NEWSLETTER ISNIP

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International Society
for the
New Identity Process

Daniel H. Casriel, M.D. - Founder

CONTENTS

The president ...

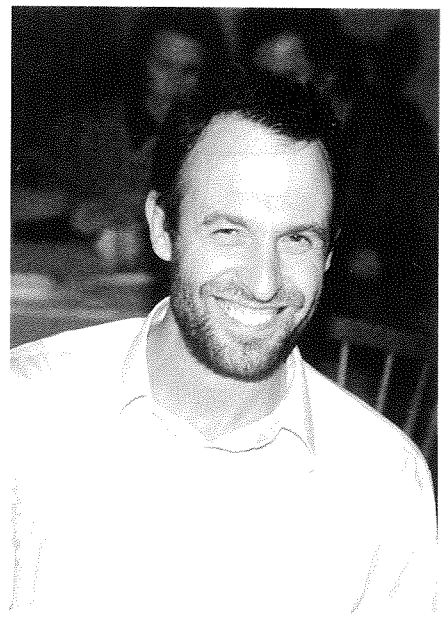
Dear friends and colleagues

In this Newsletter we have published a few more texts from lecturers of the international conference in Grönenbach, September 1993. We will collect all these texts of the presented papers in the conference book, which will be publish about end 1994.

At this moment we are preparing the Teaching Fellows meeting in Bogève, France (15 - 16 April 1994)

A special item on the agenda will be the program of the International Casriel Institute and the dates for 1995. The board members will work out the preparation amongst other things on the March board meeting. The summary of board meeting 7 will be published in the June edition of the Newsletter.

I have had little time in the past half year for ISNIP because of the explosion in the drug treatment sector in Flanders, Belgium. The organisation of The Sleutel grew from 4 departments to 8, the staff doubled to plus-minus 100. In 1993 we have treated plus-minus 1000 people with drug problems. And in 1994 we keep on growing. You may meet some of our new staff members at the ICI for training, because together with the expanding of The Sleutel, NIP is also growing in Belgium.



I hope to meet lot of you at the Teaching Fellow meeting.

Many greetings and hugs

Johan Maertens
President

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

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

My contribution has no lesser goal than to bring together theory and practical experience, to arrange a marriage between the attachment research and the practical work with the NIP, or at least to announce their engagement.

First I will present some of the results of the attachment research, and later I'll explain the advantages of their liaison with the NIP. As far as I can see the NIP has many similar, subjective experiences at its disposal, acquired in private practices, empirical individual data, which compared to the results of ethological investigations of attachment research belongs to the very same level.

We can easily come to an understanding about similar experiences or observations relevant to bonding or attachment and find common definitions, but as any other theoretical construct their explanations and conclusions need to stand up to critical scientific disputes.

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

Physical closeness in general is a taboo within the psychoanalytical setting. Some time ago, the "Spiegel" magazine published its editorial about the topic: "Therapy and sex, abuse on the couch", to which Johannes Cremerius gave an interview, ending with the words which sounded like a threat: "It's important that clients know first of all: psychotherapy is a method consisting of words. As a principal there is no physical contact. This is primacy, low, maxim."
That the difference between sexual love and attachment love, or sexuality and sensuality, is a difference that makes a difference, still is a relevant and delicate topic, well taken care of by Tillman Moser.

John Bowlby imported the attachment from ethology into psychoanalysis. The prize he paid for it: he separated from his analyst, supervisor and mentor Melanie Klein, who as he reported had forbidden him to see or treat the mothers of his young clients, strictly according to psychoanalytical theory she regarded the behavioural disturbances of the children as purely inner psychic processes. The object relations she was talking about were entirely internal relationships - they are fantasy. The notion that internal relationships reflect external relationships was totally missing from her thinking. The mother was regarded as a disturbing factor in the psychoanalytical cure, and to talk to her was regarded as acting out and therefore forbidden.
Bowlby separated from Melanie Klein and dared to be interested in real external relationships. He developed his attachment theory, that was ignored for a long time, because he tried to prove that real experiences had an important influence on child development.
He knew the work of the ethologists Konrad Lorenz and Nico Tinbergen, and living in London the phylogenetic work of Charles Darwin.
He knew some of the results of ethological research, for instance, that a new born duckling attaches itself instinctively to the first moving object it sees, and follows it. These results inspired him, and he concluded, that human beings too must have such bonding behaviours, and be pre-deposed towards sane relational experiences.
Bowlby assumed, that for all social species - including the human species - protection against something unknown, foreign or new is found in the proximity to a member of the same species.

Inspired by the fundamental work of René Spitz about the hospitalise-syndrome, showing that infants raised in foundling homes with sufficient feeding and caretaking but without handling or loving attention withered away and often died, Henry Harlow devises an experiment with rhesus-monkeys: he raises infant monkeys with two surrogate

"mothers" - one made of bale-wire mesh equipped with a feeding nipple, the other covered with terry cloth. The astonishing result was, that the infant monkey clearly preferred the terry-cloth-mother, running to it when frightened, and using it as a base for explorations - not the mother with the feeding nipple. According to psychoanalytical theory the feeding "mother" was expected to be preferred, because all mammals were postulated to go through an oral phase after birth.
Obviously the attachment to the mother does not develop orally, the infant-mother-connection is not a function of feeding, the love for the mother is not an answer to her satisfying the infant's hunger, but the sensual availability seems to be more important, at least for rhesus monkeys.

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

Up to now quite a few attachment behaviours have been described like clinging, crying, screaming, following and protesting if left alone, which are developed within the first year, independent from the quality of the car or culture worldwide, and with which the child attaches itself to his mother (or other caretaker). How far the attachment behaviour between children and parents are biologically based, and how far the behaviour of the rhesus monkeys can be applied to human behaviour cannot be answered by ethologists alone. They need support from evolutionary biologists as for instance Charles Darwin.
Only this will prevent false interpretations when human and animal behaviours are compared, as happens for instance when animal behaviour is humanised, for instance, when we label the fox with the human characteristic smart and create a myth through analogy. On the other hand human behaviour functions through evolution, like the attachment behaviour can be deducted from zoology, without violating human beings by zoo-morphising them as naked monkeys.

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

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

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

If there is no attachment behaviour, we cannot say anything about the quality of the attachment, as long as we cannot estimate how the child feels. Attachment behaviour helps to recreate security. A successful mother-child-interaction has protective and compensatory effects. Those protection factors are activated only, when the child has to face certain risks, so the children have to be made uncertain, in order to be able to see attachment behaviour.
Starting with those considerations, M. Ainsworth created an experimental struc-

ture that she called the strange situation. It mobilises the need for attachment, and the resulting attachment behaviour can be observed and documented under laboratory conditions. In 8 clearly defined steps the child is exposed to separation, and to contact with a stranger. First the child is with his mother for 3 minutes, then in a 3-minute-rhythm it is with his mother and a stranger, then left all alone, then the previously seen stranger returns to the child, and after that the mother returns.

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

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

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

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

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

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

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

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

their parents, but threaten them fundamentally.

The formerly mentioned American psychologist M. Ainswoth developed the concept of sensitivity as a way to describe the material behaviours that can be observed. M. Ainsworth says about herself: "I felt quite insecure as a child, and I believe, I never really got over it". She comments her self-doubt with such self-reflection, that I asked myself, whether the preoccupation with the issue "sensibility of the mother" is similarly autobiographic for me.
The following seems to support my assumption: Up to now I have discussed this concept twice more in detail. Each time I easily managed to present the issue in a way, that listening mothers - including my wife - became angry and protested. The more I talked about sensibility, the less of it could be found in the argument right here and now. The levels of contents and process were anything else but congruent. In any case there are two people, starting with M. Ainsworth and me, for whom the preoccupation with this issue included the dimension of self-experience as well.
It took M. Ainsworth more than 10 years to develop the concept and the examination methods of sensitivity, even though there is enough proof that she was anything else but lazy. Like other important discoveries, once that they are found, they seem to be evident, the concept of sensitivity nearly seems simple.
I want to present this sensitivity by using the example of visual contact, because it also has a function for the attachment.

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

Sensitivity is a measure for receptivity, showing the degree of fine tuning in the communication between mother and child. In 90% of the cases the phase interval lies within a limit of 2 seconds, so that the infants memory range, which last about 3 seconds, is not exceeded. That way the infant is able to see a connection between his emotional state and the mothers reaction. The faster the response to the crying, for instance. by answering "I'll be right there", the more the growing child develops a feeling of capability, grounding on the knowledge that "I am able to get my mother if I need her". Here sensitivity and capability are intertwined in a systemic sense. To create optimal conditions for attachment has nothing to do with spoiling, but it is a fundamental prerequisite for the psychic health of an infant. The harmony between need and satisfaction of the need leads to an early independence chosen by the children. On the other hand the more children are pressed by their caretakers to be independent, for instance, to play happily without their mothers, the more insecure they become and the less they feel like daring autonomy.
Sensitivity shows in many small details or things we take as a matter of course. Sensitive mothers greet their babies more frequently. They lovingly take them in their arms more frequently, they have a lower threshold for infantile signals, they promptly act upon crying, but don't disturb as long as the children play alone.
This means, sensitive mothers also hold back and don't act, as long as the child feels good. So sensitivity is the capability to perceive the chills signals, to interpret and understand them correctly, and to react adequately.

Observation about the quality of the mother-child-attachment in the first years show a large variety in maternal sensitivity, which means in an adequate response to the children needs and curiosity. The following consequences and developments became apparent.
One group of mothers reacted impatiently when the children cried, or feeling angry they signalled, that crying or other forms of attachment behaviour were not welcome, or they reacted brief and casual to the expressed wish for closeness and affection, and they put the children down with gentle vigour inspire of their clinging and against their will. At the end of one year those children showed an avoid anti-behaviour pattern, they refused closeness and cuddling, they fought against tenderness and were the opposite of clinging. As long as those children took care of themselves or played without calling, the mothers rewarded this behaviour with friendliness. The children adapted themselves to the situation and gained the mothers affection, by showing less and less attachment behaviour like crying or calling, which might provoke the mothers rejection.
It is a high risk for a child to show his weaknesses and needs, as long as it has to fear rejection right in the moment of greatest vulnerability. Even as grown-ups we only ask for help as long as we feel safe, that this weakness or need for help will not be taken advantage of, and we avoid situations in which we feel emotionally dependent upon others.
Rejected children sometimes show aggressive behaviour, accurately avoiding to direct this towards any particular person, especially not towards the mother.

Another group of mothers confused their children and acted unpredictably, their behaviour was more oriented to their own moods. Not being guided by the infants needs, their behaviour unpredictably changed between loving and rejecting, so the world of the child's needs stayed separated from the world of the mothers satisfaction of needs. Both worlds did not come together, at least not in a predictable way. No matter what those children did, nothing of their doing had to do with the mothers actions. The infant adapted their behaviour by and by to this unpredictable mother, by showing maximal strong and highly dramatic attachment behaviour, according to the matter, "all or none", thus keep-

ing a minor chance in their insecure situation of unpredictability, to get purposeful attention from their mothers. They never looked away from their mothers, as soon as they could freely move.
In some cases the mother showed sensitive and loving behaviour only then, when the infant was severely ill. The infants were constantly busy to keep their caretaker, their safety base as good as possible within reach, their attachment behaviour was constantly activated and absorbed their attention, so that there wasn't much time and energy left for play and excursions.

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

Different types of play:
The insecure avoidiant children of the 2. group, who experienced rejection and refusal when they showed attachment behaviour, went on playing externally calm, and didn't show any obvious emotion, when they had to face separations. When the mother returned, they hardly took notice of her, didn't greets her or smile at her, didn't show any form of recognition, and seemed brave and composed. But their play was characterised by lack of interest, and the toy they occupied themselves with, was optional and exchangeable, they didn't play purposefully with a toy, but only because it lay within reach. And the experienced ethologist could read from their faces and movements, that the children didn't really feel well.
Physiological parameters verify the ethological observations, that the way securely attached children play differs crucially from the way insecure avoidiant children play. The measurements of heartbeat and cortical blood level prove, that the insecure avoidiant children are distressed. The separation situation touches those children much more as is outwardly visible on first sight. Since Pawlow we know, that concentrated occupation lowers the rate of the heartbeat, but the frequency of heartbeat of the avoidiant children rises significantly when they play. This proves physiologically, that they only do as if they play and they are not really involved! The expression of their grief towards their mother was proportionally reversed to the amount of grief through separation. The more they suffered, the less they showed that to their mother. They turned away and avoided contact. As long as the children played nicely and didn't demand anything of their caretaker, the mothers seemed contented. As long as the children were nervous and needy, the mother ignored them and withdrew. In the course of the observations mother and child became more and more alienated. This helps the child to avoid pain, because more contact to the mother would create more pain.

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

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

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

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

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

A liaison of attachment research with observation data from the practical Casriel-work could first of all shed more light upon the above question. Second the described prototypes of attachment relevant behaviour patterns offer a raster

of terms that could find consensus, and which is fundamental for scientific formulation of a question. Therefore they give a scientifically based frame of orientation, which ingeniously subdivide the complex NIP-corpse, reduce optional terminology and still leave enough space for psychoanalytical, systemic or other theoretical explanations.

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

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

Bowlby defined the attachment quality, learned in childhood and internalised later Secure, avoidiant, ambivalent) as an inner working model or an inner cognitive map, and he demanded, with regard to the espy, the reconstruction of a positive self image, and of the attachment persons.
Through our daily work we empirically know, that the Casriel process provides good results for this.

You are welcome to also regard my talk as an appeal to evaluate the Casriel Therapy, and to prove its efficiency with scientific means.

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

ISNIP CALENDAR

MONTH	DATE	SUBJECT 1994
March		
April	15 until 16	Teaching Fellow Conference Bogève - France
May		
June	27 until 1 july	International Casriel Institute - Workshop 1 Ron & Pat Kissick (USA)
July		
August		
September	12 until 16	International Casriel Institute Workshop 2 Magda Baukeland (B) - George Rynick (USA)
October		
November		
December	12 until 16	International Casriel Institute - Workshop 3 Nimet Salem (SW) + ...
1995		
October	16 - 17 september or 5 until 8 october	International Conference Washington USA
1997		
		International Conference Europe

PRE-OEDIPAL DISORDERS AND BONDING

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

Introduction

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

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

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

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

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

Which patient group is meant by this?

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

- These patients often experience an "inner vacuum" and maintain that they **cannot understand what binds other people with each other**. They are literally unable to make anything of the word "bonding" and misinterpret it as "bondage".
- They are often extremely auto destructive, either by way of a polytoxicomania or by way of self-mutilation and repeated suicide attempts.
- They experience an extremely deranged identity or they experience themselves as people with "several identities" which are so varied that it would seem that several people are contained within one patient.
- The emotional world is featured by a great intensity. At the same time, the patient is afraid of strong emotions, not only of his own, but also of others.
- Aggressive or sexual impulse eruptions are common and polymorphic perverse behaviour is outstandingly frequent.
- Their behaviour patterns are marked by permanent instability, often according to the motto, "I hate you, don't leave me!". They are incapable of bearing closeness and intimacy, however upon separation they experience themselves as intolerably lonely. This is a trap which only leads to instability being the only "stable factor" in a relationship. The patient often fluctuates exceptionally strongly, i.e. "it varies from one extreme to the other", often without the slightest transition.

In the DSM IIIr of the American Psychiatric Association, precisely these features are found as diagnostic criteria of the "borderline personality destruction". This personality destruction pertains to the so-called "pre-oedipal disorders" which, indeed, are our very theme today. I will give you an explanation as to the exact meaning of "pre-oedipal" later on.

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

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

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

After a phenomenological analysis of the clinical pictures, the number of the DSM's patients grew enormously. We find this very useful when carrying out a diagnosis which is **oriented on descriptive characteristics**. The illness characteristics described in the DSM IIIr coincide with our experiences in the clinics very accurately.

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

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

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

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

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

To spare time, I will not make a differentiated comparison between Mahler's development psychology and the results of infant research, since that would be lecture in itself and would go beyond today's scope.

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

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

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

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

Conflict- versus structure pathology:

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

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

In concrete terms, this means a deficitary distinction of the ego structure during the premature disorder. This is then reflected in the more or less intense identity diffusion in the patient's experiences. Even the frequently distinct cognitive

disorders are characteristics of a deficit. This is of particular importance as regard the treatment technique: if it is difficult for the patient to perceive his ego limits, physically as well as interactionally, the affected person's limits become very quickly blurred.

Object constancy

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

Quality of fear

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

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

Defence mechanism

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

With neurotics, a stable transfer relationship usually develops with the possibility to establish a lasting working bond relatively quickly; even during difficult stages of the therapy the relationship is fairly "safeguarded from crises". The therapist experiences himself as well disassociated and has no difficulties in maintaining his professional role during the therapy. The fundamental capability of entering into a bond with another person is given in the case of a neurotic, even though frequently restricted in a certain domain (this then being the object of the therapy).

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

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

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

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

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

When do patients come for the therapy?

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

What does "bonding" mean in the case of patients with so-called "premature disorders"?

This question generally sounds absurd: for one thing, bonding and bonding capability are, of course, one and the same thing for various people - even for various ill people.

However, **technically**, there are indeed great differences: due to his disorder, the patient is usually incapable of prof-

iting from the classical setting. Either he fuses symbiotically with the bonding partner on the mat or, more frequently, he is inundated by the fear of destruction in view of the physical closeness and great emotional intensity.

The therapeutic team must always be aware that certain structures which enable the proximity-distance regulation to be carried out soundly are not yet developed in the patient's case. That means the therapist must assume these functions to begin with ("containing function" for the patient). The object is always to handle the limits clearly and to help the patient to develop a feeling for his own limits.

When a patient permits a bond beyond the initial superficial contact, it is not very often a mature bond form; the patient very quickly enters a close symbiotic bond.

Any kind of by all means well-meant enthusiasm a patient permits in order to satisfy his initial needs (according to the motto: "I need, I exist, I'm entitled") is a contra-indication. In worst cases, it can lead to a so-called **malignant regression**, a form of regression in which the patient becomes more and more dependant on oral and narcissistic influx, and receives less and less help in building up ego structures. Such psychoses as these frequently end in manifest psychoses.

Therapeutic procedure in detail

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

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

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

A patient with such a self-contained reference scope often uses this to defend the outburst of a manifest psychosis, claiming that people should leave them in peace and not have the ambition to be capable of treating them successfully as well.

The therapeutic setting which we provide for this part of the work is the contract group, for the one part, by means of which the patients are helped into drawing up their contracts. The other part entails the so-called "call-round" which you will be able to observe like tomorrow. This is a highly structured group in which each patient can say something about himself, his contract, possible violations of contract and receives feedback and confrontations.

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

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

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

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

As Jacqui Schiff, for example, puts it, it is unwise to go ahead with settings

which continue and enable a WIEDERBEELTERUNG within the scope of stationary psychotherapy of very limited duration.

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

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

Final comments

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

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

I hope to have outlined the meaning for the therapy of pre-oedipal disorders clearly enough.

EDITORIAL

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For the NewsLetter's face-lift the International office turned for semiprofessional help to Jeff - a staff member of The Sleutel (The Key) - who was willing and able to upgrade the layout. And he made a good job of it, don't you think so too?!

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

May 5th
for the **June** edition
August 5th
for the **September** edition
November 5th
for the **December** edition

Greet Coutuer
International office

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)