NEWSLETTER ISNIP

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International Society for the New Identity Process

Daniel H. Casriel, M.D. - Founder

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The president ...

Dear friends and colleagues

Ron and Pat Kissick are the members that will lead the first training workshop in our International Casriel Institute at Bogève. Many others volunteered to make this training possible. It is a good feeling when so many people join a non profit effort to spread out the method from wich many people will benefit. Thanks to Ron and Pat for running the workshop and thanks to those who will follow.

We are looking for a sponsor for a Russian participant. We admitted him to participate for free at the training on the condition that he will do the same thing for some colleagues once he can start groups in Russia.

The first workshop will bring people together from Portugal, France, Swiss, Italy, Belgium and the USA.

Many greetings and hugs ***Johan Maertens****, President*

EDITORIAL

For the ISNIP NewsLetter 1994 all chapter information and articles can be send to the international office before:

Aug. 5th for the **Sept.** edition
Nov. 5th for the **Dec.** edition

to:
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PLEASE,

if possible supply your articles on a 3,5 inch disk realised with a current word processing program (MS Word, MS Works, Word Perfect, ... eventually on Macintosh disk).

IMPORTANT: always mention the name of the program.

If not possible on disk, please supply your articles on a clean and white sheet of paper (DIN-A4 or Quarto format) typed in dark black characters (avoid corrections)

Eventually add some illustrations (black and white drawings or pictures)

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 psy-

chotherapy 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.

Diagnostic criteria for differentiation between acute and chronic pain.

	Acute pains	***Chronic pains***
Pain	0 - 6 months	over 6 months
Cause of pains	*Impending or already ensued tissue dammage *Depended of organic injury	Mental causes Idependent of organic injury
Psychic characteristics	Fear	Helplessness, depression fear, anger, retreating behaviour

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 coordinate 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 multidimensional 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 fee-lings 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.

To All Members Of ISNIP

Sometimes we are not sure that the translation of the articles are made in good English, so

We are looking for:

... people who want to help us with the correction of all texts we want to publish in the ISNIP Newsletter.
If you want to spend some of your free time to do so, please contact **Greet Coutuer** in **the International Office.**

Calendar

International Casriel Institute

A complete training over 8 workshops is offered at the ICI.
The first workshop 27 June - 1 July 1994 by Ron and Pat Kissick can definitely go ahead!
We have already received 10 subscriptions. In order to cover the costs we need 15 participants minimum. So we urgently need extra subscriptions.

Dates for 1995:
February 25 - March 01 1995 by Martien Kooyman and Asa Lööf
April 24 - 28 1995 by Inger Johansson and Peter Geerlings
June 12 - 16 1995 by Ingo Gerstenberg and Adelheid Gerstenberg
September 25 - 29 1995 by ... and ...
November 20 - 24 1995 by ... and ...
Please fill in your name if you are candidate to give one of the trainings***!!!***

Teaching Fellow Conference 1995

Will take place on ***28 - 29 - 30 April 1995*** in Bogève, France.
Please note the date on your agenda 1995.

Friday April 28th:	Teaching Fellow meeting and making the acquaintance of the participants of the ICI
Saturday April 29th:	Personal work in NIP
Sunday April 30th:	Presentations and discussion

There is a ICI-workshop planned preceding the conference from 24 - 28 April by Inger Johansson and Peter Geerlings.

International Conference 1995 USA on 21 - 24 September 1995

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 prac-

tically 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 psychosomatic 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 asthma, a cold or cytistis
"I need you"	= "I have a gastric ulcer" 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 catathymous 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.