in part, based on his own lack of formal training, as well as his stance that counseling could be a social movement. Standard issues for exploration in psychotherapy, such as transference and counter transference, cognitive dysfunction or personality restructuring were not addressed. Any insight gained from the catharsis was an individual affair, to be undertaken privately, apart from the cathartic sessions. Jackins conceived of counseling as a basic, simplified, ongoing part of people's lives rather than a cure for illness.

Arthur Janov approached catharsis from a Freudian viewpoint of repression. Janov, a psychologist and social worker, believed that all pathology is due to the repression of painful emotion. His cure was simple : the patient must re-experience the old, blocked emotions. This was the therapy of the Primal Scream.

Janov theorized that all human beings are born with basic needs; the infant needs food, shelter, clothing, warmth and stimulation. When the infant's needs are unmet he naturally feels pain and cries or rages. As long as he can feel his pain, the infant will not be neurotic. If the infant is not able to feel or express his pain, then neurosis will occur. This primal pain seeks an outlet, by generating neurotic symptoms, but can never fully expend itself (4).

In Primal Therapy, the therapist actively attacks the patient's defense system by prescribing sleep deprivation, physical isolation, and a host of other actions all deliberately imposed to heighten tension (14). With the tension mounting, Janov would then encourage a patient to immerse himself in feelings of pain. The screaming, crying and physical writhing that followed, called a "primal" could last for several hours. The patient might be isolated in a hotel room overnight, to think, and return the next day for another session. The primal method was deliberately rigorous and unrelenting in its attempt to regress patients to the pain of infancy and childbirth. Birth primal were considered the ultimate experience (1). Despite evidence to the contrary, Janov insisted that his form of therapy was uniquely original. His tendency towards wild statements and overreaching claims make his writings difficult to evaluate (15).

Daniel Casriel's New Identity Process (NIP) fell somewhere between the extremes of these two models. The NIP did not try to erase all boundaries between patient and therapist and become a model of social change, nor did it correspond to the rigors of Janov's Freudian approach, where the therapist controlled the environment completely to regress the patient back to birth trauma. While the NIP reflected some of the thought and technique of these two models, it also reached a long arm back to Reich, to bring the use of touch into the therapy session.

Casriel, a psychiatrist and analyst, attended a series of encounter groups at the Synanon Rehabilitation center in 1902 and found his approach to therapy forever changed. Fascinated by the encounter group and its ability to break down the emotional defense systems of hardened drug users, he went back to his private practice in New York

City and began to integrate the encounter techniques in group therapy with his neurotic patients (16).

Similar to Janov, Casriel relied on the Freudian container theory of repressed emotions and neurotic symptoms. He devised a variety of methods to break down the defense system and promote abreaction— including the use of group pressure, confrontation, and marathon sessions, which might include sleep deprivation. He also encouraged patients to scream and used phrases, like Janov, that fostered regression during screaming.

Casriel's theory of neuroses, called his "road map to happiness" explained his interest in bringing physical touch into group therapy. Casriel believed that humans have basic needs, including a need for "bonding," which he defined as physical closeness and emotional openness. He considered unmet bonding needs the fundamental problem in achieving emotional health. Casriel insisted that patients work in groups, not in isolation, and he added touch in the form of physical holding to his cathartic process.

Unlike most therapists before him, Casriel used touch not only to break down resistance (as did Reich), but also to create a corrective experience of nurturing. Casriel encouraged patients to hold each other during emotional discharge. He observed that, at times, the full body contact alone allowed patients to break through their resistance and enter into a deeply regressed, emotional state. The holding minimized a tendency of patients to dissociate when regressing (16,17). The continuation of holding, even after the catharsis, let patients experience a reparative level of comfort and soothing, which he termed, simply, "taking in." In this way, like Reich, he addressed the need of healthy adults to first tolerate and eventually enjoy the experience of touch and extended holding. The extended holding and quiet conversation that took place naturally while "taking in" promoted insight and cognitive integration.

Like Jackin, Casriel saw the group as having the potential to become an instant community (18). Casriel felt that the group process benefited from the use of lay therapists and "catalysts." Catalysts were laymen, experienced in this kind of group process, who did not have a professional distance from the patients and took on the job of deliberate provocation. Using non-professionals to lead groups was controversial within the mental health community, and he acknowledged this, writing, "The use of laymen as group leaders remains in question (16). "

Casriel's career was cut short by a sudden illness and early death. As a result, the NIP has modified and changed to conform less to his original personality and more to fit a broad range of settings and styles of the professionals who now use it. The NIP group process has shown unusual flexibility as a model of therapy that can work within private practice, hospitals, clinics, and week-end educational seminars. What has not changed is the continued reliance on catharsis as the major therapeutic intervention to create individual change.

One purpose of exploring lineage is that in charting the influences that brought us to this point, we can then plot our future direction. As we move forward and think about the current use of catharsis in therapy, we must be able to speak to the criticisms and objections that continually surface about its use. The most commonly heard objections about catharsis fall into one of two extreme categories : Either catharsis does too little and is ineffective, or it does too much and is harmful (1,19). I would like to speak briefly to these concerns.

The objection that catharsis is dangerous comes primarily from the studies done by Bandura and Berkowitz, social scientists, who reported that catharsis increases, rather than decreases, hostility and aggressiveness. They began with the hypothesis that any form of discharging should reduce the pent-up feelings of

aggression (1,20). But "any form of discharging" is not the accurate, psychoanalytic definition of catharsis. For example, they considered hostile behaviour, such as children hitting other children, as discharging. Hitting did not relieve feelings of anger, nor did watching violent TV, another form of discharging these activities increased aggressive feelings. In these studies, no distinction was made between the this discharging and the way catharsis is commonly used in therapy. Hitting a person was considered no different from discharging the feelings, in therapy, about wanting to hit. It is no surprise that their research found catharsis dangerous and contra indicated for already angry people. Berkowitz also wrote, quite vehemently, that therapists who use ventilation teach their patients to ventilate anger with everyone, indiscriminately, both inside and outside of therapy. He advised therapists to teach patients to control their emotions, not ventilate them (21). Again, this is a misunderstanding of ventilation a therapeutic technique, not a prescription for social behaviour.

The objections that methods of catharsis are ineffective have been harder to refute, on an empirical basis, due to a lack of specific research about catharsis as it is commonly used in therapy. Many studies are artificial, and do not try to duplicate the intensity or power of catharsis as it works in a therapeutic setting. Fortunately, Michael Nichols devoted a great deal of effort his books to address this. He reviewed the literature and found a substantial body of indirect evidence, in the unlikely form of research from behavioural scientists. One documented cure for phobias and fears, called implosion therapy, is similar in description to methods of catharsis (22). A surprising number of behaviour therapists support the claims of cathartic treatment and this support is bolstered by research evidence (1,23).

In his desire to go further with data to prove the direct effectiveness of cathartic therapy, Nichol conducted a series of five controlled studies at the University of Rochester in the iate 1970's (19). His 1974 study was the first published in the history of psychology to quantify catharsis and relate it to therapy outcome. In subsequent studies, Nichols' research shows that catharsis leads to therapeutic improvement in brief therapy; that catharsis is beneficial for clients with personality disorders; and that there is a strong correlation between the use of catharsis and the extent of personal change.

The studies, interestingly, did not show that those who screamed and cried the most, changed the most. The following factors were considered more significant than the amount of catharsis, as a indicator of the rate of change a patient could make in therapy :

1) Expressing feelings that were previously avoided, confiict-laden or unconscious.
2) Having a cognitive connection to those feelings.
3) Becoming more expressive than previously.

More direct empirical evidence of the value of catharsis in recent years has been conducted by scientists who are exploring alternative methods for healing the immune system. Most of these studies ask the question : Can cathartic psychotherapy reduce the incidence of health problems? The results are promising (24). Speigal found that cancer patients, in a group therapy model using emotional discharge and support lived twice as long (25); Pennybaker found that students using catharsis had fewer health problems (26); Kemeny found that the immune system responds positively to brief states of intensely expressed emotions, regardless of whether the emotions expressed are sadness or joy (24,27).

The next step may be the formulation of a third model of catharsis, one that will combine what therapists understand about the psychological process and what scientists can measure about the cellular workings of emotions in the body. Dr. Candace Pert, a pharmacologist and neuroscientist has published a series of studies detailing her discovery of chemicals, called peptides, that exist throughout the body. These amino acid chains modulate brain function. The neuropeptides and their receptors are a part of the network of

communication between the brain and body, and probably represent the biochemical substrate of emotion (28). As she explained in an interview with Bill Moyers, these chemicals are the bridge between mind and body; peptides are the measurable, chemical reactions that correlate to emotion. Separate feelings — anger, hunger, sadness, or ecstasy have separate peptide chains mediating them and move in distinct, measurable ways through the body.

This is a dramatic breakthrough for those of us who work with emotions. In the past, one of it great challenges to the legitimacy of catharsis has been the rejection of Freud's concept that emotions are stored indefinitely in the body until they are discharged. Even Nichols, a proponent of catharsis, has great trouble accepting this concept, writing, " (I) find this unlikely and cannot even imagine how this storage could be accomplished... If unexpressed emotions are stored indefinitely, then it would be reasonable to prescribe cathartic therapy for character disorders. (But I) find the premise unlikely (1).

Recognizing peptides as the biochemical correlates of emotion makes it possible to say that emotions are concrete and exist within the body in physical form. With time, we may begin to understand the cellular details of how unexpressed emotions react in the body. Pert suggests that unexpressed emotions may be retained in the autonomic nervous system, in the spinal chord, and that a series of inhibiting chemicals may be activated to contain them This may help to explain creation of secondary symptoms and ill health, when emotions are repressed.

Based on a recent conversation I have had with Dr. Pert, the conception of this third model seems a possible goal and one that we may work on jointly. With the formulation of such a model, we could begin to educate and inform segments of the population who, until now, have felt that the value in expressing emotion is at best anecdotal.

It is refreshing, to hear Pert and Kemeny, in separate interviews with Moyers, recommend the emotional catharsis of all feelings as a method of general health that would benefit the public at large. Pert says, "(In the past) we have been sold on high tech, incredibly expensive medicine that's bankrupting the country. Why not try a little prophylaxis ? Let's begin to appreciate simple, less expensive therapies that deal with releasing emotions, and let's get some sound scientific studies to see what works better (24)."

This can be the future of the NIP and other forms of cathartic therapy. As we understand the bridge that emotions play between mind and body, methods of emotional therapy can also be understood as bridge between treatment extremes. Psychotherapy has relied excessively on the methods of cognition to heal mental distress. It is time to move towards an equal reliance on emotions, as emotional release becomes an accepted part of general health. Therapists in the NIP can take this opportunity to position ourselves from the sidelines of mental health treatment, closer to the forefront, drawing on our clinical experience with a time-tested method of emotional expression. It is my hope that we can contribute to a new direction emerging in health, based on a comprehensive knowledge of our lineage, an ability to disseminate our clinical experience, and a willingness to actively participate in the future dialogue of mind/ body medicine.

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Working with trauma and abuse victims using the new identity process. A critical look at the strengths and weaknesses and organizing concepts of treating trauma victims using NIP

Ron Kissick

In this presentation I hope to organize information about working with trauma victims, especially survivors of physical and sexual abuse in childhood with a perspective on how and when to bring the unique tools of NIP to bear on healing the wounds. The general information presented as a reference spans a broad range, and is not intended to be totally inclusive of the field.

There have always been the occasional stories of horrible trauma brought out in therapy. Even before the women's movement made it possible for many more women's reports of rape to be believed, there were stories. Even before men came back from Viet Nam traumatized by the experience, there were stories. And even before the current explosion of awareness of childhood physical and sexual abuse, there were stories. And like a family in denial, it has only been with steady pressure over time through the courage of a few of our clients and even fewer of our colleagues that psychotherapists have come to accept that these stories are more frequent than we previously thought, and that they are substantially true. Not all are true, of course. but probably most.

I, myself, have come the way I think many therapists have come in confronting these stories and the related therapeutic issues. Initially there was a kind of denial. It wasn't that I didn't really believe my client's stories; it

was more that I didn't have an organizing conceptual framework from which to understand the importance of the information I was getting. I didn't know how to ask the right questions, and I didn't know which aspects of the trauma victim's experience required special attention. So I minimized the importance of the often disjointed bits and pieces of traumatic history I did get, and tried to work with the client pretty much the same as everyone else. The result was that these clients were not helped as much as they should have been.

I began organizing conceptually about these issues in the early 1980s with reading and peer discussions. There was not very much literature about it at the time, and most of the research that existed then was flawed by small samples and questionable methods. Then in 1985 I was asked to assist in "Critical Incident Stress Debriefing" for emergency service personnel (such as ambulance crews. police, and firemen) in our area. I quickly concluded I was not prepared for the real life drama of, for instance, a policeman fingering the trigger of his service revolver unconsciously as he talked about the drunk who had just killed an entire family, the policeman's next door neighbours. I didn't know if the policeman was thinking of killing the drunk, or of committing suicide after seeing just one too many deaths. And I didn't know how to ask. The only advantage I had over some other therapists in doing this work was that I was comfortable with the emotional intensity of the situation because of my training in the NIP.

I took two periods of training with Dr. Jeffery Mitchell, Ph. D. of the University of Maryland Shock Trauma Centre in Baltimore, Maryland. Dr. Mitchell is a leading authority in working with situations such as I have just described, and in working with victims of disaster such as earthquake, tornado, airline crash and building collapse. (1) Eventually I evolved my own protocol for working with victims of disaster in the workplace such as those affected be explosion, robbery or death of a co-worker in the line of duty. (2) I have now done 25 or so of these debriefings. Like hearing the stories from a client abused in childhood, I have never failed to be moved by the drama of their experiences.

However, the treatment of a person traumatized over a finite period of time a few hours to a few days in the past is very different than working with someone traumatized years ago. The fact of being able to address the trauma quickly means I am not doing therapy with the victims; I am helping a group of normal people deal with a very abnormal situation. if a trauma is treated in a structured fashion very soon after the event, victims show less than 1% increase in any measurable symptomatic behaviour including use of medical and mental health services, divorce, job turnover, etc. up to two years after the event. Figures are a bit different for children and for the elderly, but there is a substantial similarity in recovery. (3)

If a traumatic event foes untreated, 10%-15% will show no lasting effect. At the other end of the spectrum, about 10% will have enduring severe symptoms including, but not limited to flashbacks, emotional numbing, difficulties in concentrating and in relating to their families, eating and sleeping disturbances, etc.: in short, all symptoms commonly associated with Post Traumatic Stress Disorder as defined by the DSM III R. (3) The rest of untreated trauma victims show a range of symptoms between the extremes. Having talked this much about response to trauma, it would probably be wise to say what trauma is. Trauma is an event that is perceived be the victim to be life threatening to himself or to another he is emotionally or physically close to. So, trauma can be very different for different people. Trauma destroys, at least temporarily, a person's sense of control and predictability creating a discontinuity in physical and emotional life. The key issue is helplessness, and the primary coping mechanism is retreat from the here and now, primarily in the form of dissociation. (4)

Now think of abuse victims who have suffered their secret over time since childhood. They have at least an 85%

chance that there will be some enduring symptoms, and they have had years of experience elaborating their view of the world incorporating this trauma. Now the range of ingrained symptomatic behaviour becomes truly daunting :

Post-traumatic stress disorder
A whole range of dissociative disorders up to and including
Multiple personality disorder
Borderline personality disorder
Obsessive-compulsive disorders
Chronic depression
Phobias
Anorexia and bulimia

All of these diagnoses have some degree of positive correlation with childhood physical and/or sexual abuse. For example, acts of compulsive self mutilation by cutting are highly correlated with early childhood sexual abuse. Anorexia should cause you to question the possibility of sexual abuse around the onset of puberty. (5)

Why have we not realized the extent of trauma and abuse as a potential causal factor in so many therapeutic issues before this ? For one thing, we had a good example to begin with. Sigmund Freud originally diagnosed one of his most famous clients as having been sexually abuse in childhood. Under pressure from his peers and from upper crust Austrian society, Freud renounced his diagnosis and labelled this client's symptoms as "hysteria". (4)
Traditionally, too, we have not believed children. Therapists have labeled stories of sexual abuse as being "oedipal fantasy", or as simple lies to avoid punishment for misdeeds. There was denial on the part of therapists for how children could know, for example, of sexual information they were not developmentally ready to know. Nobody wants to believe that parents and other adult authority figures, especially our neighbours and other respected community members are capable of such awful stuff.

Historically rape victims have not been believed. In male dominated cultures this denial was often based on the attitudes that "she really wanted it", or "she must have done something to invite it", or "she's lying to cause trouble because she's angry at men".

Post-traumatic stress disorder symptoms in men is mentioned as "combat fatigue" or "shell shock" as early as world war I. There was one book written called Men Under Stress in 1946 (6), and then nothing more until 1978. Part of the problem in recognizing the effects of trauma in men is that men tend to act out their symptoms instead of talk them out. So men ended up in jails or mental institutions or as odd hermits hiding out in remote countryside.

As a side issue here, it has been noted in recent studies in the Netherlands and in the USA that combat veterans returning to heroes' welcome after WW II seemed to do well for many years, but at the time of retirement and diminished physical capacity or influence. a substantial number began having flashbacks and other symptoms of delayed onset of post-traumatic stress disorder. It is further suggested that there has been a high incidence of difficulties among these veterans in relating to their families and that these difficulties include a high incidence of child physical and sexual abuse. (5)

The nature of trauma, especially childhood trauma is that it overwhelming. Because it is too overwhelming to deal with it is dissociated, but that, of course, does not mean it goes away. The compulsion to re-enact the trauma in order to master it shows up in the variety of symptoms. Unwanted thoughts, feelings and images intrude unpredictably. For this reason, probable most of the victims of trauma you see in therapy will be "doers". They have to constantly be doing things in order to keep those thoughts, feelings and images at bay. It is hard to get them to be introspective because that makes them vulnerable to the awful memories. Sufferers of trauma will seldom come to therapy to deal with the trauma itself. They will come for help to "control" the symptoms. The trauma itself usually emerges piecemeal. Because the information is often characterized by emotional incongruity, disjointedness and a mix of other stuff, therapists and other authority figures have tended to doubt the

veracity of victim's stories. As the story begins to emerge, the client, too, will often deny the reality of it; he/she would rather believe it is not true. The desire to believe the trauma did not occur is often represented in a search for incongruities in their own memories with the hope that if they can prove some part of the awful memory wasn't true, that will mean that none of it was true.

I would be remiss if I did not give passing attention to a related phenomenon. That is what has come to be known as "false memory syndrome". One consequence of recognizing that childhood abuse is probably much more common than previously thought has led some therapists to see signs of childhood physical or sexual abuse in virtually every client. In some circles of clients it has become fashionable to have horrible stories to tell, and in order to be a "good client" some have learned to dredge up a new horror or even another alternate personality or "part" for each therapy session. This phenomenon goes to the needs of the therapist to be entertained as well as to the client's desire to please and impress an authority figure. Assuming that there is no financial reward in the offing (as in a lawsuit), nor is the client trying to avoid jail, you must look to the transference-counter transference dynamics between the client and the therapist to assess the possibility of "false memories". Findings of "false memory syndrome" are based on two kinds of disputed information. The first is spontaneous memory developed in therapy as a part of regressive work. There is strong question as to the validity of memory based on very early experience since the manner in which children remember things is different than the way adults remember things. Childhood memories, say before the age of 5 or 6, tend to be episodic and disconnected. Memories may be charged emotionally, but distorted in the way that perceptions of children are. When using memory information from this age, independent verification is very helpful. Whether independent verification of early memory is possible or not, treatment should not rely too heavily on the content, but on process. (4)

The second kind of disputed information is based on the earlier mentioned transference-counter transference dynamics between the therapist and client. It is very important to support the client in finding her/his own way through the memories and not to lead them by suggestion or by undue focus on a particular part of their history. It is quite different to direct a client to "Tell me what happened next." as opposed to "Is he touching you ?". Even in adult life, the overwhelming nature of trauma often distorts memory of the event, of the time frame, etc. Don't rely on the factuality of a victim's memory of trauma, but believe that something very important has, in fact upset this person's life. (6)

Now, turning to the treatment issues, I will again paraphrase Dr. David Spiegel of the US National Institute of Health. There are three primary pre-requisites to effective treatment of victims of abuse or other trauma. They are 1. Safety, 2. Safety, and 3. Safety. (4) The typical victim of childhood abuse, for example enters therapy five times before finally being able to stick with it. The usual course of treatment by best known methods for victims of childhood abuse takes several years. The reason for this is due in large part to the client's inability to trust adult authority figures since authority figures in the past were either perpetrators of abuse or didn't believe the client's story, or failed to act to protect child. In the issue of safety, severity of symptoms can give some indication of the patient's difficulty with trust, but this indicator cannot give any indication of the severity of the abuse itself. The two best indicators of how severe the symptoms are likely to be are :

1. The age at which the trauma occurs. The younger the age of the victim at the time of the trauma, the more likely she/he is to suffer dissociative symptoms. This makes sense when you consider that children more easily enter trance states than most adults, and the highly concentrated, narrowly focused state of attention that characterizes hypnotic trance is also characteristic of dissociated states.

2. The duration of abuse. The longer the period of time over which the abuse

occurred, the more ingrained the symptoms will tend to be.

So you can understand, with the conditions I have just mentioned, that clients suffering symptoms of abuse very much need a carefully protected safe environment and frequent reassurances of their safety.

Assessment of a client's symptoms,f course, continues throughout treatment. Current research indicates the best treatment for victims of trauma more than two years in the past is psychotherapy over an extended period of time. However, these victims also may need medication because they are much more vulnerable than others to chronic depression, anxiety states and sleep disturbances, all of which may be best treated with medication. Also, symptoms often get worse as defenses are breached.

I will follow dr. Spiegel's formulation of eight organizing concepts for treatment. He refers to these as the eight 'c's. (4)

1. Confront the trauma. It is still amazing to me how many clients come to me from some previous treatment in which the trauma was never discussed, or in some cases never discovered because the therapist just didn't ask. In some cases clients have told me that the failure of the therapist to ask about this area meant to them that the trauma must be unimportant. In a recent case a 16 year old girl was brought to me because of continued acting out in school, poor performance, and runaway behaviour. She had been in therapy for two years since the time her parents discovered she had been raped at the age of 12. It was a shock to hear that the previous therapist had not mentioned the rape, the initial trauma, since their very first session ! Failure to confront the trauma will invariably feed the client's sense of shame and belief there must be something disgusting about her/him. This part of treatment should be, substantially done in individual treatment as the client is likely to find group, especially one in which there is a lot of emitional expression and holding, too threatening. If traumatic information emerges in the context of group treatment, decision as to whether to continue the client in group treatment at that time should be made with the client based on the client's degree of attachment and integration into the group, and on the client's sense of safety in the group.

2. Find a condensation of the trauma. Don't wallow in detail. Once you and the client are satisfied that you have the essence of the traumatic history out in the open, use the client's condensation as a quick way of accessing the meaning and feeling of the trauma for the client in ongoing treatment. Abuse victims strongly tend to view the trauma as defining who they are. It is very important that the therapist walk a fine line between openness to the client's experience, and not exhibiting morbid or prurient interest in the abuse. After all, they come to us to assist them in defining that history in a new and more manageable way. One client talked about her childhood sexual abuse in detailed and graphic terms that seemed more connected with pornography than with people. She seemed detached from it even as she described these events that happened to her. I asked why she described her experience in this way, and she seemed surprised. She told me her previous therapists (more than one) had seemed pleased that the described events in this way. This client had her method of dissociation reinforced be these therapists. When I directed her to simply try to make her tone of voice, words and facial expression consistent with how she felt about the experience, the affective memory quickly began to emerge.

3. Give appropriate consolation. Again, this is an area in which the therapist must walk a fine line. It would feel inhuman me not to express sorrow and concern over traumatic events, or, once a good degree of trust is established, to reach out and touch a client's hand or

shoulder. Some therapists, perhaps those who use a rigidly analytic mode, would say this contaminates the client's process, or behaviourists might say it rewards the wrong emotional state or behaviour. But whether the details are entirely true or not, these clients have suffered and are suffering. Carefully place consolation is helpful, and it is on-going in individual and group therapy. I am not recommending full bonding as we know in the NIP in individual therapy. Full bonding is too charged, in my opinion, to be used with trauma victims in individual treatment. Bonding in individual treatment can and will reinforce the sense of secrecy that is so much a part of the trauma of childhood abuse and often other traumatic events as well. In our own self interest we should recognise that many clients diagnosed with "borderline personality disorder" suffered childhood physical and/or sexual abuse, and that clients with this diagnosis bring 80% of lawsuits against therapists.

4. Assist the client with confession. Victims of abuse or trauma experience shame and humiliation at being an object at the mercy of the elements, and especially at the mercy of a another person. Remember, the abuse or trauma has come to define the person to a significant degree if the client has sought therapy todeal with the symptoms, so you are now dealing with existence issues in the client's life. In virtually every Critical Incident stress Debriefing I have ever done, one or several of the participants voiced the belief that they should have known a disaster would strike, and should have done something to prevent it. The bank teller believes she should have known a robber was going to come in that afternoon and hold us the bank. The electric company lineman believes he should leave known the cable was going to break and snap back decapitating his co-worker. If you think about it, you will recognize this manner of magical thinking as being very like that a young child, and indeed the shock of traumatic events does strongly push its victims to more primitive thinking and behaviour patterns. Victims of various forms of post traumatic stress are trigged into this state unpredictably over and over.

Besides the traumatic events themselves over which victims had little or no control, people do not always look ahead thoughtfully, or respond heroically. Another teen aged client I saw was raped at age 12 by a 21 year old man. She was flattered by the attention of this older person, and despite knowing his bad reputation, she went against her parents' rules and let him into her house while her parents were away, and he raped her. Her shame and humiliation were such that she could not tell her parents, and for two years afterward her world fell apart. She was certain that if she told her parents, her father would feel compelled to beat or possibly kill the perpetrator, and she was right. Her father told me that if he had heard this directly from his daughter even two years after the rape, he probably would have done something violent which would have landed him in jail.

Because of the dramatic, emotionally charged nature of trauma, we as therapists are almost certainly going to have to deal with our own counter-transferance. As the father of two daughters, I could identify with the father I just mentioned, and I could see my daughters in the eyes of the girl. We must be especially careful not to fill in the blanks with our own emotional response to the client's story. We will have our own emotional response to he client's story and we must acknowledge this at times to the client. But we must not assume our responses are the same as the victim's.

This is a likely time (but not the only time) that the client's feelings about the abuser may be transferred to the therapist. Along with confession usually also comes the overwhelming sense of shame and humiliation and loss of

control associated with the trauma. The client assumes the therapist feels the same way about the client as the client feels about him/herself, and with the vulnerability of confession may well experience the therapist as re-inflicting the trauma. This phase too should be substantially explored in individual therapy, even though it will most definitely recur in group treatment.

5. Make detail conscious. This is not to be confused with the earlier admonition not to wallow in detail. The purpose here is to seek out detail which characterizes the client's strength, such as survival of ongoing abuse, taking on the abuse so others would be spared, resistance to the traumatic force or even the dissociated emotional space in which the person kept a little bit of her/his own identity alive. As in other areas the therapist must assist the client to find his\her own way in this area. This detail or set of details is to bring to consciousness something which will change the client's perception of him/herself as being defined by the trauma and there is always something. The trauma or abuse is something that happened to the client; it is not the client's identity. When an appropriate detail or set of details is found, it should be reinforced in individual and in group therapy. Often as this change takes root, other similarly transforming pieces will emerge.

6. Focus concentration on merging memory with the new perception. From my point of view this is where the balance begins to shift from using primarily individual treatment to using primarily group treatment for many clients. Dr. Spiegel repeatedly makes reference to the fact that traumatic history is most readily accessed through a mood congruent state. Indeed, it is this very fact which causes clients so much difficulty in their daily lives. Clients feel angry or hurt or scared or happy, or they hear these emotions expressed from others in a way that is consistent with a traumatic memory, and they are "back there" in the traumatic event. It does not matter if the circumstances are totally different than the traumatic scene. A look, a tone of voice or a feeling are enough to trigger the response. Now in the protected environment of the group with the proper protections and permissions and the support of others, the clients can finally experience these emotions and let go. This may be seen as a form of desensitization to the trauma using reciprocal inhibition.

   Dan Casriel was among the first to recognize that it is not necessary to dredge up every detail of history in order to heal. Emotional expression can do a great deal toward healing whole segments of emotionally related or mood congruent history.

   Part of the "protected environment" is the honest reaction of group members. As Dr. Spiegel says, "Even a dog can tell the difference between being trippled over and being kicked". (4) Just so in a therapy group the trauma survivor can begin to experience the difference between an honest expression of emotion others from himself or others as different from the abusive, manipulative or out of control experience of emotion related to the traumatic event.

   Gradually, too, the client can begin to trust his/her choice of others in sharing his expression of emotion so that it begins to translate into better choices outside of therapy. Providing a directed focus of concentration to help merge traumatic memory with the new perception of self allows the person to begin leaving the trauma behind.

7. Design your intervention to enhance a sense of control. Current research indicates some of the most effective treatment for rape victims is group therapy experience coupled with physical tasks which require the cooperation of group

members. The NIP use of peer oriented therapy with holding and other forms of support from the group has these elements. In this phase, little attention is focused on the traumatic events. When moving to help the client toward empowerment, remember that it is generally easier for the trauma victim to blame her/himself for the trauma than it is to acknowledge helplessness in the face of circumstances over which she/he had no control. After all, if the client was truly helpless in the traumatic situation, it could happen again couldn't it ? Again that delicate balance; the therapist must help the client place her/himself realistically in the world. The sentiments of Richard Beauvais, a member of one of Dan Casriel's group back in 1964 still expresses this well :

"We are here because there is no refuge, finally from ourselves. Until a man confronts himself in the eyes and hearts of his fellows, he is running. Until he suffers them to share his secret, he has no safety from it. Afraid to be know, he can neither himself nor any other—he will be alone. Where else but in our common grounds can we find such a mirror ? Here together, a man can at last appear clearly to himself, not as the giant of his dreams, nor the dwarf of his fears, but as a man—part of a whole with his share in its purpose. In this ground we can each take root and grow not alone any more as in death, but alive, a man among men. (7)

In this phase it is important to structure the emotional work and the bonding so that the client can move in and out of it without penalty. In other words, it is more important to enhance the client's sense of power and choice to approach the traumatic feeling state and to move back from it rather than to insist on "getting through it". The power of choice is essential for many in making any future steps toward healing.

8. The final step is in assisting the client to integrate her/his tragedy into a congruent sense of self. The consistent message here is that all memory can be healed. That is not to say that the memory will have no lasting effect. Much of trauma is such that persons' lives are in fact forever changed. Losses have occurred, and grieving must be done. But wounds legitimately healed bring a sense of pride and dignity.

These concepts are not discrete, but in many ways flow into one another in the process of therapy. Though I will finish my formal presentation

with that thought, the material presented here hardly touches the surface of what is to be known about trauma and abuse. In addition to the sources I mentioned during the course of my presentation, I have listed several others along with the bibliography. I encourage you to use these sources to formulate your own organizing concepts for treatment of this group of clients.

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A REPORT ON EXPERIENCES WITH THE NIP WHEN WORKING WITH ALEXITHYMOUS PSYCHOSOMATICS

Lecture at the ISNIP-conference '93 in Grönenbach
Lecturers : Jürgen Klingelhöfer and Manfred Dlouhy

Mr. Dlouhy and I would like to outline the experiences we have made during the last years concerning psychotherapy work with psychosomatic patients. It goes without saying that we pay particular attention here to the significance of the New Identity Process which, indeed, renders a valuable service as a fixed component of our therapies. We would like to describe the possibilities and borderlines of this method which was developed by Dan CASRIEL and introduced to stationary treatment by Walter LECHLER.

First experiences

In 1983 I took over the Mathildenbad clinic and together with my team at that time developed a conception for treating psychosomatic patients who were organically ill. My model strategy was a modern, experience-oriented psychotherapy integrating naturopathy and energetic medicine. To my view, modern psychotherapy meant: psychodrama, physical therapy, NIP and work with dreams.
During the first few years, NIP with main emphasis on matwork in pairs and subsequent adaptation work took place at least once a week for all patients.
The initial experiences with bonding were encouraging. As expected, patients with functional psychosomatic disturbances reacted well to the process. Even patients with mild classical psychosomatic illnesses such as asthma, hypertension and neurodermitis reacted promisingly. After emotional sessions, some asthmatics were completely free from spastic fits and breathlessness for quite a while and migraines improved astonishingly.

Setbacks and rereasoning

There were, however, warning signals: a few psychosomatics with physical illnesses reacted to the emotional work with a symptom deterioration or mini-psychoses and suicidal fantasies. Colitic patients increasingly started bleeding and in the case of neurodermitic patients, the condition of their skin deteriorated.
Our initial euphoria vanished. Uncertainty and consternation took its place when we finally heard that a female patient, whose process we had been content with, had died of status asthmaticus about 6 months after our treatment.
Something we were doing was fundamentally wrong - but what? Up until then, we had treated psychosomatics as people with solid neurotic strategies, character-wise, but who had developed physical illnesses as an outlet. We took reference from REICH and for psychosomatics, from ALEXANDER's (1977) and SCHULTZ-HENCKE's (1973) models. We frequently recognised the "typical compulsive intestinal illness" or the "oral stomach illness". However, working through the oral, rigid or other character subject matter not only produced but a minor relief but, on the contrary, a symptomatic and psychic deterioration.
Psychosomatics reacted differently to what I had come to know for example when applying the New Identity Process or the physical work according to Reich on addicts with a character neurosis. We decided to pay a closer look at the therapy process.

The psychosomatics had totally varied character structures but surprisingly, the atmosphere within the group was always determined by orality; adjusted, helpless, indigent behaviour towards the therapist, passiveness and mutual protection of the group members. The sessions made the therapists tired and worn out but they could hardly find access to their anger. The emotional solution, namely the oral theme about frustration, indigence, pain and anger was sometimes possible, but did not produce a satisfactory therapeutic solution as a rule.

We searched for explanations in psychosomatic literature and examined the clinical phenomenon of alexythymia more closely. Alexithymia had already been known for a long time, but its psychodynamics described in more detail by KUTTER (1980, 1981) in recent years. For some, alexithymia was characteristic for severe psychosomatoses (CREMERIUS, 1977) and others questioned its existence entirely (AHRENS, 1987).

Alexithymia
What is alexithymia?

This clinical syndrome is characterised by a lack of unconscious fantasies, the incapability of differentiating feelings sufficiently and extremely concrete and mechanical ways of thinking and perceiving. Its classification in psychoanalytical pathology has not been discussed thoroughly. Alexithymia is described as an independent personality disturbance with a defensive character (French school), but also as a characterological defensiveness against early archaic destructive impulses (KUTTER, 1980, 1981). KUTTER develops the image of a damaged ego, a narcissistic basic disturbance at an early oral phase which is well compensated by a perfectly self-trained social role behaviour (an outline was done about alexithymia by VON RAD (1983), to name an example).

In her book entitled "Solitude and self-estrangement"(1987) Karin ASPER describes this variant of narcissistic injury very vividly. It is characterised by silent depression together with internal helplessness and a feeling of emptiness, archaic unproportioned anger, excessive shame, a lack of biographical consciousness accompanied by a good superficial adjustment in functionalised relationships (pathological person maintenance according to JUNG). While dealing with this subject matter it became clear to us that in the case of numerous patients we had underestimated the depth of the narcissistic disturbance and real helplessness with regard to the differentiation of emotions. These patients had even socially adapted themselves to the emotional work, including the NIP work, leaving out several experience phases, however. Consequently, the price they had to pay was a symptom deterioration, a latent suicidal tendency and the danger of a psychosis. With our psychosomatic patients, we had reached a similar point as to CASRIEL in 1963: when writing about his synanon experiences, he stated that he knew several of his patients were strong enough to bear group attacks. However, it could have been possible that others hadn't had a sufficiently strong ego. He needed to find a way not only to give his patients support and love, but also a challenge. (CASRIEL 1972, page 62)

Psychosomatic conception

It was 6 years ago that we worked out a new plan with an altered therapy strategy. Since then our experiences have been very promising.
The guiding points we give our therapists are as follows:

1) Structured, procedure that reduces anxiety (see also BUCHBORN, 1984)
2) Gradual becoming familiar with the physical and fantasy experiences via structured physical perception, work with creative media and imaginative methods (this has, in the meantime, also been described as helpful by other authors, e.g. WILKE/LEUNER, 1990).
3) Work WITH the symptom: handling of the narcissistic illness (SENE, 1993) which means illness for the psychosomatic plus handling of the meaning of the symptom. This includes the problem of specific structure (SCHULTZ-HENCKE, 1973) and the problem of the specific conflict (ALEXANDER, 1977) alongside the individual build-up of the 'affected patient's myths concerning his illness.
4) Parallel to these methods, well communicated medical treatment, as far as possible by means of naturopathy (physiotherapy, homeopathy, acupuncture and various bioenergetic and biophysical methods).

In terms of the contact and binding behaviour of the patient, we respect, to begin with, the learned contacts within the scope of the social defensiveness but at the same time sensitise the patient's physical perception level and his concealed desire to be accepted as an indigent person, in order to lead progressively to a direct physical contact (by way of the hands and upper part of the body to begin with).
NIP work is an essential component part of the emotional cathartic work which follows subsequently with a build-up of new adequate binding patterns.
Permit me to give you an example of such a case:

CASE 1 - ELKE

Elke, a nursery-school teacher aged 26 years, has suffered from neurodermitis since puberty. As a child, she had asthma which disappeared when the neurodermitis arose. Her parents led a bad marriage and she described the atmosphere as tense and aggressive. She had never experienced security. Even at the beginning of her life, she made the experience in an incubator that for weeks on end her parents were unable to take her in their arms. During her childhood, it was always her sister that they had favoured and she had resigned herself to her fate and withdrawn herself internally.
She was unable to enjoy sexual contacts during her puberty since she had "only wanted to cuddle". Her current relationship to her partner, with whom she has been together for many years, has cooled down considerably, although she doesn't dare to put an end to it. She finds closeness and distance difficult to cope with. Elke has a moderately pronounced alexithymia syndrome with larvated depression.
Our hypothesis at the beginning of the therapy is as follows: perhaps as a result of the very early traumatisation and her constitutional weakness, Elke decided as a child, within the tense atmosphere of the primary family, to make a silent retreat, rather than to articulate her desire for love towards her parents, or to work off her sisterly rivalry openly. She developed asthma parallel to this. Later on, she was incapable of living mature sexual relationships owing to the fact that she was unable to live deeper desires for bonding and emotional satisfaction in relationships. Her skin then reacted with illness. The neurodermitis took the place of the asthma.

Psychotherapeutic procedure

(Manfred D. describes the medical naturopathic procedure subsequently)
As previously mentioned, during the first weeks Elke is warmed up by way of creative work, physical perception etc. for the purpose of perceiving her trapped feelings. In therapy groups, she first takes the role of a quiet observer. A few group members denote this as a refusal. Elke can feel that she is not only helpless, but also defiant. Also, she never wants to become "as hysterical as her mother". The therapist gives her an encouraging back signal for this self-information, but demands no other steps. During the time afterwards, Elke seems more awake and interested.
After approx. 5 weeks of therapy, we take Elke to a two-day marathon outside the clinic. It is a special marathon for psychosomatics. By means of a structured procedure in the first group sessions, matwork is to be prepared in pairs (bonding work).

During the first session, we encourage participants with the help of rods, ropes, balls, etc. to make contact with each other (compare GRAFF, 1989, for example). This work involves contact by way of a play medium. In the therapeutic process, psychosomatics soon regard these objects as "interim objects" (WINNICOTT, 1974) which they often didn't have as children.

Elke spontaneously grabs a rod. During a subsequent discussion she remembers that her mother had often beaten her with 8 stick. Anger and sorrow can be read in her face but cannot be disengaged. We regard this as a vital warming up for later bonding work. During the second session we first give a detailed verbal explanation of bonding work and NIP, then we organise perception exercises for dealing with closeness and distance.

Exercises

Try out various distances, standing with eyes closed and open, stretched out hands and finally with body contact. Always leave phases in-between to exchange the individual process steps. After this, perception exercises lying next to a partner, without contact at first and then various body contact stages.

After this session, the patients are free to enter the bonding group. Alternatively, we offer a group for the continuation of the perception exercises. All participants - including Elke - decide in favour of bonding.

Elke evidently makes every effort at the emotional work. She seems strained and tries out careful shouts and later on even louder ones. It sounds like fear and yearning in one.

Afterwards, she writes down that the "EMO"s (this is what we call our bonding groups) were both strenuous and devastating. She had experienced total ambivalence with closeness. She had remembered her mother, whose beatings and cuddles could interchange from one instant to another.

During the next 2 weeks, Elke seems extremely stirred internally. She decides to moan no longer and to let out her power instead "and to abandon rejective behaviour". She practises this visibly very gradually, not only in small groups, but also within the therapy community.

The next bonding group is 2 weeks after the marathon. This time, she gains deeper access to her fears of solitude and vulnerability. Anger is not yet relevant in the emotional work but all the more so as regards her behaviour in asserting herself with her therapist. The EMO gives her a better feeling as to "how much closeness I can bear and when I want to disassociate myself".

In the following weeks Elke seems more clear-headed and resolute. She wants to "get rid of her filthy side". We do not take this message up in the NIP, but instead agree with her upon a fasting

week during which she can perceive and work on the numerous nuances of physical and mental filth.

No other bonding work is done with Elke, since 10 weeks of therapy have now passed and the last stage is to serve for the integration of what has been experienced.

After 14 weeks of stationary treatment, Elke gives the impression of being distinctly more clear-headed, full of life and self-assured. She thinks "this is the first time ever that she has developed a feeling for her needs and boundaries" and "much better able to cope with life".

Comments

Throughout the 14 weeks of therapy, Elke only participated in the bonding work twice. This group work was carefully prepared and worked over step by step. In the perception of herself and in our estimation, the bonding work helped Elke to achieve a deeper emotional outlet. An emotionally founded cognitive reorientation did not occur as adjustment work directly after the matwork but, instead, distributed over other therapy groups and always grounded in concrete situations.

So much for this case of a patient with neurodermitis, asthma and psychosomatic alexithymia.

CASE 2 - HANNELORE

(Manfred D. describes the medical naturopathic procedure subsequently.)

Neurotic mechanisms are predominant in the case of people with functional body and conversion symptoms. The emotional process can be focused quickly. We frequently apply the New Identity Process here, but insist that any bonding work is worked through very carefully and that new decisions are grounded in concrete situations. We respect and work through the reactivation of the symptom in the therapeutic process as a necessary phase in the case of neurotic conversion symptoms and do not treat it as a behaviour relapse for example.

Permit me to give you an example of such a case: Hannelore, a 32 year old nurse, reports that she has permanent severe backache in the lumbar vertebral syndrome area, from which she has suffered since puberty. Again and again, she had been confined to her bed and was incapable of working for months. Symptoms of pain are particularly intense when she has friendships with men. Intensive sexuality is practically never possible because of the pains.
The point in time when the pains started during puberty is connected with the separation of Hannelore's parents which came as a sudden blow to her. She lost the childhood that appeared heavenly looking back, and clutched internally at her mother. Together with her mother, she demonized the father that she had by all means loved before. She relapsed into an infantile symbiosis with her mother and her sexual development remained at a childish oedipal level, whereby she denied and physically converted her genital sexual desires.
After a brief acclimatisation, we integrate Hannelore into the bonding work. She finds it hard to open herself emotionally. In her position as helper during the matwork she notices that she can easily give, but that she can no longer feel herself during this time. Once she starts the emotional work, she experiences unconsciousness and the feeling of being left at mercy coupled with mental pain.
During the next few days the backache increases again. While participating in the imaginative work about experiencing her body, her back gives the impression of being an armour and protection shield. Alongside pain, she now begins to feel anger which she first experiences as anger against dependence (on her mother) and then as identity anger.
After this emotional work, she is still agonised by severe pains in the back. We stop the EMO work in order to work thoroughly on freeing Hannelore from the symbiosis and to fortify new decisions.

In a physical therapy group, by working on the lower area of the back and pelvis Hannelore touches on the subject of sexual desire and the fear of it. "I can't develop into a woman, otherwise I could become a rival for my mother." With the help of the NIP she can oppose this prohibition with permission. Her backache decreases significantly but does not disappear completely. During symptom-oriented work Hannelore realises the complexity of the different desires and aspirations connected with her back troubles, e.g. the prohibition to develop herself as a woman together with "her fight to be accepted as a woman by her father" and "her eternal desire to remain a child" etc.
Hannelore has learned a lot during the therapy. Before leaving the clinic her back pains increase once more. However, instead of feeling left at their mercy, she has now found a way out of the symptom. Summing up, she says it was a fascinating, dreadful, painful, salvaging and happy time. She was grateful for every hour, for every day.

Comments

It will certainly take years for Hannelore to develop into a mature independent woman. The well-aimed application of the NIP gave her vital impulses. Emotions and needs are connected in a very complex manner with the long-lasting physical symptom i.e. chronic backache, and can only be activated step by step. Hence, Hannelore was not relieved of her pains after intensive emotional work. According to our experiences, dealing with this physical symptom requires a methodical, multitracked procedure with differentiation and deceleration of the emotional self-perception and emotional expression, acceptance of the symptom and an accompanying physiotherapy treatment.

I hope these two examples have illustrated the importance and integration of the New Identity Process in the stationary treatment of psychosomatics.

Now to the two example cases from the naturopathic point of view, by Manfred Dlouhy:
CASE 1 - ELKE

As you already heard from Jurgen K., Elke had asthma as a child, lost it during puberty and promptly developed neurodermitis. From the naturopathic point of view, this development of symptoms is regarded as a positive development since the illness came from an internal organ to the surface (i.e. to the skin).
When she came to our clinic, she suffered from chronic sinusitis which, in our opinion, is always a sign of a chronic intestinal disturbance. We treated the sinusitis with salt water rinses, snuffing symbioflor I drops and red light radiation in order, if

possible, to turn the chronic condition into an acute one again. Naturopathically, most chronic processes can only be ultimately healed by returning to the acute state.

Elke came to us on the recommendation of her group therapist after several weeks of suffering from itchy palates and swollen lips after eating apples. We were asked to carry out an allergy test. We did so by means of electric acupuncture tests. The results of these tests not only indicated that she was allergic to apples, but also to lemons, meat, milk, eggs and hazelnuts. Elke confirmed these foodstuffs frequently didn't agree with her, whereby the reaction was either diarrhoea, itchy eyes and palates and also a deterioration of her neurodermitis. We further tested the intestine for candida infestation which is often found as background promoter in the case of neurodermitic patients but also in the case of other skin illnesses. In Elke's case the test results were relatively clear, which led us to suppose that there was either a candida infestation of the intestine or at least toxic leftovers in the intestine. Our initial step was to put Elke on a diet, omitting all the above mentioned foodstuffs. This therapy ameliorated the allergic reactions. However, prior to our wanting to start treatment on the intestinal fungus, Elke had reached a point in her psychotherapy process at which it was recommendable to fast as the next step. During the one week of fasting with two enemas per day, herbal teas as well as kidney and liver teas, the patient started increasingly to discharge acids (we measure the urine pH value several times a day and in Elke's case the value fluctuated between 4 and sometimes 5). This excessive acidity, corresponding parallel to this to a chronic psychic state of being sour or cross, showed motion during the fasting cure. The first aggressive encounters with the therapists were promptly noticed. After the week of fasting we came to the arrangement with the patient that at home she should undergo another allergy treatment and strengthen her immune system with proper blood injections and possibly after repeated tests a further candida treatment.
In the symptom group we gained the following knowledge: asthma corresponds to internal crying. Elke remembered that she never become as hysterical as her mother. As regards neurodermitis, i.e. leprosy,i.e., Elke confessed that she "never wanted to let out her filthy sides". The allergy, i.e. immunity disturbance, i.e. aggression disturbance, meant that she scratched her own self and not others.
So much for the first example.

CASE 2 - HANNELORE

As mentioned, Hannelore has been suffering from backache since her puberty. At the same time, she notices a displacement of general lust to an eating lust. She has known her lust for eating ever since 1988, i.e. from the age of 27. Her weight is regulated by the persistent diarrhoea. In 1990, at the age of 29, after a horse-riding accident she loses 7 front teeth and fractures a jaw. Furthermore, she has a large scar slanting over her left lower lip and downwards. In 1991, she undergoes operation on her right side due to varicose veins. This indicates a congested or possibly poisoned liver. From August 1992 to January 1993, the patient spends most of the time in bed due to severe backache. Naturopathically, this case appears to be very interesting since all these symptoms can be allocated to a function circle, i.e. meridian pair, from the point of view of acupuncture. The function circle, kidney/bladder includes the basic feeling of fear which, indeed, the patient-knows only too well, both psychically and physically (diarrhoea). Furthermore, she often has cold hands and feet. she has a scar and injuries in the incisor tooth area which pertains to the kidney/bladder meridian and the main symptom in her back is situated directly below the bladder meridian line. Logically, we began the therapy with neural therapy on the scar on the lower lip and acupuncture on the bladder meridian. Hannelore also underwent physiotherapy and autogenic training. We treated her cold feet daily with two increasingly footbaths, whereby we only increased the warmth on the left leg since only accompanying treatment via the consensual effect was desired on the right hand side due to the varicose vein operation. Owing to the strong-smelling stool, the patient received a teaspoon of healing earth three times a day in order to relieve the intestines and the liver consequently. The patient reacted so well to this therapy that her backache improved during the therapy to such an extent that she could participate in all therapies.
In the symptom group her most

important statement or perception was, "I can't stand the pressure. I simply can't go through it and so I must go to bed to escape the pressure of the ambivalencies". A further aspect she perceived was, "I mustn't give vent to my feelings, because if I do I'11 explode or I'll be too much for the others".

New adjustments with psychosomatics As Jurgen K. already explained, patients with "alexithymia" struck us in the NIP as well-behaved, adjusted and very painstaking. Throughout the therapy, the physical symptom often got lost and it was only in the closing discussion that it was mentioned again: Therapy went well - only my intestinal haemorrhage has unfortunately not improved. One of our solutions was to introduce a symptom group. It was I who organized and led the group during the first two years. It takes place 1 1/2 hours a week for both psychosomati groups respectively. To begin with, the first half of the symptom group was used for a symptom round where each patient briefly described the present state of his symptoms and received naturopathic advice and therapy instructions. In the second half, symptom work was carried out in which the patients tried to work at the symbolism of their symptom and their attitude towards the symptom and body. This symptom work is related to adjustment groups, only a little milder and only cut out for psychosomatics. Today, the two halves have been turned into two separate groups: the symptom group takes place 1 1/2 hours per week and the naturopathic group 45 minutes per week.
Allow me to say a few things about the adjustment work with alexithymous patients: it is our theory that in the case of neurotics, emotion develops from stimuli in the body which can be vented again via affects. Alexithymous patients know no name nor pattern for the emotional state and keep the emotion fixed within their body (one dominant feature of a psychosomatic is his high control and functionality). Therefore a physical symptom = nameless emotion.

For example, instead of

" I am angry" = "I have a migraine" or "I am allergic"
"I am afraid" = "My heart is racing, I can hardly breathe or I have sciatica"
"I am sad" = "I have astma, acold or cytistis
"I need you" = "I have gas-tricular etc.

Hence, it is vital to name the emotional state again, i.e. in a situation involving anger, the therapist should emphatically convey to the patient, who first reacted with headache, that he (the therapist) would have been angry in this situation (thus naming the emotional state), therefore helping the patient gradually to show his anger. At the same time, the patient learns a lot by copying, imitating and practising until he succeeds in naming and expressing his emotions.
This is often a longer way with extremely gradual steps, whereby naturopathy can render us good services as a revealing and attractive method in supporting the psychotherapy.

Particulars about Jurgen Klingelhofer:

I am a psychiatrist and neurologist with Jung training analysis and education in catahymous image experience and psychodrama. I have gathered thorough knowledge about the stationary psychotherapy according to the Herrenalb model as Doctor-in-Chief under Konni STAUSS ever since the build-up of the clinic in Grönenbach in 1980. I learned the New Identity Process from Dan CASRIEL and Walter LECHLER and, above all, its practical application from Konni STAUSS. I, myself, gave regular training sessions and made an extensive individual primary therapy experience in order to deepen my knowledge. My main psychotherapeutic field: psychodrama (Instructor and Supervisor).

Particulars about Manfred Dlouhy:

I have been working at the clinic in Grönenbach for 7 years. I am a masseur, medical bath superintendent, doctor and entitled to instruct treatment with natural remedies. Prior to becoming familiar with the NIP according to CASRIEL, I experienced two intensive three-week phases of primary therapy in Munich, but I underwent actual training through Konni STAUSS (I regularly supervised the EMO as Group Therapist in House I for over 2 1/2 years). Further experiences were gathered by way of a hospitation with Walter LECHLER in Herrenalb and training workshops with George RYNIK and Jeff GORDON. I was able to experience the curative influence of bonding and adjustment work in the cases of numerous patients.

THE EXPERIENCED WORLD OF BONDING AND THE NARRATED WORLD OF ATTACHMENT THEORY

Lecture at the ISNIP-conference '93 in Grönenbach
Lecturer: Dr. Michel Oppl, Psychosomatische Klinik, Bad Herrenalb.

My contribution has no lesser goal than to bring together theory and practical experience, to arrange a marriage between the attachment research and the practical work with the NIP, or at least to announce their engagement.
First I will present some of the results of the attachment research, and later I'll explain the advantages of their liaison with the NIP.
As far as I can see the NIP has many similar, subjective experiences at its disposal, acquired in private practices, empirical individual data, which compared to the results of ethological investigations of attachment research belongs to the very same level.
We can easily come to an understanding about similar experiences or observations relevant to bonding or attachment and find common definitions, but as any other theoretical construct their explanations and conclusions need to stand up to critical scientific disputes.

In Germany the Casriel Therapy plays more a secondary role, if it isn't actually excluded in an autistic way. It exists without any considerable important professional exchange to neighbouring disciplines, without scientific communications, the Casriel Therapy could be called scientifically excommunicated. The Casriel therapy shares its autistic fate with the attachment theory in as much, as Freud early set the course of psychoanalytical development in a direction, where the primary need for attachment stayed mostly unrecognised.
Freud regarded all feelings of love - and love is another word for attachment - as sex drive, and therefore the primary, non-sexual need for attachment stayed unobserved.

Physical closeness in general is a taboo within the psychoanalytical setting. Some time ago, the "Spiegel" magazine published its editorial about the topic: "Therapy and sex, abuse on the couch", to which Johannes Cremerius gave an interview, ending with the words which sounded like a threat: "It's important that clients know first of all: psychotherapy is a method consisting of words.

As a principal there is no physical contact. This is primacy, low, John Bowlby imported the attachment from ethology into psychoanalysis. The prize he paid for it: he separated from his analyst, supervisor and mentor Melanie Klein, who as he reported had forbidden him to see or treat the mothers of his young clients, strictly according to psychoanalytical theory she regarded the behavioural disturbances of the children as purely inner psychic processes. The object relations she was talking about were entirely internal relationships - they are fantasy. The notion that internal relationships reflect external relationships was totally missing from her thinking. The mother was regarded as a disturbing factor in the psychoanalytical cure, and to talk to her was regarded as acting out and therefore forbidden.

Bowlby separated from Melanie Klein and dared to be interested in real external relationships. He developed his attachment theory, that was ignored for a long time, because he tried to prove that real experiences had an important influence on child development. He knew the work of the ethologists Konrad Lorenz and Nico Tinbergen, and living in London the phylogenetic work of Charles Darwin.

He knew some of the results of ethological research, for instance, that a new born duckling attaches itself instinctively to the first moving object it sees, and follows it. These results inspired him, and he concluded, that human beings too must have such bonding behaviours, and be pre-deposed towards sane relational experiences.

Bowlby assumed, that for all social species - including the human species - protection against something unknown, foreign or new is found in the proximity to a member of the same species.

Inspired by the fundamental work of René Spitz about the hospitalise-syndrome, showing that infants raised in foundling homes with sufficient feeding and caretaking but without handling or loving attention withered away and often died, Henry Harlow devises an experiment with rhesus-monkeys: he raises infant monkeys with two surrogate "mothers" - one made of bale-wire mesh equipped with a feeding nipple, the other covered with terry cloth. The astonishing result was, that the infant monkey clearly preferred the terry-cloth-mother, running to it when frightened, and using it as a base for explorations - not the mother with the feeding nipple. According to psychoanalytical theory the feeding "mother" was expected to be preferred, because all mammals were postulated to go through an oral phase after birth.

Obviously the attachment to the mother does not develop orally, the infant-mother-connection is not a function of feeding, the love for the mother is not an answer to her satisfying the infant's hunger, but the sensual availability seems to be more important, at least for rhesus monkeys.

In a different research situation Harry Harlow provoked fear in the infant monkey, letting a war toy, an army jeep, drive noisily directly towards the animal. As a second peculiarity the infant monkey moved towards the frightening stimulus, jumped over the toy jeep and found safety clinging to the terry-cloth-mother. Through the arrangement of the experiment the infant monkey could only reach the surrogate mother by moving towards over the frightening stimulus, and therefore it became obvious, that escaping from the frightening stimulus is secondary, compared to the movement towards the terry-cloth-mother. Flight alone does not provide sufficient protection. The classical social-learning theory teaches, that a child runs away from a threatening stimulus. The attachment theory however shows, that a frightened child actively looks for the person to whom it relates, to find safety in its proximity.

Up to now quite a few attachment behaviours have been described like clinging, crying, screaming, following and protesting if left alone, which are deve-loped within the first year, independent from the quality of the car or culture worldwide, and with which the child attaches itself to his mother (or other caretaker). How far the attachment behaviour between children and parents are biologically based, and how far the behaviour of the rhesus monkeys can be applied to human behaviour cannot be answered by ethologists alone. They need support from evolutionary biologists as for instance Charles Darwin.

Only this will prevent false interpretations when human and animal behaviours are compared, as happens for instance when animal behaviour is humanised,

for instance, when we label the fox with the human characteristic smart and create a myth through analogy. On the other hand human behaviour functions through evolution, like the attachment behaviour can be deducted from zoo-ology, without violating human beings by zoo-morphising them as naked monkeys.

Those protection oriented behaviour patterns, though biologically anchored, cannot be regarded as intuitive behaviour. This supports the idea, that a sense of community can only develop in a social human context, where the members of this group know each other.
For this more than an instinctive behaviour repertoire is necessary, an expectation system has to be built up, an inner-working-model, which is learnt at an infant age, and trained in social preferable exchange.
Here the enormous meaning and quality of the earliest communication becomes obvious - facial expression, body language, emotional expression.

In the company of the mother the child learns what it needs to survive and to find his role in his society. Not the behaviour programs themselves, but the capacity to program and develop internal maps of the world is passed on.
Phylogenetically the infant owns the "internationally" comprehensible communicative capacities like crying, screaming, clinging etc. , which provide the fundament for a social-emotional relationship, and give the infant the inborn and acquired capacity, to create a connection to his caretaker. This behaviour is only activated when the child feels insecure. The secure child plays and explores the world around it. Attachment and exploration behaviours are inseparable linked. When a child needs help and support, because it feels bad, is hungry, tired or ill, it clings to his mother in the background if necessary, then it goes out for adventures and explores his world.
The first 6 months are relatively general, which means less specifically designed for a certain attachment person, more operating with instinctive behaviour; only then the relationship starts to become more individual. A genetically based instinctual behaviour alone could not provide the adaptation work of the individual, constitutional differences as we see them between child and child or mother and mother.
The adaptation capacity, the learning capacity of the infant is limited to 3 people mostly, and when asked too much it reacts distressed towards strangers.
Ethologists like the Grossmanns described for 1 or 1 1/2 year old children typical distinguishable attachment patterns, which means acquired attachment patterns, which reflect characteristic interactions serving the attachment between mothers and their children. Hereby the children take active initiative, they are not only passive - recipient, as postulated from the perspective of the psychoanalytical oral phase. Because attachment behaviour is a potential, latent, evocable behaviour, it needs to be provoked and activated.

Mary Ainsworth very early developed the idea, that children experience safety through the proximity of their parents, and that they need this secure base, to develop curiosity about the world. In later years her idea was confirmed through field studies in Uganda. The infants in Uganda were used to always having their mother close by, and if ever the mother started to leave the room without them, they instantaneously stopped playing and started screaming, doing everything they could to provoke her to come back. It could directly be observed, that for those children their parents are their secure base.
The children of the western civilised hemisphere were used to having their mothers come and go frequently, so it was more difficult to find out, whether the parents represent the same secure base for those children.

If there is no attachment behaviour, we cannot say anything about the quality of the attachment, as long as we cannot estimate how the child feels. Attachment behaviour helps to recreate security. A successful mother-child-interaction has protective and compensatory effects. Those protection factors are activated only, when the child has to face certain risks, so the children have to be made uncertain, in order to be able to see attachment behaviour.
Starting with those considerations, M. Ainsworth created an experimental structure that she called the strange situation. It mobilises the need for attachment, and the resulting attachment behaviour can be observed and documented under laboratory conditions. In 8 clearly

defined steps the child is exposed to separation, and to contact with a stranger. First the child is with his mother for 3 minutes, then in a 3-minute-rhythm it is with his mother and a stranger, then left all alone, then the previously seen stranger returns to the child, and after that the mother returns.

Mary Ainsworths strange situation provide a practical research instrument, and led to an increasing interest of researchers in mother-child relationship patterns. For more than twenty years it helped attachment researchers to provide an abundance of observations and examinations results.

Now I want to summarise those publications of the researching couple Karin and Klaus Grossman from Regensburg University, which seem to be important for Casriel Therapy as well. It might not seem very original to give a talk about the results of the Grossmann research, but it might be novel to present this material to Casriel therapists.
The scientific work of the Grossmanns is based on M. Ainsworth's research results and J. Bowlbys assumption, that the early attachment experiences form the basis of personality development. I want to emphasise, that we talk about the basis, not the cause of personality development.

The Grossmanns distinguish 3 or recently 4 types of behaviour strategies, and lead to consequences in the emotional development of the child. A child changes his attachment behaviour dependent on his attachment person in two different ways:
1. When for instance, the mother often conscious or unconsciously rejects the child, even though it shows attachment behaviour, for instance, cries, calls, clings to her, protests when she leaves or follows.
The rejected child very early learns to hold back his feelings with the initial, childlike naivety to his attachment person. The child seems outwardly untouched, emotionally inexpressive, at the cost of a feeling of alienation.
2. When the mother reacts unpredictably upon the attachment behaviour, being more focused on her own needs, for instance to cuddle the baby because she feels like it, even though the baby plays with concentration, or she regards the screaming of the child as being personally aimed at her. So the initial state of the mother, not the initial state of the child, determines whether she reacts to the attachment behaviour, preventing synchronicity in the reciprocal behaviour of the mother-child-dyad. To learn the proverbial emotional language is made more difficult that way, because the child can't reach his mother reliably and constantly with his emotional language. Her approachability is oriented to personal and egoistic motifs, not to the child needs. If the child needs and the satisfaction of those needs by the mother would come together, it would happen by chance, and not as a result of a successful dialogue between mother and child. Needs and the satisfaction of needs then seem to be incoherent units.

At this point similarities to Casriel typology of the acceptor and the rejecter come to mind. Casriels image, that the child builds an inner castle for protection, which becomes a prison for the grown-up, is an adequate metaphor for the rejected child as the Grossmanns describe it.
Feelings and emotions have an evaluative function, helping to select valuable and meaningful events. To the extent that the ascription of meaning is no longer transparent for fellow humans, the other person becomes alien, because we can no longer assess what he likes and appreciates.

The first type, the so-called insecure avoiding child:
The autistic child shows an intensification or so-called insecure avoiding behaviour that beats everything, rigorously rejecting care, building no emotional bonds, avoiding eye contact and refusing to speak.

The second type, the so-called insecure ambivalent child:
The child exposed to unpredictability becomes dependent on his mother, pushed towards passivity by learning, that the reasons for his mothers coming closer, are not his activities like screaming or crying. This child has no good reason for activity, because the mother acts independent of his attachment behaviour, taking care of the child or leaving it alone. The child experiences no difference, whether his behaviour is active of passive. Such a child is always put on the alert, because it never knows, when his security base is in reach or not, and because it can't take any influence with his attachment behaviour onto the desired result. Out of fear of losing his caregiver, his attachment system is constantly

activated, and it lives in constant distress.

The third type, the securely attached child:
As long as children receive comfort, care, protection, support and help as soon as they ask for it, and on the other hand have permission to curiously go exploring or out for adventures without hindrance, they easily develop an attachment system. To feel secure about their mother helps them to move away from her.
The child develops trusts in his attachment person, and approaches her instantaneously and directly, as soon as a secure harbour is needed. It feels secure in proximity as well as on exploring. Loving connectedness and devotion lead to the securely attached children.
Alienation (via rejection of the mother) leads to insecure avoiding children, and dependence (via unpredictability of the mothers reaction) lead to insecure ambivalent children.

Those 3 prototypes of parent-child-attachment have been found by researching families chosen by chance, which means normal families without clinical evidence for pathology.
Those who work with young or grown-up children ought to know, that children - similar to ducklings who follow the first moving subject, even Konrad Lorenz, after they hatched out - always attach themselves, following their biologically based attachment system, that children bring along with them from the time of birth. That means, that they attach themselves also to parents, who do not take care of them really well, do not offer them a secure base, or slow down their exploration drive. The attachment program runs for good or bad, even if those attachments become unhappy ones. And evidently the children react in the same way to the separation of unhappy attachments - which is distressed. As a consequence we do not bring relief to children that are treated badly or suffer abuse by their parents, by separating the children from their parents, but threaten them fundamentally.

The formerly mentioned American psychologist M. Ainswoth developed the concept of sensitivity as a way to describe the material behaviours that can be observed. M. Ainsworth says about herself: "I felt quite insecure as a child, and I believe, I never really got over it". She comments her self-doubt with such self-reflection, that I asked myself, whether the preoccupation with the issue "sensibility of the mother" is similarly autobiographic for me.
The following seems to support my assumption: Up to now I have discussed this concept twice more in detail. Each time I easily managed to present the issue in a way, that listening mothers - including my wife - became angry and protested. The more I talked about sensibility, the less of it could be found in the argument right here and now. The levels of contents and process were anything else but congruent. In any case there are two people, starting with M. Ainsworth and me, for whom the preoccupation with this issue included the dimension of self-experience as well.

It took M. Ainsworth more than 10 years to develop the concept and the examination methods of sensitivity, even though there is enough proof that she was anything else but lazy. Like other important discoveries, once that they are found, they seem to be evident, the concept of sensitivity nearly seems simple.
I want to present this sensitivity by using the example of visual contact, because it also has a function for the attachment.

Most of you know the eye-bonding and understand that "looking at hand - looking away" are relevant for attachment. If the mother's and the child's looking at and looking away is in their connection shown in a graph, there has been found synchronicity in the eye-contact between mother and child for all sensitive mothers.
In this context Daniel Stern talks about eye dialogue. The more sensitive the mother is, the more active the infant takes control over the beginning, the length and depth of the eye contact. Concerning eye contact, mother and child are equally competent in its social exchange. On this level, the infant becomes an equal partner in the relationship for the first time, with a balance of giving and taking.
The fine tuning, the way how mother and child are tuned in to each other, the parallel exchange of looking at and looking away from the other between mother and child, the synchronicity of the social eye-contact, the mutual interplay how eyes meet and separate again, is disturbed if for instance. The mother constantly looks at the child to stimulate it. Then it happens, that she over

stimulates and the child refuses to look at her, or in the case of extreme over stimulation shows the so-called overstep-reaction, like yawning or scratching.

Sensitivity is a measure for receptivity, showing the degree of fine tuning in the communication between mother and child. In 90% of the cases the phase interval lies within a limit of 2 seconds, so that the infants memory range, which last about 3 seconds, is not exceeded. That way the infant is able to see a connection between his emotional state and the mothers reaction. The faster the response to the crying, for instance. by answering "I'll be right there", the more the growing child develops a feeling of capability, grounding on the knowledge that "I am able to get my mother if I need her". Here sensitivity and capability are intertwined in a systemic sense. To create optimal conditions for attachment has nothing to do with spoiling, but it is a fundamental prerequisite for the psychic health of an infant. The harmony between need and satisfaction of the need leads to an early independence chosen by the children. On the other hand the more children are pressed by their caretakers to be independent, for instance, to play happily without their mothers, the more insecure they become and the less they feel like daring autonomy.
Sensitivity shows in many small details or things we take as a matter of course. Sensitive mothers greet their babies more frequently. They lovingly take them in their arms more frequently, they have a lower threshold for infantile signals, they promptly act upon crying, but don't disturb as long as the children play alone.
This means, sensitive mothers also hold back and don't act, as long as the child feels good. So sensitivity is the capability to perceive the chills signals, to interpret and understand them correctly, and to react adequately. Observation about the quality of the mother-child-attachment in the first years show a large variety in maternal sensitivity, which means in an adequate response to the children needs and curiosity. The following consequences and developments became apparent.
One group of mothers reacted impatiently when the children cried, or feeling angry they signalled, that crying or other forms of attachment behaviour were not welcome, or they reacted brief and casual to the expressed wish for closeness and affection, and they put the children down with gentle vigour inspire of their clinging and against their will. At the end of one year those children showed an avoid anti-behaviour pattern, they refused closeness and cuddling, they fought against tenderness and were the opposite of clinging. As long as those children took care of themselves or played without calling, the mothers rewarded this behaviour with friendliness. The children adapted themselves to the situation and gained the mothers affection, by showing less and less attachment behaviour like crying or calling, which might provoke the mothers rejection.
It is a high risk for a child to show his weaknesses and needs, as long as it has to fear rejection right in the moment of greatest vulnerability. Even as grown-ups we only ask for help as long as we feel safe, that this weakness or need for help will not be taken advantage of, and we avoid situations in which we feel emotionally dependent upon others.
Rejected children sometimes show aggressive behaviour, accurately avoiding to direct this towards any particular person, especially not towards the mother.

Another group of mothers confused their children and acted unpredictably, their behaviour was more oriented to their own moods. Not being guided by the infants needs, their behaviour unpredictably changed between loving and rejecting, so the world of the child's needs stayed separated from the world of the mothers satisfaction of needs. Both worlds did not come together, at least not in a predictable way. No matter what those children did, nothing of their doing had to do with the mothers actions. The infant adapted their behaviour by and by to this unpredictable mother, by showing maximal strong and highly dramatic attachment behaviour, according to the matter, "all or none", thus keeping a minor chance in their insecure situation of unpredictability, to get purposeful attention from their mothers. They never looked away from their mothers, as soon as they could freely move.
In some cases the mother showed sensitive and loving behaviour only then, when the infant was severely ill. The infants were constantly busy to keep their caretaker, their safety base as good as possible within reach, their attachment behaviour was

constantly activated and absorbed their attention, so that there wasn't much time and energy left for play and excursions.

The securely attached infants, who had dependable mothers, allowed their mothers to leave as long as they played and it could be proved that they were concentrated and in a good state. When they got insoluble problems, they turned towards their mothers, protested when she left, complained openly and showed their grief when the mother returned, calmed down fast in the safety of her lap, her arms, or her proximity. As soon as they felt safe again and the attachment behaviour had fulfilled its function, they started again to explore. After wards they didn't show any mistrust and came to terms with the next separation without negative consequences. It could be seen that those mothers liked to respond to the needs of their infants, and that if necessary they found compromises according to the infants needs. They could let the children play alone, intervened only when insoluble problems came up, and only as long as the child needed to be able to come to terms without her.

Different types of play:

The insecure avoidiant children of the 2. group, who experienced rejection and refusal when they showed attachment behaviour, went on playing externally calm, and didn't show any obvious emotion, when they had to face separations. When the mother returned, they hardly took notice of her, didn't greets her or smile at her, didn't show any form of recognition, and seemed brave and composed. But their play was characterised by lack of interest, and the toy they occupied themselves with, was optional and exchangeable, they didn't play purposefully with a toy, but only because it lay within reach. And the experienced ethologist could read from their faces and movements, that the children didn't really feel well.

Physiological parameters verify the ethological observations, that the way securely attached children play differs crucially from the way insecure avoidiant children play. The measurements of heartbeat and cortical blood level prove, that the insecure avoidiant children are distressed. The separation situation touches those children much more as is outwardly visible on first sight. Since Pawlow we know, that concentrated occupation lowers the rate of the heartbeat, but the frequency of heartbeat of the avoidiant children rises significantly when they play. This proves physiologically, that they only do as if they play and they are not really involved! The expression of their grief towards their mother was proportionally reversed to the amount of grief through separation.

The more they suffered, the less they showed that to their mother. They turned away and avoided contact. As long as the children played nicely and didn't demand anything of their caretaker, the mothers seemed contented. As long as the children were nervous and needy, the mother ignored them and withdrew.

In the course of the observations mother and child became more and more alienated. This helps the child to avoid pain, because more contact to the mother would create more pain.

The insecure ambivalent children, the children who didn't have a chance to experience their mother as a safety base, because she never was predictably reachable, seemed increasingly anxious and helpless within one year. They were clinging to their mothers, they got into a panic if a strange person instead of the mother was present, and separation made them deeply uncertain. With deep desperation they broke into unbridled rage, and uncontrollable weeping and nothing could calm them down when their mothers undividedly gave them their attention, which again made their mothers desperate.

They sacrificed most of their exploratory behaviour to the constant attempt to keep the mothers proximity.

Those children, who had been examined here at the age of one year, are now 16 years old. Follow-up studies provided more interesting results about the course and the further development of those children The Grossmanns found out, that those 3 described attachment qualities: - securely attached, insecure avoidiant and insecure ambivalent - stayed stable for about 90% of the children at a check up 6 years later, the aspects of security, avoidance and ambivalence could be proved with certainty after 6 years.

Secure or insecure attachment behaviour to the primary caretaker also characterised the arrangement of relationships in Kindergarten to the other children and the nursery-school teacher,

as a mirror and expression of the forming self-image and feeling of self worth. Insecure children have less trust in others, expect less that others could be willing to help them, and regard rejection as the normal case according to their understanding of themselves. The strength of the securely attached children lies in their ability to express painful feelings, not having to suppress them, and also to have memories available about painful situations, so that with their assistance they can find the help, comfort and support of familiar persons. They have a high level of social competence at their disposal, which gives them a feeling of self worth.
The goal of a successful mother-child-relationship does not lie in an egoistically, emotional independence, but is found in the dependability of good connections to familiar persons in times of trouble, crisis, disease and emotional distress.

The identification and characterisation of the 3 prototypes is relatively easy, the determining method can be learned, its quote of success lies over 90%.

The more important questions for those working in the clinical field are not yet answered, whether those attachment patterns can be influenced, changed or treated. Only clinical studies can provide those answers.
In America, where many people go for psychotherapy and many different forms of therapy are applied, it has recently been proved, that clearly not all of them had changing effects on the attachment pattern.

A liaison of attachment research with observation data from the practical Casriel-work could first of all shed more light upon the above question. Second the described prototypes of attachment relevant behaviour patterns offer a raster of terms that could find consensus, and which is fundamental for scientific formulation of a question. Therefore they give a scientifically based frame of orientation, which ingeniously subdivide the complex NIP-corpse, reduce optional terminology and still leave enough space for psychoanalytical, systemic or other theoretical explanations.

The presented attachment theory is compatible with Casriel theoretical and practical outline, within this frame they need not give up their identity, nor give away degrees of freedom for further developments.
The terminology of the attachment theory is much better adapted to the practical work of a Casriel therapist, than the psycho pathological terminology, which comes from narcissistic, drive- and object-theoretical or ego psychological constructs, or a medical nosological terminology, which is even further away from attachment relevant topics.

Finally I want to express my opinion to the methods and goals of therapy, as Bowlby worded them.
If we look through the most recent publications in the field of psychotherapy, psychosomatic and psychiatry, we can see that more an more subjects like children development, attachment dynamics in the family, the relationship between physiological parameters and emetic net support to research meaning and determination of the early mother child bond, results of infant research with regard to their psycho analytical, clinical importance, etc. are taken up. The general interact in attachment topics increases, but at the same time there are no statements or references to how a solution oriented practical treatment could look like or can be achieved.

Bowlby defined the attachment quality, learned in childhood and internalised later Secure, avoidiant, ambivalent) as an inner working model or an inner cognitive map, and he demanded, with regard to the espy, the reconstruction of a positive self image, and of the attachment persons.
Through our daily work we empirically know, that the Casriel process provides good results for this.
You are welcome to also regard my talk as an appeal to evaluate the Casriel Therapy, and to prove its efficiency with scientific means.

My report ends here, but the actual work is only starting.

PRE-OEDIPAL DISORDERS AND BONDING

Lecture at the ISNIP-conference '93 in Grönenbach
Lecturer: Dr. Bernd Sprenger

Introduction

We were of the opinion that the organisation of the workshop for which we have all gathered here today should be as practice-oriented as possible. Accordingly, we will be working directly with a group of patients tomorrow and the day after tomorrow there will be an opportunity to join in order to discuss own cases.

Today, I would like to try to give you a theoretical introduction speaking "from practice", as it were. To put it more concretely, I am speaking from the perspective of a classical NIP therapist who was used to work with patients methodically according to the Casriel technique, no matter what the disorder, that is to say, lying on the mat in the direct physical contact with the other one.

About seven years ago, we discovered an increase in the number of patients whom the classical method not only did not help, but also whom this method even seemed to harm.

After group work on the mat, these patients were apprehensive, tense, confused, sometimes suicidal and in certain serious cases, even psychotic, whereby the psychotic state usually quickly improved once the patient left the therapy room and distanced himself.

At first, one tried to find understanding of these phenomena within the Casriel frame of reference. One was the opinion that it was evidently a matter of particularly serious dysfunctional cases where emotions were not admitted etc. Furthermore, it was true that if the patients were given sufficient permission to express the emotions they had experienced on the mat by crying out, they would be sure to perceive an improvement, just like all the other where this technique worked exceptionally well. Instead, however, any intervention in this direction only worsened the problem and appeared to increase the patient's troubles.

Which patient group is meant by this?

Once one begins to search for mutualities within this group of patients who react as described above, the following common features can be ascertained:

- These patients often experience an "inner vacuum" and maintain that they ***cannot understand what binds other people with each other***. They are literally unable to make anything of the word "bonding" and misinterpret it as "bondage".
- They are often extremely auto destructive, either by way of a polytoxicomania or by way of self-mutilation and repeated suicide attempts.
- They experience an extremely deranged identity or they experience themselves as people with "several identities" which are so varied that it would seem that several people are contained within one patient.
- The emotional world is featured by a great intensity. At the same time, the patient is afraid of strong emotions, not only of his own, but also of others.
- Aggressive or sexual impulse

eruptions are common and polymorphic perverse behaviour is outstandingly frequent.

- Their behaviour patterns are marked by permanent instability, often according to the motto, "I hate you, don't leave me!". They are incapable of bearing closeness and intimacy, however upon separation they experience themselves as intolerably lonely. This is a trap which only leads to instability being the only "stable factor" in a relationship. The patient often fluctuates exceptionally strongly, i.e. "it varies from one extreme to the other", often without the slightest transition. In the DSM IIIr of the American Psychiatric Association, precisely these features are found as diagnostic criteria of the "borderline personality disorder". This personality disorder pertains to the so-called "pre-oedipal disorders" which, indeed, are our very theme today. I will give you an explanation as to the exact meaning of "pre-oedipal" later on.

Perhaps at this point I should say a little about the diagnostic: during the sixties and early seventies, there was a strong movement among therapists who objected to "diagnostic labels" in psychiatry and to psychiatrists' methods in general. "Psychiatry is ill, not the patient" and "Don't label people" were among the key words, and traditional psychiatry and psychotherapy were accused of labelling people so as to be able to administer them more easily then. In many cases this was indeed a justified reproach. Even within the ISNIP I am still often confronted with this line of reasoning today.

In my opinion, this argumentation is biased and too extreme and unfortunately it led to the fact that one treated all patients alike and, in certain cases, realised too late that the patient had received a treatment that harmed him.

In other words, we regard exact diagnostics as absolutely imperative in order for the patient to receive the treatment that really helps him. In our opinion, encounters and exact diagnoses are not incompatible contradictions.

In DSM III is the product phenomenological analysis of a great number of patients. We find the DSM very useful when carrying out a diagnosis which is ***oriented on descriptive characteristics***. The illness characteristics described in the DSM IIIr coincide with our clinical experiences very accurately.

The scientific discussions of the past years have increasingly shown that it is rather pointless in proceeding unilaterally "bound by ideology" and then after this or the other therapeutic school to treat all patients equally. The research for therapy effectiveness, in particular, allows this conclusion to be drawn. This knowledge is reflected in our practice in such a way that to begin with, we make a diagnosis according to the DSM IIIr. When we continue with our work we strive for a depth psychological comprehension of the respective individual case. Even the therapy is, on the one hand, oriented on the symptom; on the other hand, however, an attempt is always made at considering the psychodynamic dimension of the illness as accurately as possible.

After the descriptive aspects, now a few psychological comments on the development and depth of pre-oedipal disorders.

Descriptive diagnosis on the one hand, and depth psychological-psycho dynamic comprehension on the other are, to our view, not incompatible but, on the contrary, two complementary procedures.

In analytical usage, "pre-oedipal" encompasses all happenings prior to the occurrence of the oedipal conflict, i.e. during the oral and anal stages, or the stages where, according to traditional analytical doctrine, the mother-tie and the development of the arch-trust are primarily concerned. In other words, "pre-oedipal" involves roughly the first three years of life. It is during these stages that the foundations are laid for a subsequent stable feeling of identity and a coherent self-experience.

As you know, M. Mahler in particular, and then later Masterson and Kernberg presented an extremely differentiated development theory regarding this so-called "early" development period and its pathology. However, in the light of modern infant research many conceptions of these analysts are no longer tenable.

To spare time, I will not make a differentiated comparison between Mahler's development psychology and the results of

infant research, since that would be lecture in itself and would go beyond today's scope.

You will see that the changes in the comprehension of development psychology are of more interest from the academic than the practical point of view. There is practically no alteration in the therapeutic procedure. Indeed, this is no wonder because the above mentioned phenomena have not changed as far as the clinical manifestation of the respective illnesses are concerned.

To me, the most essential result in infant research is the fact that, to a high degree, man is an interactional being ***from the very beginning***. For instance, there is no autistic stage, this implying that bonding is a basic human constant from birth onwards. It would seem that the genetically prior-given development lines take shape in dialogue with the first care givng persons, i.e. with the mother, as a rule. Therefore, pathological developments are also always interactional disorders from the beginning; in other words, disturbances in the bond.

Now for a NIP therapist, that is more less an old hat. After all, you may say, we have always regarded man as a "bond animal" and the entire classical NIP therapy is a therapy about the lack of bonding and insufficient subsequent satisfaction of needs in contact with others. That is true. So why doesn't the classical procedure function sufficiently with pre-oedipal disorders, I mean as far as the treatment technique is concerned?

Here, it is important to remember the fundamental differences between a pre-oedipal and a so called "more mature" disorder.

Conflict- versus structure pathology:

Mature neurosis involves conflict pathology (e.g. intraphysical conflict between Id impulses and superego prohibitions). Such a conflict as this, for example, part of the NIP attitude work.

A premature disorder is a question of structure pathology: the structures which are needed in order to experience an intraphysical conflict at all, are underdeveloped.

In concrete terms, this means a deficitary distinction of the ego structure during the early disorder. This is then reflected in the more or less intense identity diffusion in the patient's experiences. Even the frequently distinct cognitive disorders are characteristics of a deficit. This is of particular importance as regard the treatment technique: if it is difficult for the patient to perceive his ego limits, physically as well as interactionally, the affected person's limits become very quickly blurred.

Object constancy

There is no object constancy in the case of a early disorder: neither the self-representances, nor the object representances exist distinctly enough and the world of objects is split into "good" and "bad" objects which cannot be linked intraphysically.

Quality of fear

Neurotic fear is usually the fear of being rejected when one is as one is. Fear, in the case of for instance a borderline disorder, is an existential dread of destruction: to be identical to oneself means a danger of destruction.

One can easily understand the reason for this when hearing the life stories of these patients: in the anamnesis of these people, one regularly finds extreme cases of battery, frequently of life-threatening character. Sexual abuse during childhood is the rule and not the exception among our patients with a diagnosis in the early disturbed field.

Defence mechanism

A neurotic employs more mature defence mechanisms, e.g. repression or reaction build-up. Typical forms of defence in the case of early disorders are splitting, projective identification, omnipotence and devaluation, disownment and primitive idealising of the object. In the case of these defence mechanisms it is striking that the interaction field is required extremely intensely in order to be effective (e.g. in the case of projective identification). When dealing with the various patients, the usual greatly differing relationship between the ***therapist and patient*** is high significance.

With neurotics, a stable transfer relationship usually develops with the possibility to establish a lasting working bond relatively quickly; even during difficult stages of the therapy the relationship is fairly "safeguarded from crises". The therapist experiences himself as well disassociated and has no difficulties in maintaining his professional role during the therapy. The fundamental capability of

entering into a bond with another person is given in the case of a neurotic, even though frequently restricted in a certain domain (this then being the object of the therapy).

It is quite a different matter with patients with pre-oedipal disorders: a person with a an early disorder has restricted ego functions and disturbed relationship patterns. It is much harder for him to establish a stable therapeutic liaison. The person vis-à-vis helps primarily to satisfy his needs at a primitive level and a real dialogue is not yet possible, at all. At the same time, the pressure of the patient's anxiety when in contact perfectly and to avoid any spontaneity. The patient seems extremely indigent in a narcissistic sense and oral ansprüchlich orally.

The therapist often has great difficulty in maintaining a good distance. He is torn between great pity for the patient and strong rejective emotions. Confrontation is consistently more violent than with neurotic patients: that goes for all perceptible affects during the confrontation. The therapist often feels forced to do something for the patient which he normally wouldn't do. Even experienced therapists "take their patient home with them innerly", even into their dreams. It is though the therapist's soul has been "infected" by the patient's world of emotions or as though it has "infiltrated" the ego limits of the therapist, as it were. Patients know how to arouse strong feelings of guilt if the therapist fails to behave as required.

To quote an example, a patient comes to our Clinic because she has heard of the "miraculous NIP method" and feels an absolute desire to "work on her feelings", as she puts it. She experiences herself as the victim of intense, sometimes very contradictory affects and has downright magical expectations about the "healing power of crying out".

The result of the diagnosis is a borderline personality disorder. The therapist refuses to allow her to participate in NIP mat work, correctly arguing that any type of regressive work would probably only plunge her deeper into her emotional confusion. The patient reacts extremely aggressively with strong reproaches of guilt and claiming that the therapist cannot possibly know what will really help her. Her reproaches are interspersed with theoretical set pieces for mat work which she has acquired by reading. Finally, the therapist starts to doubt his competence and lets himself be convinced. He sends her to mat work after all, upon which she is inundated by paranoid fear in the sense of a mini psychosis, during the very first session.

In this example, the therapist has undergone a "masochistic subjection" in accordance with the desires of the patient, and this kind of reaction is quite typical for what can happen when a doctor and patient come in contact in the case of a pre-oedipal disorder. It is not until the supervision, that the therapist realises the dynamism of his involvement and that he can make clear therapeutic decisions again.

When do patients come for the therapy?
As a rule, these people have gone through long-lasting, horrendous sufferings, without really realising what the matter was. They have often desperately tried to establish bonds, but have inevitably failed again and again due to their great fear of closeness. Often they come for a therapy shortly after or shortly before an attempt at suicide: "being dead" seems to be a more pleasant state for many, than to continue leading this life. From time to time, the self-destruction of often very young patients has assumed alarming proportions. Frequently, they have already had experiences with the NIP therapy or other regression-promotive therapies and noticed that their illness became worse instead of better.

What does "bonding" mean in the case of patients with so-called "pre-oedipal disorders"?
This question generally sounds absurd: for one thing, bonding and bonding capability are, of course, one and the same thing for various people - even for various ill people.

However, ***technically***, there are indeed great differences: due to his disorder, the patient is usually incapable of profiting from the classical setting. Either he fuses symbiotically with the bonding partner on the mat or, more frequently, he is inundated by the fear of destruction in view of the physical closeness and great emotional intensity.

The therapeutic team must always be aware that certain structures which enable the proximity-distance regulation to be carried out soundly are not yet developed

in the patient's case. That means the therapist must assume these functions to begin with ("containing function" for the patient). The object is always to handle the limits clearly and to help the patient to develop a feeling for his own limits.

When a patient permits a bond beyond the initial superficial contact, it is not very often a mature bond form; the patient very quickly enters a close symbiotic bond.
Any kind of by all means well-meant enthusiasm to permit a patient in order to satisfy his initial needs (according to the motto: "I need, I exist, I'm entitled") is not indicated. In worst cases, it can lead to a so-called ***malignant regression***, a form of regression in which the patient becomes more and more dependant on oral and narcissistic influx, and receives less and less help in building up ego structures. Such psychotic episodes frequently end in manifest psychoses.

Therapeutic procedure in detail
First of all, it is important to provide a setting in which the limits are clearly defined. This applies not only as far as the house rules are concerned, but also the expectations from the treatment. A verification has to be made as to whether the patient is capable of entering a therapeutic bond, at least in order to work specially on his pathology.
In details, this means: to begin with, the patient passes through a so-called "guest stage" involving the creation of this therapy bond. Contract are elaborated together with the patient, stating two imperative items:

- Willingness to confront his or her self-destructive behaviour and to confront his or her conflict renunciation and projective identifications (general confrontation contract).
- Renunciation of his or her destructive behaviour, whether to oneself or to others ("non" contract, e.g. non suicide contract).

If the internal frame of reference of a patient is self-contained to such an extent that the two above-mentioned preconditions cannot be fulfilled, then therapeutic work is not possible (e.g. in the case that the patient experiences himself through and through as the victim of wicked intrigues and regards the therapist as a sadistic pursuer. However, therapeutic work is feasible once she possesses inner authority which gives way, at least partially, to a relativity of this view).

A patient with such a self-contained frame of reference often uses this to defend the outburst of a manifest psychosis, one should leave them in peace and not have the ambition to be capable of treating them successfully as well. In these cases pharmacologic therapy is more helpfull to the patients.

The therapeutic setting which we provide for the first part of the work is the contract group, for the one part, by means of which the patients are helped into drawing up their contracts. The other part entails the so-called "bell-round". This is a highly structured group with a bell going from patient ot patient in which each patient can say something about himself, his contract, possible violations of contract and receives feedback and confrontations.

As you can imagine, a distinct framework develops already by means of this work which is primarily oriented to the symptoms and, indeed, which the patients find very helpful. At the same time, this procedure is very cognitive-oriented. Strong emotional outbursts are stopped, rather than encouraged and so it is a completely different procedego" or in certain parts, an "auxiliary ego", the target being enable the patient to build up his own ego structure by means of the offered role examples. From the very start, the patient receives information about this illness which also fortifies the cognitive ego functions.
One must always bear in mind that in the case of these patients bonding first of all results from the experience of clear structures and the personal reliability of the therapist who is the guarantor for the structures, and less likely from emotions which are indeed unpredictable.
On conclusion of the "guest stage" the patient is integrated within the therapy group. Here, specific work is carried out on the individual problems of the patient, whereby particular emphasis is made again on the cognitive clearance, the reason being that most patients lose their head as soon as strong emotions are involved.
Quite contrary to Casriel's book, "A scream away from happiness", the central problem of these patients is the construction of an inner

structure to allow the integration of emotions and understanding.

At this stage, many patients notice for the very first time that they are beginning to be capable of accepting a deeper bond at all and are no longer having to experience bonding as such a threat that they must hide behind their symptom.

This realisation often only sets in after three to four months and in my experience, after the renunciation of the symptom, this moment represents the worst bottleneck for the therapy. Frequently, patients abandon the therapy at this point owing to the fact that their fear of entering a bond (with a fellow-patient or with the strongly once more and the patient has to decide whether he wants to continue with the next step.

If they do decide to carry on, they can participate in the so-called "family group" or "playground". This therapy is very much less structured. The most regressive elements are here. What happens at this stage of the therapy is most similar to a classical NIP group, however with one essential difference, namely that before a patient enters a regressive process he agrees exactly to the experience which he wishes to make, how long is to remain regressive and which roles the therapist is to play. In other words, even the regressive work takes place under the direction of an unblurred ego.

As Jacqui Schiff, for example, puts it, it is unwise to go ahead with settings which continue and enable a WIEDERBEELTERUNG within the scope of stationary psychotherapy of very limited duration.

Furthermore, the patients participate in body work parallel to the work in the therapy group. The function of this work also differs to neurotic cases since then, generally speaking, it usually concerns the relaxation of hardened structures at the physical level.

However, the body work in the pre-oedipal disorder field deals with structure build-up and differentiated perception of structures, just like in the psychological field. In bodyworks terms, we differentiate between a holding and supporting and between a relieving an controlling function of the physical structures. The body work concentrates on the build-up of these structures, perception and systematic exercise and regressive elements remain clearly in the background.

Final comments

Dan Casriel's basic idea that bonding is the vital point of a therapy process is more acute today than ever before, especially since we are living in a world where bonding and engagement seem to be diminishing more and more. Obligatory, safety-giving structures always dissolve quicker in post-modern industrial societies. On the other hand, I think it is very important not to exalt Casriel's ***therapeutic technique*** to the status of a life philosophy, but instead to apply it where its beneficial impact can unfold most.

When we are convinced that our capability of binding ourselves to other people, to nature or to God makes us human, it is just then that we are obliged to verify the meaning of this for the therapy of special cases.

I hope to have outlined the meating for the therapy of pré-oedipal disorders clearly enough.

OBJECTIVES OF PAIN

Lecture at the ISNIP-conference '93 in Grönenbach
Lecturer : Johannes Vogler

Permit me to explain the facets of the pain phenomenon as a psycho physical total occurrence, whereby not only physical components are involved in its development and maintenance, but also relative cognitive and affective components. The programme comprises a combination of relaxation methods, imparting of knowledge, cognitive and behavioural therapeutic structured group work, bio-energetics and various techniques of physical exercise. When making a diagnosis, the following aspects must be considered:

1) The accompanying depressive symptomatic and social retreat.
2) The patient's fear regarding the further development of the pain disorder.
3) The accompanying psychosomatic symptoms during the state of pain and its consequence.
4) Emotional strain due to restrictions in movement, handicaps or physical impairments.
5) Great discrepancies between the pain experience and the pathological findings of the organs.
6) Medicine consumption.

The general target is self-control, self-observation and the competence to vary and minimise the pain experience. The point is to achieve a change in the patient's attitude as regards the illness since, indeed, pains are not a fate at the mercy of which the patient is completely helpless also a question of breaking down attitudes of helplessness; furthermore of reducing excessive expectations from the therapy like entire liberty from pain for example. A further goal is to reduce the consumption of painkillers and sedatives.
Pain is a perception which depends on a maintained consciousness. It depends on a central nervous processing of emotions from the periphery. The cognitive processing takes place in the cerebral cortex and the affective processing in the sub-cortical structures. unknown An actual "pain centre" is still known as such.

Cognitive control strategies:

When experiencing pain, patients can only separate their thoughts from the pain with difficulty. They experience it as an increasing uncontrollable threat to their own existence. These thoughts influence the patient's emotional world and frame of mind to a great extent. His perception of pain is usually accompanied by feelings such as fear, helplessness, despair and depression which divert the patient's attention to his pain again and again. In order to influence his thoughts specifically, a series of cognitive control strategies are worked out with the patient such as self-verbalisation, pain diary, attention training and self-observation.

Relaxation methods:

Pains frequently occur together with an increase in the sympathetic activity which leads to an anxious and tense expectancy or a depressive ill feeling, hence triggering off a vicious circle. Relaxation methods can break this. Thanks to the physiological effects of relaxation (decrease of tonus of skeletal muscles, peripheral vasodilating, experience of increased rest and composure as

well as decrease of anxiety of the psychological side), the patient learns to counteract pain through relaxation (progressive muscle relaxation, autogenous training, breathing therapy, biofeedback, Tai-Chi, holding and bonding).

Handling patients with chronic pains:

In the psychosomatic clinic we work with patients suffering from chronic pains. These patients receive varied therapy propositions. They are frequently asked too much by the proposition of a psychotherapy since they are not easily able to see a connection between their pains suffered and the proposition of a psychotherapy. In heterogeneous groups which take place three times a week, the patients frequently do not know what to make of creative therapy, psychodrama or conversational psychotherapy. To facilitate the first step into this therapy we offer special group work with "Pain" as the central theme.

Pain is a phenomenon which cannot be observed directly by other people. It is a subjective and private experience. Any adequate pain diagnosis and treatment therefore requires a valid recording of the facts of the pain in question. Pain is a complex, subjective phenomenon with extremely varied qualities. It is the perception of an aversive stimulation which threatens the freedom from bodily harm. Alongside qualitative features, pain also has chronological characteristics. The pain can be persistent, attacking, momentary, immediate and repetitive. The momentary perception, the memory of previous pains and the anticipation of coming pains all pertain to the term, "pain". In order to record the pain, we make use of various pain questionnaires (referring to the back, head, etc.), a pain diary, and in special cases we carry out a structured, biographical anamnesis for pain patients. The recording of the pain illness by means of the structured questionnaires and the anamnesis investigation often help the patient decisively in getting himself understood and expressing his subjectively experienced affliction in such a way that it can be recorded by the therapist in its own individuality.

Anatomy:

Pains are conducted through nerves. They are differentiated according to their conduction speed, morphologic structure and function. We differentiate in myelinised A-beta fibres which are responsible for the sense of touch, for the feeling of vibrations and for the proprioception. The A-delta fibres are responsible for the perception of cold and for the intensity of the perception of pain. The heat receptors and other feeling receptors are situated in the C fibres. Together with the sensory imparting of information, the C fibre group also has efferent functions. Noxic information is conducted to the brain via specific paths of the contra lateral front tract. At this point an action system is localised which is responsible for the perception of pain and reaction.

Pain is perceived in the following areas of the body: Skin, muscle, joint, vessel periphery, inner organs.

Free nerve-ends (named nociceptors) end in these body areas and conduct temperature, pressure or painto the rear horn in the spinal cord either via fast conducting fibres or slow conducting fibres. We differentiate between surface pain and a deep pain. The perception of the quality of the pain varies and an acute pain is described as clear, stabbing, can be localised exactly, or a chronic pain as dull, piercing, burning, difficult to localise and slowly easing. The feeling of pressure, sensitivity to temperature (cold) and clear pain is conveyed via fast conducting A delta fibres. Touch, tickling, warmth, itching and dull pain are conducted via slow conducting C fibres.

We differentiate between acute and chronic pains:

Acute pain subsequently leads to a change in the heartbeat and blood pressure, profuse perspiration, increased muscle activity, restlessness, troubled sleep and disturbed appetite. As far as the patient's psyche is concerned, the feeling of fear and helplessness evolves with an acute pain.

A chronic pain is differentiated between the quality of the pain and the duration of the acute pain. A pain illness is a chronic and long-lasting process with psychic changes. Depression, fear, over-carefulness, social retreat! increased uncontrolled consumption of medicine, disturbed sleep, libido loss and a decrease in fitness are the consequence of these pain illnesses. In the case of a chronic pain illness, the patient concentrates on the pain irritation. The patient has too little information regarding the possibilities of handling the pain.

The Gate Control Theory with the

three-level model developed by Melsak and Wall is applied for describing the pain behaviour. These three levels enable the recording of physiological, inner psychic and proportional changes. On the one hand, the physiological level (1) is described, whereby reference is made to the vegetative nervous system, heart circulation changes and changes in the blood pressure. The affective level (2) refers to the inner psychic changes, thoughts, feelings and imagination of the patient. The behavioural level (3) includes proportional changes such as the description of muscle tension, mimic art, gestures, lamentation and over-carefulness.

The basic idea of the Gate Control Theory consists in the fact that the transmission of the pain irritation to the spinal level is modulated presynaptically through activity in competing fibre groups (e.g. through rubbing of hands). The transmission of pain impulses is inhibited. Pain information is undermined or not conveyed further. Superior brain centres above the ascending rear tract system also influence the "gate mechanism". The central adoption of the Gate Control Theory is seen in the fact that pain impulses can already be influenced at spinal level by several periphery spinal and super spinal structures which are linked by dynamic reciprocal actions.

The three level model developed on these ideas means:

1) The sensory discriminative system,
2) The motivational affect system and
3) The cognitive evaluative system.

The sensory discriminative control system is responsible for the time analysis of the pain irritation. The motivational affective system activates emotional processes such as fear, depressive moods and lack of drive or tendency to seek refuge. The interpretation and evaluation of this pain is ascribed to the cognitive evaluative control system. All three systems co-ordinate and modulate the pain experience. Furthermore, the control components affect the motor system which is responsible for the operation of the pain behaviour. The Gate Control Theory gave psycho physiological pain research vital impulses. It provided the very first conceptional framework model for the relationship between physiological and psychological aspects of the pain occurrence such as vigilance and emotional, motivational and cognitive processes. According to this conception, pain should not be understood as a primarily sensorial and physiological entity, but as a complex psychophysiological process involving equal shares of sensory, cognitive and emotional behaviour. Theoretical attempts at comprehending pain should clarify the following aspects:

1) The lack of pain in the case of prolonged injuries.
2) The enhancement of the experienced pain through fear.
3) The existence of pain without injury of the periphery or of the peripheral or central nervous system.
4) The hypnotic assuagement or production of pain.
5) The decrease in the perception of the pain due to familiarity with the pain irritation.
6) The effectiveness of placebos during treatment of the pain.

Learning processes for the explanation of chronic pains:

The reflex process still remains the outstanding model even for all psychic achievements. Despite this information from Freud regarding the significance of learning processes, these are still marginal importance as far as psychoanalysis is concerned. The operand conditioning and social emphasis for the maintenance and chronification of pain processes play a particularly decisive role.

In behavioural medicine, physiological pain theories are reported which are capable of explaining why chronic pains can occur without pathological organ findings. The Gate Control Theory drawn up by Melsak and Wall in 1962 provides an explanatory model which exonerates patients who have chronic pains but no pathological organ findings from the accusation of hypochondria. For this reason, it is worthwhile explaining this model to patients and making clear to them as to why they can experience and suffer pain without pathological 7 explainable findings being ascertained by means of medicinal examinations. At the same time, it can be made credible to them that it is quite unnecessary to .or causes by means of X-ray equipment and operations.

Psychodynamic explanatory models as to the origin of pain illnesses:

In 1959, Engel drew up a comprehensive clinical and theoretical report which summarised characteristics of patients who where easily prone to pain. It is a question of people who repeatedly suffer from physical impediments. According to Engel, these patients almost always feel excessively guilty, either consciously or unconsciously. It would seem that this experience of pain has been inflicted on them as a penalty in order to free them from their guilty feelings. Such patients as these involve themselves repeatedly in situations or relationships in which they become hurt or disappointed. During these periods they enjoy the best of health. In the reverse case, they suffer from pain again once their life situation improves. This is the reason why success is unbearable for them. Engel's observations and statements were investigated in empirical studies. Aiming to differentiate between psychogenous and organic causes, a structured biographical anamnesis survey was developed for pain patients (Egle). A pain illness of psychogenous origin is frequently found among patients when the circumstances listed below are ascertained in the anamnesis:

- No strong experience of the relationship to the mother or father.
- The love and care of the parents was seldom expressed physically but all too often materialistically and coupled with achievements.
- Psychogenous pain patients report significantly often about regular or frequent beatings and maltreatment by the parents.
- The parents quarrelled excessively and divorced or separated during the first seven years.
- The professional situation of the parents was characterised in such a way that they ran a small family business or both parents were very busy with their jobs. Differences in opinion arose as a result of this and personal discussions with the parents were rarely possible.
- A favourite toy very often took over the role of a substitute parent person.

Explanatory models exist about the psycho dynamic basis for the development of pain. The following gives you a few outlines:

1) The psychoprosthetic function of pain:
Through pain, psychic functioning can be maintained and a psychic correlation avoided. Within the framework of the narcissistic mechanism, it is the avoidance or restriction of a subjective self-esteem crisis in which pain stops an inter psychically perceived deficit.

2) The conversion mechanism is the most frequent principle applied to explain the evolution of pain, in the predominantly or partly responsible psychogenous sense. It is based on the assumption of inner conflicts which are expressed by a physical symptom. This physical symptom is of relevant importance.
Freud discovered and first described conversion in the case of hysteria as the displacement of a psychic conflict within the body and the joint attempt at resolving it with physical, i.e. motor or sensorial symptoms. Physical symptoms developed in this way are of symbolic importance.
Wilhelm Reich's character and muscular shell conception also proves very useful as regards the comprehension and treatment of psychosomatic pain. It is the consequential further development of Freud's actual neurotic fear theory on the basis of a libido congestion. Reich's discovery was that the character shell concerned the striped muscular apparatus which he denoted as the muscular shell. Sexuality, fear, anger and hate are "stored" here, predominantly in the muscles of the back, however. In Reich's opinion, the psychic and physical sides are one real functional unit. Complementary to Freud's erogenous areas, Reich postulated a segmentary arrangement of the muscular shell which also becomes apparent in the arrangement of the vertebra and nerve exits. He differentiates between the eye, oral, neck, breast, diaphragm. abdomen and pelvis segments. The majority of these segments are connected to the back or are a part of it themselves. The neck, breast, diaphragm and pelvis segments are of particular importance in back pathology. In the case of back troubles or illnesses, vessel and muscle tensions in this area are understood as energy blocks or libidinous congestion. Their psychic equivalents are the characteristic, enclosed, aggressive and sexual emotions as well as fantasies pertaining to each segment. The price to be paid for the shell is an inner or outer rigidness and the loss of physical mobility and psycho social liveliness. Contrary to psychoanalytical treatment, a helpful complement in the treatment of psychosomatic pain is the

therapeutic work on the muscular shell and body which liberates emotions and fantasies concealed here and restores the free flow of vegetative energy. These ideas adopted from bio-energetics find their counterpart in Chinese medicine where life energy blocks are lifted with the help of acupuncture or Tai-Chi. The object relationship theory including latest research results on the observation of babies and infants suggest that back tension is frequently caused by the lack of tension regulation as a consequence of insufficient holdings. A partnered relationship with the body is rarely observed, and is only achieved after a physical illness and a psycho physical maturation process. Of all things, it is the ill body that is in urgent need of tension-regulating holdings, not only from the treating and caring people around the patient, but also from the patient who has become responsible for himself.

In the development of the human being, the back has an especially psycho physical fate, making it the primary venue for frequent troubles. Indeed, it is the back of our body that is chiefly responsible for our hold and self-hold.
As it grows, a foetus lays backwards on the abdomen wall and pelvis of the mother in order to find a firm hold. Even after birth, the holding mainly takes place here, i.e. during breastfeeding or resting. Whereas an increasing differentiation between the psychophysical unity of one's body and taking possession of it takes place during various development stages in the front area of the body by means of the security-giving and satisfying interaction with the mother, this does not take place in the area surrounding the back due to the lack of the same extent of experiences in the front area. Paradoxically, one could say that on the one hand the back is the earliest constant experience of the body boundary, but on the other hand, the backing contact point of the symbiotic development stage which even adults gladly regress to when taking a soothing, relaxing sleep. Despite mature development stages which follow the symbiotic oral stage, we remain more or less linked via our back to the holding function of the mother or matrix.
All the more so, when the oral symbiotic phase and the subsequent anal phase with practice and repeated approaches (which are often accompanied by anger and destructiveness) are burdened by non integrable interferences. Above all, this concerns the development of independence and psychomotoric mobility, connected with upright sitting, standing and walking. It has become apparent that conflicts concealed in back tensions and pains are always multi-dimensional and result from different development stages.
However, in its psychosomatic sufferings, the back can also release orgastic potency, undreamed-of powers and vitality, birth fantasies and experiences as well as transcendental experience.

Furthermore, the back stands in a dialectic between dependence and independence: on the one hand the desire for protection and being held, on the other hand for autonomy, making oneself independent, and rising above oneself. Therefore, the psychosomatic topology of the back resembles a map with one or two white unknown areas, according to the success of psychophysical integration of the objective and subjective body description.

These areas are often psychically dead, delibidinated like one colony from another, usually occupied by a symbiotic object and hence withdrawn from its own propriety. Pains that occur here are desperate cries for help as it were, but which are seldom heard and usually instrumentalised due to the negative attitude towards one's own body. The instrumentalisation of back pains complies extensively with a biologically-oriented medical science with examination and treatment methods which exclude and distance the subject.

Three areas of unbearable feelings can be blocked by pain

1) The depiction of previous negative experiences is linked with the symptom.
For example, the childhood is first idealised. However, emotional deprivation becomes clear after more careful scrutiny, and can even mean physical maltreatment and/or N previous excessive physical demands.

2) Relief of feelings of guilt
The pain exists as a type of atonement process through which aggressions and subjective guilt are supposed to be absorbed. Pain is experienced in order not to feel the emptiness and senselessness of life. The pain distracts the attention from the

psychic to the physical area.

3) Holding a treatened social relationship

Here, pain symbolises the continued existence of a relationship. Pain is of vital importance in the relationship between mother and child. Pain contains the certainty that the mother will come and give comfort.

This closeness and comfort relieves the pain. As long as the pain exists, the unconscious motive of not being left alone is fulfilled. Proceeding from the observation that as far as the psychological development is concerned, all affects are experienced physically at first and that they are only psychised during the process of becoming adult, vegetative tense conditions can occur as an equivalent to an affect in the event of a lacking desomatisation or a distinct secondary resomatisation. The result is a sympathicotonous muscle tension. As an unspecified reaction towards various stress situations with the scope of unsuccessful solving of conflicts, disturbances arise in the experiencing of affects. In ego pathology, the psychic aspect of the pain is devaluated and attention is concentrated on the physical part of the disturbances. These patients are particularly convinced of purely organic healing of their problems.

Object of therapy:

A curriculum is compiled with a recording of the anamnesis, a photograph of the body, a questionnaire and a pain diary. The imparting of knowledge, bio-energetic exercises which enable affective working through of repressed feelings and the experience of holding and bonding all help the patient to accept his pain. Pain therapy involves helping the patient to accept the fact that he has pains. After 20 years of experience with chronic pain patients, Sternbach described 7 steps which characterised a successful pain patient:

- Accept the fact that you have pains
- Set yourself clear goals in your working, hobby or social domains
- Feel free to show your anger towards your pains if it does you good
- Plan out your activities
  a) Get into good shape
  b) Learn to relax and do it regularly
- Take your medicine regularly and then reduce the doses
- Only permit your family and friends to support your health behaviour, not your invalidism
- Be honest to your doctor and do not ask the impossible

Within the scope of the 6-week curriculum we strive to accompany, encourage and support the patients. During the pain therapy, the patients' wishes are complied with as far as possible. The pain diaries are discussed regularly and physical exercises are carried out which originate partly from bio-energetics and partly from Tai-Chi. These exercises are brought over to the patients in such a manner that they can be practised and continued at home if the patients find that they have benefited from them. Furthermore, we have concentrated ourselves on teaching the patients basic massage techniques. We consider it worthwhile when patients learn to massage themselves or their partner. This means a variety of coping strategies in order to learn to express and receive closeness and sympathy. The patients are instructed daily to carry out either the Jacobsen relaxation or autogenous training exercises. The reduction of medicine is accompanied and carried out individually.