International Society for the New Identity Process

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Founder

NEWSLETTER

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CONTENTS

- Preface
- Boardmeeting 5 summary
- Boardmeeting 6 summary
- General Meeting summary
- Nomination Teaching Fellow
- International Casriel Institute
- Request
- Advertisement for golden huggers
- Calender 1994 activities
- Conference Book
- Texts conference
  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 *by Ron Kissick*
  The tradition of Catharsis in Therapy *by Lynn Grodzki*

PREFACE

Dear friends
Dear colleagues

The conference is behind us for a few months now. We remember the intense meetings of a high quality standard, including the dance party ... A conference book will be availabe during 1994. Paul Markert and the International Office are working on it. In the meantime we will publish some papers of lecturers in every Newsletter until the conference book is completed.

Everybody received a leaflet of the International Casriel Institute. I hereby would like to stress the importance of participating for all trainnees. The ICI is a meetingplace for our organisation where we can study, write and work on the future of the method. In my opinion the future of the ISNIP organisation is related to the succes of the ICI. It might be easier to maintain a non active organisation, but that is not my ambition ! I herebe connect my office as president of this organisation to the success of this institute. Therefore I count on the full support of all fellows in general and the teaching fellows in particular. As a contribution to the succes of ICI the teaching fellow will lead a workshop almost voluntarily and also will have to motivate candidates to participate in a workshop,

And at the coming turn of the year I would like to wish everybody a
☆ ☆ ☆ Merry Christmas and Happy New Year ☆ ☆ ☆
Hope it may bring some moments of tranquility for the necessary reflection.

Johan Maertens
President

BOARDMEETING 5

September 15th 1994

Present : Ron Kissick (on proxy by Pat Kissick and Marilyn Ellis), George Rynick, Friedrich Ingwersen, Jeff Gordon, Martien Kooyman, Nimet Salem, Johan Maertens, Inger Johansson.
The Italians were excused from the Board Meeting today.

Report : Inger Johansson

AGENDA

1. Alterating the bylaws

The non-voting for members is postponed for a later General Meeting with a stipulation that makes it possible for a Chapter to have voting members for the local Chapter.

All the proposed changes to the bylaws were accepted upon to be proposed to the General Meeting with the specification for : "Teaching Fellow have demonstrated their ability in NIP including 5 years of experience as NIP group leader and fellow."
Ron Kissick made a reservation, Johan Maertens said that we can't change in this General Meeting the period mentioned. However the Credential Committee will accept ecxceptions for those it applies to. And in the next General Meeting we will do a new proposal.

2. Nominations

Carlo Kreiner and Dario Cipano were nominated to be Teaching Fellow.
Walter Lechler was nominated to be a honorary member.
George Rynick was nominated to be honorary president.

Johanna Martens, Belgium, will be nominated as a Teaching Fellow in 1994. This will be published in following Newsletter and confirmed by the next BM.
Domingos Netos, Portugal, will be nominated as a Fellow in the future. This will be decided by the Credential Committee.

3. New board members

The question of Rachel Light, treasurer in ASNIP, being a new board member was up. The board decided that it is the responsibility of the Chapter to see that the money gets to ISNIP. If needed Rachel Light can be invited to a board meeting.

4. Foundation of Portugees Chapter

Cfr. the bylaws, it is too early to apply for a Chapter.

5. Information of the International Casriel Institute

Johan Maertens showed a leaflet of La Soleillette. Johan will inform the General Assembly on Sunday.

6. Board Meeting 6 : Saturday 18th September 1993 at 18.00h - 19.30h.

BOARDMEETING 6

September 18th 1993

Present : Johan Maertens, Ron Kissick (by proxy), Martien Kooyman, Jeff Gordon, Inger Johansson, George Rynick, Nimet Salem.
Italian Chapter gave a proxy to Johan Maertens

Report : Greet Coutuer - International Office

AGENDA

1. Approval of the report Boardmeeting 5.

2. International Casriel Institute

Things to stress :

- there is a full program for 1994 on the theory spread over the 2 years
- program and curricula of the trainers will be avalable to the committee
- a plan of 8 workshops
- a continuation of the program for those who follow several ones
- the price is descreased to 15.000 BEF all in
- division of the profits - evaluation over 2 years
- candidates for 1995 : Martien Kooyman, Jeff Gordon - invite other TF
- participants all degrees in human recourses

The leaflet on the International Casriel Institute will be send to all the members during the month of November 1993.

3. Financial report

3.1. Membershipsfee 1993 - the same rate for every Chapter !

TF 50 USD
F 32,5 USD
MIT 22,5 USD
M 15 USD do they pay ISNIP fee or don't they ???

No chapter pays for members to ISNIP.
But a Chapter can decide that the Members should pay (for the Chapter).

Credit to pay :
Germany : about 957,5 USD + MIT
USA : about 1.110 USD + credit of the ISNIP account in American to be transferred on the ISNIP bank account.

Treasurer of each Chapter has to transfer all of the ISNIP membershipsfee to the ISNIP bank account by the end of the month April every year + return the according (corrected) membershipslist.
The same goes for the American Chapter. From 1993 onwards the ISNIP fee will also be transfered to the bank account in Belgium.

Can someone become a Fellow without being Member In Training ?
All of a sudden somone pops up as a Fellow while we have never known him/her as a Member in Training, and no membershipsfee is ever been paid !

There will be no fines but avoid this in the future (there are exceptions).

3.2. Profit of the Conference

The profit of the conference (if there is one) will be used for making and translating the lecturers for the conference book. This conference book is going to be made, the articles must be collected before the end of the year.
If there is still some profit left after the conference book, half of it goes to the members to stimulate them to cross the Atlantic Ocean for research, visit the Chapters, International Casriel Institute, etc...

3.3. Balance sheet 1993 : probably a break even of a small profit (+- 5.000 BEF).
Budget 1994 : a loss of about 80.000 BEF (the reserve of 100.000 BEF will be totally used).

The financial report has received the approval of the treasurer.

3.4 To raise of the ISNIP membershipsfee as of 1994 :

TF 60 USD
F 40 USD
MIT 25 USD

Conclusion :

- the reserve will be used in 1994
- ICI has to be a succes
- when ICI will profit > research

4. Date and place of the following conferences :

- International Conference 1995 USA - Washington - September the 3rd weekend or the first weekend in October (cheaper rates).
  Suggestion : 5 - 8 October 95 in USA.

- International Conference 1997 Europe.
  Locations : the Netherlands perhaps ? Italy is a candidate but it been so short since it has been there.

- There will be a small conference for NIP in TC's in 1994, probably in Belgium:

- An alternative to do in between the International Conference is also a conference in Italy on 28-30 April and in September the TC's meet in Boedapest.

Suggestion to alter in bylaws : to change the Presidency from 3 to 4 years.
The problem or the reason is it will always be USA or Europe. If we change it to 6 year the president election could be one year in advance, before transferring the function, which the vice-president should do.

Everyone is in favour of 6 years !!! The procedure to alter the bylaws will start from the next boardmeeting on.

5. Agenda General Meeting

1. Confirmation of the board
2. Reports of the different offices
3. Nominations
4. Alterations of the bylaws

GENERAL MEETING
September 19th 1993

Present	:	members present	27
		members by approxy	53
		in total	80

AGENDA

1. Confirmation of the board of directors

From October 1rst 1991- to prolonge until 1995

USA	:	Marilyn Ellis, Pat Kissick, George Rynick
FLand/Neth	:	Martien Kooyman, Johan Maertens
Germany	:	Jeff Gordon, Fiede Ingwersen
Italy	:	Dario Cipani, Silvio Quirico
Sweden	:	Bo Göran Gustavsson, Inger Johansson
Switzerland	:	Thomas Renz, Nimet Salem

and to relieve one another during the conference in Washington, probably 5-8 October 1993.
Suggestion : to elect the board for 6 years in a row.

2. Reports of the different offices

The reports of the Membership Committee, the Credential Committee and the Treasure were presented.

Concerning the finances the meeting agreed to use the existing reserve of about 100.000 BEF to invested in promotions for the ICI. The financial situation will be evaluated during 1994 taking into account the succes of the ICI.

3. Nomination of the Honorary President and the Honorary Member.

4. International Casriel Institute

The International Casriel Institute was talked over and had the full support of those present. The Institute Committee will work out the project in concern with the Board of Directors.

5. Alterations of the bylaws - general voting

The alterations were accepted unanimously exept for the voting of the members that will be postponed until the next general meeting.

NOMINATION TEACHING FELLOW

Johanna Martens is nominated by the Credential Committee.

Remarks of any society member can be send to the president of the Board, Johan Maertens.

If there are no remarks she will be accepted as Teaching Fellow at the following conference after she has presented her paper.

INTERNATIONAL CASRIEL INSTITUTE

Hereby we would like to motivate all the trainnees to participate in a workshop in the trainingscenter - cfr. plea of Johan Maertens.

For all information contact the International Office.

REQUEST

In order to promote the International Casriel Institute we would like to publish in renowed psychotherapy periodicals in most European countries. Therefore we need addresses of the journals.

If you can help us to collect these addresses please contact the International Office.

DANEL JEWELERS
50 WASHINGTON AVENUE
ENDICOTT, NEW YORK 13760, USA

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ISNIP CALENDER 1994

month	date	subject
January	24-28	International Casriel Institute - Workshop 1 Peter Geerlings (NL) - Inger Johansson (S)
February		
March		
April	28 - 30	Conference in Italy
May		
June	27-...	International Casriel Institute - Workshop 2 Ron & Pat Kissick (USA)
July	...-1	
August		
September	12-16	International Casriel Institute - Workshop 3 Magda Baukeland (B) - George Rynick (USA)
		Therapeutic Communities in Budapest
October		
November		
December		International Casriel Institute - Workshop 4 Nimet Salem (SW) - Johan Maertens (B)

1995		
October	5 - 8	International Conference Washington USA

1997		
		International Conference Europe

CONFERENCE BOOK

Request for the presentations of the lecturers.

In order to make up the conference book we need all the reports. Please send them to the International Office as soon as possible. Paul Markert will organize the translation of the German texts.
We would like to publish some in following editions of the Newsletter. Texts on the same subject will be combined in the same edition, e.g. on NIP in the therapeutic community, etc.

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 nonprofessionals 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 weekend 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, of 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 on-going 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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NOTE FROM THE EDITOR

The new year will bring a new lay out for the Newsletter. Wait and see ...

All suggestions and chapter information for the Newsletter are welcome at

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