NEWSLETTER ISNIP

Number 3 - September 1994

International Society
for the
New Identity Process

Daniel H. Casriel, M.D. - Founder

The president ...

Dear friends

After a period in which the level of activity at the International Office was quite low due to Greet's absence because of her exams for Marketing (in which she succeeded very well) and my holidays which were long, warm and beautiful, we are back at work again.

We especially have to thank two persons who helped us survive this period.
First of all Nimet Salem who took care of a lot of organisational problems during the first workshop in La Soleillette and secondly, Isabelle Duroi, who took on voluntarily the secretariat of I.S.N.I.P. on a full time basis during the month of July.

The first International Casriel Institute workshop in June was a good happening and a first step in the re-establishment of an international institute for I.S.N.I.P. We thank Ron and Pat Kissick for giving the first push and all the participants for their role as guinea pigs.
We are working hard to make the ICI a success, but we will only succeed if we can count on everybody's support !

Johan Maertens,
President

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BONDING IN A THERAPEUTIC COMMUNITY FOR DRUGADDICTS

Lecture at the ISNIP-conference '93 in Grönenbach
Johanna Martens, PhD, Psychotherapist, Co-director T.C. DE SPIEGEL

A. Introduction

Today four people are going to speak about NIP in the T.C. for drug addicts. This gives us a fantastic opportunity for a rich exchange. Most people in the audience are familiar with the work in the T.C. Therefore I think it will not be necessary to give an extensive introduction about this work. I guess it would take a separate lecture to do so because the treatment network for drug addicts has become so complex these days.

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

B. What is drug addiction?

1. Common definitions

Following the chronology of history, I think we have to go back to the definition of addiction as it was written down in the World-Health Organisation - memorandum of August 1980.

In an article of 1982 Edwards, Arif and Hodgson made a summary of the evolution of this definition over the last 30 years and they quote the mentioned WHO-memorandum as follows. The word "addiction" has been changed into "dependence" (Edwards et al, 1982).

They write that: "Drugdependence is a socio-, psycho-biological syndrome with a pattern of behaviours, where taking the psycho-active drug has become more important than other behaviours that used to be of much bigger importance before",

Later in 1987, following the same line of reasoning, we find the descriptive definition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R).

Drugdependence is defined here as "a disorder with a cluster of cognitive, behavioral and physiological symptoms that indicate that the person has impaired control of psychoactive substance use and continues the use of the substance despite adverse consequences." A difference is made between drug-dependence and drug-abuse. This is only a matter of the severity of the problem

measured by 9 criteria who indicate the loss of control and its consequences. A classification is made of the substances used (APA, 1987, 165-185).

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

2. Casriel's idea about drug addiction

For the purpose of this lecture it is important to look at Casriel's view of the problem.

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

So, from the historical point of view, NIP is very much connected with the treatment of addicts. I even have the hypothesis that the NIP-method was first made for addicts and proved also to be useful for other patients later on. To me the general theory of NIP refers very much to the specific treatment of addicts, namely first stop the acting-out behaviour and then teach them to handle the emerging emotions and attitudes in cathartic groups.
What more does Casriel write about the phenomenon of addiction? In my review about this matter I'll be referring mainly to Casriel's basic book "A scream away from Happiness" (1976) and Janneke Coolen's doctoral dissertation (1985).
Casriel's classification of psycho-pathology is very simple. He speaks about three large categories: neurotics, character disorders and psychotics. For him most addicts belong in the category of character disorders. (Casriel, 1976, 148).
He considers symptoms as external signs of an internal emotional disturbance. They are the result of specific defense mechanisms of the person against too much pain. People with a character disorder cannot handle the pain. Instead of transforming their basic emotions, as the neurotics do, they have no contact with their basic emotions. They disconnect them from their consciousness, "freeze" them and so don't feel them. At the most, they feel a vague tension that they try to channel temporarily with acting-out behaviour (taking drugs). This acting-out behaviour has a destructive character for others and for themselves and it can also take the form of aggression or control (in the case of anger), of flight or withdrawing (in the case of fear).
Following Casriel's idea, Kooyman explains that their acting-out behaviour can be understood as a defence against being hurt, for the most important fear of addicts is to be rejected. In fact they are the ones who provoke this rejection by their acting-out behaviour. But if they cause this rejection themselves, it looks as if they have more control about it and this seems to be more bearable. (Kooyman, 1985).
Their fear of being rejected is connected to their extreme negative self-image. They have a very strong conviction that they are "condemned to lose" (failure identity). Kooyman says from his experience that most of them can't feel that they have the right to exist. And he says that if one does the necessary research one generally finds that there is a situation during their first year of existence that shows a problem in the relation with the person who is supposed to take care of them. From this experience the child can get the feeling not to be wanted (Kooyman, 1985, 163).

Casriel thinks only a small part of the addicts are neurotics and in that case the addiction is secundary to the neurotic problems. The most frequent addiction in this group is alcohol- and medicine-addiction. Casriel says that neurotics do feel their emotions but have problems to express them. Their defense mechanism is the distortion of their emotions.
Casriel writes that even a smaller group of addicts have a psychotic disorder. With these people the addiction can be seen as a way of self-medication to control the psychiatric symptoms. These people suffer from uncontrollable emotions and

their defense mechanism is to disconnect from the "so painful" reality. The psycho-dynamics of all forms of character disorder are very similar for Casriel and for this reason he treats them all in a simular way. We'll talk about this later. What I like about Casriel's way of thinking is the way he puts it into a social context. He says that it is the social reinforcment that makes certain forms of addiction more socially accepted than others.

He speaks about the same disturbance with "workaholic, succesfull businessmen, compulsive housecleaners, mild-mannered bookworms, reckless drivers, long-term underachievers, overeaters, unhappily married people" as with "people who shoot dope, drink heavily or are sexually promiscuous". The common denominator is anaesthization of basic emotions and encapsulation of the feelings behind a defensive shell which is extremely hard to penetrate in traditional psychotherapeutic situations. (Casriel, 1976, 3).

Other factors such as individual background, social values and rules, knowledge about and attainability of the substance or the behaviour, age, individual preference etc. are the ones that decide how the addiction is going to look (Casriel and Amen, 1971).

Casriel goes on with his social analysis and says that addiction is partly caused by society itself. He points a finger at our society and describes it as going from a neurotic type of society to a character-disorder-type of society. He describes how the change in the structures of society have their influence on the development of new emotional disturbances such as addiction (Casriel, 1976). Important factors for this change, says Casriel, are the disappearence of the big family, the competitive city life and the social mobility. These living conditions have their influence on the fact that it is getting hard to have deep emotional relationships and develop a feeling of belonging. Going away is often easier than fighting for something that is difficult to get.

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

3. Conclusion

As a conclusion to this search for a NIP-vision about drug addiction, I can formulate the following definition, for which I will be using the familiar "A-B-C"-concept which refers to "affect-behaviour-cognition". A drugaddict is a person who's behaviour is characterized by acting-out in such a way that he or she has lost the control of the use of a psycho-active substance. On an emotional level this person "freezes" his emotions and feels only a vague tension which is released through his acting-out behaviour. On the cognitive level there is a deep negative attitude towards life which means that he or she doesn't believe to have the right to exist and be succesfull in life. Addicts have big difficulties to give and to receive tenderness and bonding, and therefore don't have long lasting intimate relationships.

From this NIP definition of drug addiction it is easy to think that the proper treatment for addicts will consist of: first stop the acting-out, secondly teach the person to manage his emotions and thirdly help him to acquire positive attitudes towards life. Emotional but also physical closeness will be an important part of the treatment.

C. Drug addiction: How can it be treated?

1. Introduction

Neurotic drug addicts can be helped by outdoor treatment with individual-, group- and/or system - oriented psychotherapy. The difficulty here is the control of the use of the drug. For this reason urine-control needs eventually to be part of the treatment. Sometimes these people also need a short or longer hospitalization. This is the case when they have almost no social networks supporting them.

Drug addicts with a psychotic personality usually belong in psychiatric hospitals. But these hospitals sometimes have problems to control their drug abuse or other ways of acting out (violence for example), and send these "difficult" clients to the T.C. In fact the T.C. is not the proper place for people with little ego—strength because of the penetrating techniques that are used such as confrontation, stress and intimacy. More and more exceptions are made on this point, especially in the case of borderline patients who are getting a specific treatment in the usual hierarchical structured T.C. This new treatment has been elaborated by people such as the Stauss group here in Gronenbach. We'll be able to learn more about this during this conference in a separate workshop.

In other places I heard about discussions about the proper "number" or "kind" of borderline patients that would be welcome in a regular T.G. Janneke Coolen writes about a statement of Casriel who said that he would allow maximum one borderline patient in a group (Coolen, 1985,

25). I remember a statement of Peter Geerlings (in a NIAD-course of april 1991) saying that the "symbiotic" (vervloeiende) but not the "compulsive-destructive" borderlines would be welcome in a T.C. This because of the big anxiousness that emerges when intimacy or feelings of belonging start to come.

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

2. The hierarchically structured T.C.

Most of you are familiar with the work in a T.C. for addicts. And as I told you in my introduction I shall only try to tell you what seems essential to me about this matter. For more details I would like to refer you to Kooyman's recent book, which is a real manual about the T.C. (1993), and also to my own writings (Martens, 1989, 1990 c, 1993).
For me a T.C. for drug addicts is a kind of self-help community with a rather strict supervision by a clinical and/or by experience trained (ex-addicts) staff. The treatment deals with all the aspects (such as medical, psychological and social) of the addiction problem in a well integrated treatment consisting of socio-, psycho-, body- and family therapy. The most important acting-out behaviour is stopped at the beginning of the therapeutic program by forbidding drugs, violence and sex with each other.

The social reintegration of the addicts is programmed step by step, first inside the T.C., later outside, until the ex-resident is able to manage his own life.

3. Nip in the T.C.

Where does NIP appear in this T.C.?

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

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

NIP-groups fit into the psychotherapy-part of the T.C. The psychotherapy of the T.C. is mainly group psychotherapy. Only during the later phases of the treatment, individual psychotherapy is sometimes added. The group therapy usually is the encounter group, the so called "confrontation - encounter" wich was developed from the "Synanon-game". During these encounter groups the residents of the T.C. confront each other about their destructive behaviour here and now in the T.C. This confrontation is very intense because of the yelling and the screaming. If there is a connection with the past, this is worked out in the here and now situation. The objective is to change the negative behaviour of the confronted resident and make him understand himself better. On the otherhand, the objective is also the full expression of emotions in the people who are confronting others. For more detailed information, I would like to refer to Kooyman's very didactic writings (Kooyman, 1985, 168-169; 1993, 71-79).

The encounter groups are considered to be the most important therapeutic tool of the T.C. Although they have their limits. On the one hand, it is necessary to limit the work in these groups to the here and now situation to be able to channel the tensions and conflicts which emerge from the very demanding community life, on from the other hand, the techniques used are not sufficient to allow a full emotional release if a connection is made with the past. And here comes the importance of the bonding-group. As you know, NIP groups allow and stimulate this emotional regression to the past, not only to release, but, also to work on emotional blockades or traumatic experiences from the past.

This working-on seems to be necessary to be able to start a new life. If this is not done, the traumatic experiences from the past can go on having their destructive influence.

4. Advantages and disadvantages(?) of NIP in the T.C.

Having NIP in the T.C. brings more adventages than only giving the opportunity for deep emotional work.
An important advantage is the theory which is introduced with NIP. This theory makes it explicit that a complete treatment should take care of behaviour and emotions and attitudes. The behaviour correction is mostly done by the socio-therapy. Emotional work happens mostly in the encounter- and bonding groups.

The cognitive change (insight and changing basic attitudes) grows during the whole treatment but it is especially trained during the last period of the treatment connected to the concrete social reintegration. The theory of NIP is simple and easy to use as a common language by staff and residents.

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

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

NIP as a theory and as a practice shows the way to not only a "neutral" but certainly a "pleasurable" life. Addicts have a serious problem taking in pleasure as they are afraid it will soon disappear and that will hurt. So, it is very good that the NIP points clearly to that problem for them.

From the technical point of view, NIP-sessions are very economic: lots of people can work individual at the same time. The used techniques of bonding and screaming are also a safe way to handle very intensive emotions which would normally lead to acting-out or leaving the T.C.

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

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

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

Another limitation of NIP is that it is not useful for people with a weak ego, at least when NIP is used in the common way. The risk of getting lost within their own emotions is too big. We'll talk more about this further on. Going on the mat together can be problematic for residents who have been sexually abused. The physical contact can evoke the traumatic experience before they are prepared to deal with it emotionally. Waiting some time and giving them individual psychotherapy can be a solution.

For some "tough" boys the physical contact on the mat is not something they want because they make the association with homosexual experiences. This, of course, is only a form of resistance and càn be worked with as a resistance.
But NIP can also be abused by residents! In Deinze I already told you the story of one of our residents who was working on the mat with his fear to be caught for his secret sexual contacts with a female resident. But he was doing this without telling anybody what his fear was about! Other boys and girls just try to make fun together on the mat without allowing any real intimacy. (Martens, 1986, 61-62). In this case it is very important to teach the difference between intimacy, sensuality and sex.

D. My personal experience with NIP in T.C. De Spiegel in Brussels.

1. Introducing NIP

Shortly after I started to work in T.C. De Spiegel in 1983, I started to talk about introducing NIP into the T.C. Together with another staffmember, who was an ex-addict, we were convinced by our personal experience that NIP would bring the necessary depth to our therapeutic program, as it was originally thought out by Casriel. My arguments were more or less the ones I just mentioned. The big doubt of my colleagues was whether such a "strange" method would not interfere with the other very reality oriented parts of the therapy. We decided that each staffmember would check it with his personal experience and participate in an NIP-workshop. This happened

during the spring of 1984 and the experience was mainly positive. So we decided to introduce NIP and I went on with my training.
The question remained how we would bring the residents to use NIP. We finally saw an opportunity during a crisis we had that summer. We had to discharge several residents for a while because of drug abuse. When they decided to reenter we took advantage of the situation to ask "more" of them. From now on they were expected to express their feelings during groupsessions by screaming and hitting matresses. We were making go-arounds, holding hands screaming and making eye-contact as it is used in our usual attitude groups. At the same time we gave them seminars about the NIP-theory. But we still didn't dare to use the groupscream or propose the full body contact and work on the mat. This finally happend during a five day marathon in February 1985 which was started and supervised by Alix Kremer. Since that time we have been doing our weekly 3-hour session in the familiar way.
As we have only a small T.C. with about 13 residents, we thought we would need all of them to have reasonably good dynamics in the NIP-group. As you can imagine this was very scary to young residents. We respected their fear and handled it by asking them to participate only at a behaviour level: be there, look, listen, eventually start to scream and touch. They were encouraged to express their fear, respect it and demarcate their limits.

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

2. Evolution and situation today

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

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

I noticed that one can recognize a certain chronology in the emotional work of the residents. Most male residents first dare to let out their anger. They already know this from the haircuts and the encounter groups. They experience it as a real relief to be able to release this anger fully and use for this not only their voice but also their body by hitting the matress or doing an anger-attack. Female residents usually first start to express their pain and have big difficulties to do so with anger.
For the character disordered male, pain comes second, if it comes at all, because this is very hard for them. It usually happens after a few months in the context of their clean but painful contacts with the outside world. Seeing back the family and the rests of their junklife (social isolation, debts, juridical problems) brings up the pain about what is and what was missing in their lives.
At that moment the emotional regression to the infant-period may happen.

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

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

First the anti-social ones. These residents have a lot of resistance because of their fear of loss of control and more specifically for their own aggression. It is important to help them understand the difference between aggression (against the other) and anger (with themselves) and invite them to have enough faith to express their anger in a direct way without violence.

Hitting matresses and screaming makes it easier for them to make the evolution from an expression only "via the body" to an expression only "via the emotion". The next step is letting out the pain and this is very hard but very important for a positive prognosis. Their pain is the pain from early deprivation or rejection in their childhood. They experience the same pain in their conflictuous relationships with figures of authority and society. This turning point happens about the sixth month of their stay in the T.C. There is usually an emotional break-through or a splitting away from the T.C. at that time.
If they come to the end of the one year treatment they usually have to fight with their paranoid attitudes. They are convinced that there is no place for them in society. It is true that most of them have to deal with big debts to pay or even the possibility to have to go back to jail.

With the borderline residents, on the contrary, emotions come very easily on the mat. But soon you will realize that they don't really work on/ through their emotions. They don't experience any relief as they go on release and they feel disappointed. There is no regression. Some of them get panic stricken by fear.
To me the only meaningful thing to do is to let them work with ego strenghtening attitudes such as: "I am I" and "I can control myself". Later we decided to give them individual psychotherapy instead of bonding. This is more helpful for them and it saves me a lot of preoccupation during the NIP-session.

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

3. Specials!

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

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

E. General conclusion

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

REQUEST

A therapist is looking for information on existing literature and practice with bonding and NIP with respect to palliative care and the treatment of cancer patients.
Please send your information to the
I.S.N.I.P. - International Office
p/a De Sleutel - Greet Coutuer
Hundelgemsesteenweg 1
9820 Merelbeke - Belgium
Tel ** 32 9 231 54 45
Fax ** 32 9 231 67 15
Thank you.
Johan Maertens

REQUEST

Boardmeeting 7

March 1994

Present:Jeff Gordon, Fiede Ingwersen, Martien Kooyman, Carlo Kreiner, Inger Johansson, Bo Göran Gustafsson, Thomas Renz and Johan Maertens

The board voted unanimously for following items

1. The International Casriel Institute

1.1. Data for 1995

February 20-24
April 24-28
June 12-16
September 25-29
November 20-24

As the September dates coincided with the International Conference, the dates of the work shop were changed to 4-8 September 1995..

1.2. Program

There is shift in the program due to the cancelling of the 1rst workshop.
As a result, the June workshop becomes the first workshop.

The complete program is published on page ...

2. Alterations in the bylaws

These alterations will be published at least 60 days before the International Conference - cfr. the bylaws - where a general voting on the changes will be organized.

3. Agenda Teaching Fellow meeting April 1994

See report Teaching Fellow Meeting page ...

5. Planning 1995

A location for the 1997 edition of the International Conference in Europe is not planned yet. The board suggested the Netherlands, but nothing has been decided definitely.

BONDING IN A THERAPEUTIC COMMUNITY

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

Lecture on the occasion of the 6th I.S.N.I.P. conference in San Felice - Italy. Adapted and elaborated for the 8th I.S.N.I.P. conference at Grönenbach (Germany) - September 1993. To be published in "Psychiatrie en Verpleegkunde" (Psychiatry and Nursing).
Magda Baukeland, psychotherapist, co-founder of De Sleutel and at present instructor and supervisor of the staff

1. History

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

2. The population

2.1 Number

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

2.2. The Symptoms

Addiction:
- alcohol
- illegal drugs
- medication

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

2.3. The Personality

In addition to their addiction problems, many have psychiatric problems. In some American studies (Mc Lellan) research was carried out on drug addicts proving that 80% of the research population had encountered at least ONCE in their life psychiatric problems BEFORE their drug dependence became apparent.
Psychiatric disorders can be a result of drug using but psycho pathology is a risk factor for addiction.

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

For the identity level the system of Kernberg was used.

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

Starting out from his psychoanalytic background Casriel taught us that an addict has a defective guilt mechanism. The absent parent is not fulfilling needs and as a result the reaction is : I don't have needs anymore. The ego becomes weak, the control system is weak and the behaviour is anti-social. The addict only loves himself (narcissism).

The two most important defence systems are fight or flight. In these people Casriel found a third defence system which is to freeze, to withdraw like a turtle. To withdraw within themselves from the pain of reality which becomes the only way to survive. This primitive defence system works well at the beginning but becomes dangerous afterwards.
That is the reason why an addict has no inner motivation to change. He does not feel the pain. He is not like a neurotic who feels the pain of a bad tooth.

2.4. Conclusion

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

3. The Treatment

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

The rules are as follows :
-**general rules:** no drugs - no aggression - no sexual relations
-**house rules:** no isolation, grow or go ...
There is a hierarchic structure based on a Daytop model:
three groups made up of residents, a person responsible for each group and the co-ordinator.
They work, eat and play together. It is a community run on the basis of self-help with a staff who supervises.
Many therapeutic systems and games are used to train the residents. The games are based on five basic values: responsibility - honesty - friendship - respect -authenticity.

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

3.1 The program

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

TC

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

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

3rd phase: the aim is - to be themselves, to make plans for the future, to make new friends, to develop a social conscience -to assume more responsibility in the TC, to be a model for new residents -to integrate new values - to prepare for re-entry

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

3.2 Therapy

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

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

3.2.2. In 1977 we were trained in encounter techniques in accordance with the Synanon model : a lot of provocation, people aggressively confronting each other (cfr. Daytop-system).
The encounters mirrored the tension within the TC and the personal tension of the residents brought them together. The TC became more secure and closer. Per group there were two-hour sessions three times a week. In the first phase the TC worked on the level of the personality : rules, standards, values, defence systems ...
The confrontation with their behaviour : dependent people became more aware of their weak ego. The structure and hierarchic model in which residents who had been in therapy for a longer period act as role models, gave them the possibility to identify. The caring and warm feelings opened them up and they tried to trust people again.
Residents became once again capable of friendship, stopped loving themselves and tried to make friends.
As psychotherapists, we were not always happy with these provocative and hostile confrontation techniques, because to us they often seemed very destructive. We also believed that the deeper problems of these primitive defence systems had to be solved.
One part of the population did not always feel happy either with the methods used and from our observations we knew that a lot of them never opened up and that some of them guarded their feelings as if against danger.
From dr. Casriel we learned the new identity process (NIP) and brought it into our programme.

3.2.3. For about two years we discussed the introduction of the NIP group (place - frequency) into the hierarchic model.
After the training (4 staff members) we were so enthusiastic that we stopped the encounters and replaced them by 3 NIP groups of 3 hours a week. After 6 months there was too much aggressive acting out and so many daily conflicts that we did not have time for own psycho-dynamic processes.
The conclusion was 1 encounter group and 2 NIP groups; much later 2 encounters and 1 NIP group and 1 minithon every month or a marathon every 2 months.
The schedule for the last 5 years has been as follows :
1 NIP session of 3 hours a week with 1 therapist and a group of 10 to 12 residents. A minithon (8 hours of therapy) every month led by 2 therapists or a marathon of 2 to 3 days (20 to 24 hours of therapy) with 2 therapists.
One needs a minimum of 2 therapists (1 man and a woman) for a group of 12 participants (with a minimum of 10) in a large room or in 2 adjoining rooms. If one does a marathon of 2 to 3 days, it is necessary to involve all staff members.
In addition to the therapist, the other staff members can organize other activities such as dancing, creative activities, relaxation sessions, sport etc...
My 15 years of experience with NIP in a TC with this particular population has convinced me that this combination is the most obvious one.

3.2.4. When to start with NIP in the programme !!!
With this kind of population characterized by their obvious primitive defence systems and the high percentage of non-conformist behaviour, it is opportune to start by confronting them with their behaviour which is also the target of the first phase.
Keeping this in mind it is better for the residents to start with the NIP groups after having spent some months in the TC (about 3 months).
In the encounters they learn to abreact their tensions, their aggression. They learn to talk about their feelings, their ideas, their needs. They are confronted by their peer-residents. In this way, they begin to realize a hidden agenda, a blind part of their awareness, which is necessary before starting the NIP group.
The procedure to become part of the NIP-group consists of writing a report to the therapist. The therapist and resident then make an appointment to talk about motivation. The result is discussed during the clinical staff meetings.

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

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

In the early days we let the residents decide for themselves when they were ready to participate in the NIP group, but we soon realized that they were not really capable to take this decision. It would be like giving them the chance to decide whether or not to participate in the encounters. So we decided that NIP would be a part of the whole programme.
The question is whether NIP therapy is always the right answer for every resident?
Sometimes we noticed that a resident needed individual therapy on top of

his participation in the NIP group. The NIP therapist took care of these individual appointments. This led to good results for the resident, but these individual sessions had a bad effect on group dynamics.

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

3.2.5 How can we work psycho-therapeutically with people with a primary defence system?

According to me the TC is the basis. The NIP therapy only works with this population as a result of the structure and the whole hierarchic model. I will now describe a working group and some of the techniques used. Residents in a TC use these techniques on a level differs from the one used by people in an out-patient group.

The session starts with a group discussion. Each member of the group talks for some minutes about how he/she feels, what he/she wants to work on in the group, who he/she wants to work with and how he/she realized what was decided at the last meeting.Everybody sits down on mats and holds hands. The therapist also talks about his/her feelings.

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

At the beginning of the therapy (the first period: some weeks, some months) residents have difficulties talking about their feelings. They will say : "I don't know how to feel, I don't know what I feel, I don't feel anything." It is as if their feelings are atrophied. Sometimes they cannot express what it is they feel (alexythemia). The therapist or other residents have to tell the resident what he feels. This happens by means of trial and error e.g.

A > screams A > no

F > screams F > yes

in this way an intrinsic frame of reference is constructed.

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

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

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

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

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

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

Scream exercises:

During all these exercises we use the scream as a pre-verbal manner in which to express feelings. We often say a lot more in this way than by using words. Especially for this population, the scream AAAAA growing in volume can produce feelings.

At this stage of the therapy it can be observed that there is only a scream, not a content (only music, no meaning/words). The scream is also more aggressively abreacted. This comes from the encounter group where the abreaction technique is used.

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

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

Attitude training:

After the individual work on the mats, the residents form a circle. Those who want to work tell the therapist that they want to do an exercise.

Attitudes are the individual cognitive process of someone. To work on attitudes, one has to withdraw into oneself to come into contact with what one is feeling. During the first months of the therapy, the therapist has to specify the attitude as the resident is not as yet able to do so. Later on the residents know their programme and they are more open

and able to identify the attitudes and to alter them from negative to positive attitudes (e.g. 'I'm not good enough' becomes 'I am good enough').

Confrontation techniques:
In the circle, residents can confront each other not by saying things that hurt, but by expressing their feelings. For instance they can say "you make me angry" instead of "you're an asshole!".
The difference between the NIP group and the confrontation-encounter-groups is a serious problem. Sometimes residents refuse to take responsibility for their own feelings and they want to hurt someone else.
As a therapist it is necessary to be a firm leader in order to avoid feelings of insecurity.
After the exercises the group members sit together, form a circle and they end with a final group discussion. Everybody tries to formulate a resolve for the next session. A resolve might be : 'the next time I want to work some more on my anger, or I intend to hug 5 times a day with 5 different persons, ...'.

Afterwards everybody hugs everybody, the therapist included. That is the end of the session.
It is my experience that in a TC a rigid timetable is necessary, for instance
30': initial group discussion
2 hours: emotional work
30': final group discussion and hugs
In an out-patient group one can freely mix the steps of the process. In a TC a rigid structure is preferred.

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

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

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

The two basic pitfalls for the therapists are :
1. Strong feelings of negative counter-transfer when residents are not open enough.
2. Too strong a counter-transfer because deep down there is a huge cry for help > take away my pain, my suffering. The therapist is confronted with stories which can be very traumatic.
For NIP the therapist needs a lot of energy and training. This powerful method requires therapists to be well trained in fundamental attitudes such as honesty, truthfulness and unconditional positive acceptation of the clients (do not judge them even if they have committed crimes).

4. Conclusion

What is the influence of NIP on a TC?
Our experience has led us to believe that residents stay longer in a TC. If they run away they generally come back for the closeness, the bonding (if they really feel it), the atmosphere in the group because it is less hard and warmer, more open and less manipulating.
NIP is the place in the programme which can be compared with the uterus of the TC.
Residents can show their emotions and try to become themselves. They are born again and it brings them in real contact with other human beings.

EDITORIAL

For the ISNIP Newsletter number 4 1994 all chapter information and articles can be send to the International Office before: November 5th 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, WordPerfect, eventually on Macintosh disk)

Response to our questionnaire

We have received 22 answers which is 15% of the 150 members of the 1993 membershiplist. We've had a very good response from Sweden, the Flemish/Dutch society and very little reaction from Italy, the USA and Portugal.

Hereby we want to share some of the results with you. We hope to be more succesful with our next questionnaire in 1995 (March - April).

- 22% of our members (who answered) work in institutes with N.I.P.
- 54% work in their own private practices
- 22% are trainees
- from the therapists 23% have had personal experience with N.I.P. during the year 1993
- 50% from the respondents attented the international conference in Grönenbach - 30% will participate in the conference in Washington in 1995.

A few members wrote some articles which were published outside the Newsletter :

- Juul de Klerk Roscam - Abbing (NL)
1. Paper presented at the First World Conference of the International Society for Traumatic Stress Studies, June 21-26 1992, Amsterdam
"I exist and I own myself" Treatment in N.I.P. grouppsychotherapy of a female patient, who was sexually abused in the latency stage.
2. Article "The Casriel Method" published in "Handboek Groeps-psychotherapie", pages 1-34, January 1994

- Martien Kooyman (NL)
Short description of the use of N.I.P. in a therapeutic community for addicts in "Therapeutic Community for Addicts Intimacy, ... and Treatment ... 1993"

On the scientific level, Swedish members report some improvement with MS patiënts and mention that a report is possible in 1995/1996.

We already have eight Teaching Fellows who enlisted for the Teaching Fellow Meeting in Bogève ICI at 28-29-30 April 1995: **Peter Geerlings, Asa Lööf, Inger Johansson, Gunvar Gustavsson, Fiede Ingwersen, Martien Kooyman, Magda Baukeland and Johan Maertens.**

We know at least of 4 others who will participate in our work, N.I.P. experience and playing. I especially invite our US friends to join if possible or to send at least some representatives.

Johan Maertens and the International Office

INVITATION

Michel Oppl is organizing a weekend seminar at his clinic for November dealing with the therapeutic uses of attachment theory and research. The seminar will be co-sponsored by the DGNIP (German Chapter for New Identity Process).
Simultanious translation will be provided for.

Date: 19 - 20 November 1994

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