NEWSLETTER ISNIP

Number 3 - September 1995

International Society for the New Identity Process

Daniel H. Casriel, M.D. - Founder

CONTENTS

The president ...

Dear friends and colleagues,

The time you read this Newsletter we will be packinng for the international conference in Washington.
We are preparing the boardmeetings for the conference where we have to look at our financial problems. Running our organisation in a more and more professional way costs money. The work we do with the international office is done by people who work for a compensation of 9 $ an hour! Less is not possible, more will be needed for the future. We do only the most necessary tasks : correspondence, bookkeeping, newsletter, membership administration, organisation ICI, boardmeetings and teaching fellowmeetings.
I would like to pledge to honour the engagement from our staff with answering more rapid and correctly to their demands. Without their actions we wouldn't exist !
My second question concerns the financial level. Our organisation is too small to collect the needed money for the international office out of the membershipfees. There is only one other solution : the ICI can make profits if the training that is organised would be attend by more people. So you can help ISNIP not only by paying your membershipfee through your chapter, but by coming or sending people to the ICI workshops.
We did all we can to organise everything, our teaching fellows make a big effort to support the ICI program... Only you will be making the difference.
If we have to limit us to the membershipfee you can only expect us to organise :

1. written boardmeetings
2. 2 newsletters a year
3. keeping the accounts
4. membership administration

If we have more possibilities we can have also :

5. 4 newsletters a year
6. international training institute
7. representation in other international organisations for psychotherapy
8. professional bookkeeping

At the conference Nimet Salem and myself will present a paper about the feasibility of the ICI program for both trainers and trainees and the vital importance of its existence for our organisation as a project in which all chapters and all members could be involved.

I hope that I can count on you to join our efforts to make of ISNIP a living and productive body.

Johan Maertens
President

COUNTERTRANSFERENCE AND ITS SIGNIFICANCE

by Ameon Struijk

addition to : *Bonding and attachment theory: a conversation by Irena Precob (Newsletter June 95)*

Fletch DuBois, Ph.D. (Universität Heidelberg) is currently Assistant Professor in the National College of Education, National-Louis University at its Heidelberg International Center.

Jeff Gordon, B.A., M.L.A., is a Teaching Fellow of I.S.N.I.P., and is the current President of the German Society for N.I.P. He and his wife Julia have a private praxis and group center near Heidelberg.

In this study will be explained successively what generally is meant by transference and countertransference. After that the therapeutic benefit of countertransference is examined in more depth. Apart from psychoanalytical and groupdynamic theoretical opinions, what is described about the concept in literature on New Identity Process (Bonding-Psychotherapy) will be treated.

Transference

The concept of transference was not developed or invented. Transference is a phenomenon which the intrapsychic, but also interpersonal explorer S.Freud began to distinguish in relational development around 1905. This happened after one of his female patients, just after a hypnotic deduction, had thrown her arms around him. All this much to his alarm (Bulhof 1983;p 366).

It is the phenomenon in which present situations (c.q. relations, persons) are experienced in the same way and provoke the same feelings as situations, relations, persons of the past and in this case without the notion that it is in fact a matter of projection of this old situation. In other words transference amounts to a whole range of former psychical experiences, now unconscious, which in the present are connected with the other person. Mostly they are discordant emotional ties with formerly important persons which are transferred to persons in the therapeutical situation. It is a matter of a characteristic replacement. In essence transference allows for a re-experience of emotional events from the past.

The psychoanalyst de Blécourt (1974) calls it repetional compulsion from a genetic point of view, he makes a crucial distinction between

1. the compulsion to learn to control and
2. the compulsion to return.

In the first case it is a tendency to return to the problem that could not be solved and was thus repressed. In most cases a re-experience of early childhood traumas is concerned. This regression is a necessary condition to learn how to control former unsolved conflicts and is therefore called 'regression in the service of the ego'.

In the second case regression occurs out of a longing for a primitive fulfilment of needs and for a situation of rest and relaxation. In therapeutical terms this is coverred by the term 'resistance'.

In group psychotherapies transference is complex. Clients form transferences with their analyst, other members of the group, sub-groups and their group-as-a-whole. Often the group-as-a-whole represents the mother (Winnicott 1965).

In New Identity Process there is a preference for large groups. Groups of 20 to 30 participants are no exception. The complex character of such a group especially evokes the early childhood perception, in which there was a question of an environmental-mother, rather than an object-mother.

In spite of a psychoanalytic training the founder of the New Identity Process allots only little room for transference in his theoretical essays on this form of therapy.

In 'A scream away from Happiness' (Casriel 1972; p 228) he writes that in general transferences continuously take place in the group, as they take place outside of it.

He says he sometimes uses transference, but more fundamentally, by using his approach, he tries to quickly expose the transference, to understand it and tackle it on a behavioural level. Somewhere else Casriel says (1978; cassette 7) he even prefers to prevent transference. For this he propagates self-helpgroups, but in his argument in favour of a therapy among equals, I think he

mystifies the inevitable, partly uncontrolable effect of the unequal aspects in a therapeutical relation.
Furthermore I do not want to detract from the therapeutical value of self-helpgroups, such as co-counceling etc., but I am of the opinion that Casriel does not do his method justice by speaking of 'peer-therapy', because his form of therapy offers very useful transference phenomena, the working through of which can be very fruitful.
Henceforth the working through of transference phenomena do get a structural place in publications of other authors. Geerlings and de Klerk-Roscam Abbing (1985) distinguish, apart from five techniques taught by Casriel and aimed at catharsis, also the working through of resistance and transference phenomena through emotional confrontation. De Klerk-Roscam Abbing (1993): New Identity Process can be seen as a form of psychoanalytical groupdynamical group psychotherapy. Resistance and transference are used and its working through plays a major role.
According to Berk (1992; p 97) transference takes a central place in any form of psychoanlytical psychotherapy. He illustrates this in a simplified way with three theoretical assumptions:

1. The basis for neurotic symptoms, neuroses, charachter neuroses, narcissistic images, psychosomatic images, depressions etc. is formed by interpersonal situations, which 'did not go well' during development.
2. It is possible to actualize these interpersonal situations, which had a neurotic potential. Such an actualized relation or event is called transference.
3. By solving these transferences, we solve the neurosis. In this 'solving of transference' catharsis, corrective emotional experiences and development of emotional insight play a role. In this way the blocked development can be set off again.

What is meant by Countertransference

To Freud countertransference was a resistance based on unaccepted conflicts evoked in a therapist by material or behaviour of his patient (de Wolf en Cassee 1994). A.Reich (1951) explains this classical view: Feelings, wishes, needs from the analyst's past are projected onto the analysand. Attitudes of the analysand can provoke these countertransferences. The analyst's countertransference is a reaction to the analysand's transference. In this vision countertransference is considered mainly a problem.
Apart from this 'classical' view Kernberg (1965) in his survey distinguishes a 'totalistic' view. In this view countertransference is seen as the general emotional reaction of the analyst to his patient in a therapeutical situation. Rabin (1974) in his article about countertransference in group psychotherapy lists no less than seven different interpretations of the term 'Countertransference' (see Table I). Here one finds B.D. Lewin and Flescher in the broadest definition. For them conscious and unconscious attitudes, emotions and needs in the therapist are covered by the term countertransference. Such a broad view one also finds with M.Balint, who also includes the professional attitude of the analyst. For Rachman (1975) even the choice of profession is part of this very common form of countertransference. According to him, psychoanalysts need intimate relationships of short duration, in which the therapist himself can draw the line and experiences protection through the framework of the therapy.
Although being a familytherapist Willi (1994;originally 1975) reserves the term countertransference for a more limited field, which is that of the emotional reactions of the therapist to the transference of his patient, he points out that it is highly determined by the conflictual readiness of the therapist to enter a relationship.
Willi illustrates the complexity of the relation therapist-patient by talking not only of transference of the therapist with a countertransference reaction of the patient but also of transference from the patient with a countertransference reaction of the therapist.
In long term therapeutic relations there is a strong tendency of collusion between the therapist and his patient. They are in danger of working towards a certain patern which shows a common 'blind spot'.
According to for instance De Jonghe et al. (1991) the therapeutic relationship includes, apart from the transference relationship, a working and a realistic relationship as well. In case of collusion all these aspects get mingled.
Willi distinguishes four of these deceptive therapist-patient relationships. The narcissistic collusion is an idealizing transference as described by Kohut (1971), which got out of hand. In this case it turns out to be specifically the therapist's need

Table I: Different interpretations of the term 'Countertransference'.

1.Countertransference encompasses all unconscious attitudes, emotions and needs in the therapist.	Flescher (1953) B.D. Lewin (1946)
2. Countertransference embraces all of the therapists's unconscious attitudes, emotions and needs that affect his impact on the patient.	A. Reich (1951)
3. Coutertransference implies the therapist's transference to his patient or group of patients.	Grotjahn (1953)
4.Countertransference is descriptive of behaviour induced int het therapist, which is responsive to transference demands in the patient and which lead to transference satisfaction.	Schwartz and Wolf (1964)
5.Countertransference is considered counscious realistic feelings induced in the therapist by a patient or a group (objective countertransference).	Winnicott (1949) Ormont (1971)
6. Countertransference reflects the level of conflictual development of the therapist himself, which is often induced by this type of problems in a patient.	Fried (1972)
7. Countertransference is the therapist's transference to the group-as-a-whole, while the group in specific is given a good or bad mother function.	Liff (1973)

Source: summarized from Rabin 1974.

to act as an identification object in order to receive idealization. In oral collusion the therapist offers himself as the ever giving mother, hoping for thankful confirmation. In anal collusion the therapist enjoys his power over the patient who depends on him. In phallic collusion for instance the therapist feels confirmed as a man if he succeeds in having his female patients fall in love with him.

Willi also writes about a cognate phenomenon, which is called indirect countertransference elsewhere (see Kernberg 1965), namely the therapist's transference to the patient's relatives. In many cases it is more important and also more difficult to control countertransference to relatives than to control countertransference to the patient. Collusions between therapist and his patient are often identical to those between the patient and his partner. In this respect Willi points to possible oedipal problems in the therapist. The recognition of collusion implies the supposition of repressed oppositional tendencies, which are delegated to the other person.

Another transference recipe related to the therapist's personality is Schmidbauer's 'helpless helper'-syndrom Berk (1986) writes about. It includes the following symptoms:

1. A social facade with a strong superego and high ideals.
2. A denial of one's own weakness and need for help.
3. The evasion of reciprocity in intimacy.

Now this is countertransference which no longer fascinates me: with these ingredients no encounter takes place and as a matter of fact there is no longer question of a therapeutic relation.

There are many different definitions of countertransference. Underlying reasons for a certain definition can be multifarious. Supporting a broad definition of countertransference is a recognition of the complexity of the personal involvement of the

therapist in the relations with his profession,with his client, with the group and all its implicit processes and problems. Such a broad definition, however, does not always serve the purpose of manageability. After the concept countertransference was given a broader significance historically, it is remarkable that at the moment there is also a tendency to limit the significance of countertransference. With this I do not mean a trivializing of the issue. Apart from a limited defintion of (counter)transference for instance a working relationship, a realistic relationship and even a primary relationship are distinguished in that case (De Jonghe et al. 1991). Using another term this comprehensive issue is given the specific attention it deserves. Overlap and interaction must ofcourse be taken into account.

Another example of redifining is the concept of matching (Beenen 1994), where the attention is given to the combination of specific aspects of therapist and client, which determines whether or not the two get along.

In his publications Casriel does not use the term countertransference. In his criticism of psychoanalysis, however, he does point out that there is a risk of deforming of observations on the part of the therapist due to his own unsolved problems. For fear of equal relations, according to Casriel many therapists prefer to support actively and maintain the neurotic transference relation. In that case it means that the therapist does not give his patient the opportunity to grow.

Casriel (1972; p. 174) gives the following illustration of this: "Certainly in my early days of practising analysis, when a patient suddenly sat up and looked me directly in the eyes, I felt that he was being nasty and aggressive. The truth is, I was frightened. But I blamed the patients who made eye contact with me. I analyzed their resistance, rather than my fear. In truth, both were involved."

Casriel argues in favour of group psychotherapy, partly in order to give less chance to blind spots and deformations related to any human being, so to any therapist as well. The analyst on his own is also very vulnerable to possible deceptive maoeuvres of his patient. It is clear that Casriel means the development of collusions, which will get far less of a chance in a group: "There are too many people in a group system to let such a game succeed for long. You just can't fool everybody all of the time."

The significance of Countertransference for the Therapeutic Process

For a long time there were only publications about the interfering influence of countertransference on the therapeutic process. Around the fifties a change set in and people started to recognize that attention for countertransference could lead to a better understanding of the patient as well.

Thus Heimann (1950; p.81) states that within the analytic situation the analyst's emotional response to his patient is one of the most important instruments for his work. She assumes that the analyst's unconscious exactly understands the patient's unconscious and that he should use his emotional reactions in order to better fathom the unconscious processes in his patient. However, she does not find it advizable to express these countertransference feelings.

Although Little (1951) would be a more of an adherent of the classical view on countertransference, she undoubtedly could be considered a pioneer in the (radical) application of countertrans-ference feelings in the therapeutic communication.

Little draws attention to the illuminating and insight giving aspects of interpretating the countertransference for the patient. She thinks keeping away of these interpretations, or obscuring the truth to be harmful. With a carefully handled honesty the result of wrong or misplaced interpretations can be neutralized. The patient is given the opportunity to express his anger. In terms of Berk about the solution of transference, such a situation gives a possibility for catharsis, corrective emotional experiences and emotional insight.

Casement (1989;originally1985) points out the importance of the therapist being able to distinguish between that part of his reactions which contains clues for the unconscious communication of the patient and that part which should be ascribed to his personal life. As long as this difference is not clear, a therapist should not bother his patient with the unasked for display of his feelings. In his book Casement describes the method of the 'internal supervisor', with which, during the therapy, the therapist learns to find the liberty to detach himself from his countertransferences and to no longer identify with that part of him which in the psychological field of transference-countertransference is activated.

In order to make a more accu-

rate use of countertransference reactions in the fathoming of the unconscious processes in the patient, Racker (1957) distinguished two forms of identification in countertransference. They are concordant and complementary identification. In concordant identification the therapist experiences the same emotion the patient experiences at that moment. Therapist and patient identify with similar components of the psychical structure (ego with ego, superego with superego, id with id). Empathy can be considered to be a direct expression of concordant identification.
In complementary identification it is the therapist who identifies with the patient's transference object. For instance the therapist then identifies (object-relationally) with the concerned mother of the patient, or (from the structural point of view) with the patient's superego projected onto him. Racker states that the therapist fluctuates between these two forms of countertransference identifications. A prolonged existence of one of the two types of identification can be harmful and could for example lead to collusion.

Projective identification, as M.Klein introduced the concept, is a very elementary primitive mechanism in the development of object relations. There is much confusion of tongues concerning this concept. Sandler (1988) tries to cover all different meanings with one umbrella by describing the development of the concept in three stages.
The first stage projective identification within a therapy is Klein's and takes place in the patient's fantasy. The patient unconsciously projects his own unbearable thoughts and feelings with which he can not identify into the fantasy object of the therapist. This fantasy creates a distortion in the patient's perception of the therapist. Projective identification in this case is a matter of bad differentiation between self and object, which occurs especially in borderline and psychotic problems.
In second stage projective identification the patient tries to realize unconsciously longed for transference fantasies and in doing so puts pressure on the interaction with the therapist. These unconscious manipulations will sooner or later evoke a response of the therapist, which in some way resembles the fantasized object. In this case it is a question of Racker's complementary identification. A spontaneous change from a concordant to a complementary identification can be brought about by this process of projective identification. It is a matter of an identification with a fantasy object. This identification will be highly personal and it therefore includes countertransference.
In the third stage projective identification is described as if the externalization of parts of the self occurs directly into the external object. The patient expresses his selfthreatening unbearable feelings of, for example, sorrow, despair and hostility to the therapist, who in turn tolerates ('contains') these feelings. Bion's container model is based upon this and this is related to Winnicott's good-enough-mothering. It is a question of affective identification brought about projectively: projectively by the patient and introjectively by the therapist (transmitter and receiver). The unbearable feelings are transferred to the therapist. Through the therapist's tolerance the patient learns that those awful feelings do not need to be disastrous. Therefore they become less threatening and subsequently can be re-internalised in a more acceptable way by means of interpretations.

Berk (1992;p.160) summarizes Ogden's communicative projective identification as follows: The first step is the patient's wish to lose a part of himself or an internal object, because his self is in danger of being destroyed by it, or because that part could be destroyed by other parts of the self and therefore needs to be put in safety with another person. In the second stage the one who uses projective identification puts pressure on the receiver of the projective identification to behave congruously to the projected fantasy. This will only work if the other person will experience himself in the same way and possibly will behave like it (like an aggressor p.e.). In the third stage the receiver will (partly) experience himself like he is pictured in the projective identification (p.e. like the persecuted person).
Ganzarain and Buchele (1993; origin. 1986) describe in their article on countertransference in the treatment of incest problems how this projective identification can lead to role elicitation, role conversion and confusing role fluctuations. The authors explain how the problems to be treated usually involve with a history in which relationships are characterized by multifarious opposite reciprocal roles, such as 'parent/child', 'favorite/victim' and 'rival/dependent child'. All these roles were played by patients in different moments. In this way they

put pressure on the therapist to take the opposit attitude. Because of fluctuations this can be very confusing for therapists and can lead to all sorts of countertransference reactions. Projective identification clearly manifests itself as a defence mechanism, which shows resemblance to the specific defence mechanism of identification-with-the-aggressor, discussed by A. Freud (1988,-origin. 1936).
Gabbard too, in his survey article on countertransference in therapy with borderline patients points to the complex and chaotic transference and counter-ètransference reactions. Countertransference within projective identification is described in this article as a joint creation of therapist and patient. The author reaches the conclusion that the feelings and behaviour corresponding with the projections to which therapists are forced by borderline patients, are purely repressed or split-off aspects of the therapists themselves. With this conclusion Gabbard cancels out a possible conceptual dissociation and once more endorses the necessary and inevitable contribution of countertransference to the therapeutical process. Whether this is a profitable contribution constantly depends on the watchfulness of the therapist and his readiness to continuously examine himself and his relational life.

In training for the New Identity Process the own learning therapy takes up a very important place, but within the literature about New Identity Process countertransference has had little attention so far.
Casriel most of all acted in an inventive interactional way. In my opinion he was a pragmatist rather than an analyst. Expetrimentially he developped his method in a period in which all prevailing standards and traditions could 'simply' be put aside. From 'An Analyst's Journey' (Casriel 1972; p.57) it becomes clear that countertransference reactions have fundamentally contributed to the development of his method. Casriel was a pioneer and unconsciously made use of countertransference. That way he made creative inventions and wholesome discoveries, but apart from that he will, without intending to do so, have caused harm as well. This notion, by the way, holds true for almost all explorers.
Any way, we cannot afford this anymore. The intrapsychic conditions leading to countertransference reactions are unconscious. We should, however, become aware of its manifestations. I therefore endorse the old opinion of the psychoanalyst K.Menninger (1958; p.90), that countertransference is only dangerous there where it is forgotten.

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REPORT BOARDMEETING 10

April 1995

Summary

1. The financial report of 1994 will not be presented at boardmeeting 11 for approval. The international office (Europe) will change the system into double bookkeeping conform the legal demands. The total balance sheet will be completed with the European and American accounts and the international Casriel institute activities. We will try to rearrange this before the boardmeetings in Washington.

2. The conference 1997 will take place in the Netherlands. A group of members in training will organize it with the support of the Flemish-Dutch association.

3. The board agreed on providing 500 USD a year to ASNIP to help its members to attend meetings in Europe (ASNIP did the same).

1995 CONFERENCE 21-24 SEPTEMBER COLUMBIA, MARYLAND

location :

Holiday Inn, Columbia Maryland

Cost :

$ 115 if registered before August 1
$ 125 if registered after August 1

For more information :

Contact Linda Harter, M.S. at (301) 71-2678

BEYOND WORDS : CATHARSIS AND THERAPEUTIC TOUCH IN PSYCHOTHERAPY

Keynote Speakers

Candace Pert, Ph.D.
The Biochemistry of Emotions
The Mind-Body Bridge

Rudolph Bauer, Ph.D.
Subtle touch and the Inner Connection

Candace Pert, Ph.D., a pharmacologist, is Adjunct Professor in the Department of Physiology and Biophysics at Georgetown University School of Medicine, and a consultant to the sponsors of Peptide T, a nontoxic AIDS therapy now in phase II trials. She was formerly Chief of the Section on Brain Biochemistry of the Clinical Neuroscience Branch at the National Institute of Mental Health. She discovered the opiate receptor and many other peptide receptors in the brain and body. Her international reputation has led her to lecture worldwide on brain biochemistry and her theories on emotions and mind-body communication.

Rudolph Bauer, Ph.D., a Diplomat in Clinical Psychology, is Director of the Gestalt Psychotherapy Center of Washington, D.C. He is widely published in the area of experiential psychotherapy, existential psychology, and clinical hypnosis. He did post doctoral work in existential phenominology at the University of Louvain, Belgium and studied meditation in India with Swami Muktananda. He is former Director of Psychology Training at the University of Maryland School of Medicine.

Presentations by therapists from the U.S. and Europe :

• Issues of sexuality, intimacy, and boundaries • The limits of talk therapy
• Individual vs. group techniques • Historical development of NIP
• The ethics of using touch • Integrating NIP with other methods of therapy

CONFERENCE SCHEDULE

September 21 - Thursday Evening Kick-off

Time	Event	Location
3:00-4:00 p.m.	ASNIP Board Meeting	TBA
7:30-8:00 p.m.	**Welcome** Ginny Hurney, Conference Committee Chair	Kentucky Room
8:00-10:00 p.m.	Informal Gathering	Kentucky Room

September 22 - Friday Presentations

8:15-9:15 am	Registration	Hotel Lobby
9:30-10.00 am	**Presidents Welcome** Ron Kissick, MSSW, President ASNIP	Kentucky Room
10:00-11:30 am	**Keynote Address** ***Subtle touch and the Inner Connection*** Rudolph Bauer, Ph. D.	Kentucky Room
12:00-1:30 p.m.	Lunch	
1:30-3:00 p.m.	**Panel Discussion : *The Ethics of Touch*** Yetta Modifica, MSW; Ron Kissick, MSSW; Pat Kissick, MSW	Preakness room
	The Limits of Talk Therapy William Wolfson, MD; Peter Geerlings (Netherlands), Johan Maertens (Belgium)	Kentucky Room
	The History of the New Identity Process Janice Frank, MSW; George Rynick, M.Div	Room 146
3:30-5:00 p.m.	***The Shadowland of Carl Jung :*** ***Bonding with the Self*** Yetta Modifica, MSW	Preakness Room
	Speaking the Naked Truth : ***The Emperor's New Clothes and The*** ***Paradox of Touch*** Lynn Grodski, LCSW	Kentucky Room
	The Imaginative Body : Healing Through ***Expressive Arts*** Alma Ruth Burger and Tania Gerich, MA	Room 146

September 23 - Saturday Presentations

8:15-9:15 p.m.	Registration	Hotel Lobby
9:30-11:00 p.m.	Keynote Address ***The Biochemistry of Emotions :*** ***The Mind-Body Bridge*** Candace Pert, Ph.D.	Kentucky Room
11:30-1:00 p.m.	***Dimension of Therapeutic Touch*** Robin Seiler, MSW, LICSW	Preakness Room

	Looking At Boundary Issues Ron Kissick, MSSW; Pat Kissick, MSW	Kentucky Room
	Early Wounding in Childhood At the Identity Level Linda Harter, MS	Room 146
1:00-2:30 p.m.	Lunch	
2:30-4:00 p.m.	***Problems and Patterns in Therapy : Seeing the Forest Instead of the Trees*** Jeff Gordon (Germany)	Preakness Room
	The Deification of Emotion Marilyn Ellis, LCSW-C	Kentucky Room
	TBA	Room 146
4:30-6:00 p.m.	***The Four Levels of Emotion, Attitude and Behaviour*** George Rynick, M.Div.	Preakness Room
	Why Talk Therapy Cannot Heal : Understanding How the Brain Heals Chris Wright, MA	Kentucky Room
	TBA	Room 146
6:30-12:00 p.m.	***Cash Bar, Buffet Dinner, and Dance***	Kentucky Room

September 24 - Sunday Meetings

9:00-10:00 am	ASNIP Board of Directors Meeting	TBA
10:00-11:00 am	ISNIP General Membership Meeting	Preakness Room
11:00-12:00 am	ISNIP Board of Directors Meeting	Preakness Room

CONFERENCE REGISTRATION

Dates : Thursday, September 21, through Sunday, September 24 (Conference ends at 12:00 noon) ISNIP Conference Business will be conducted on all four days. Keynote speeches, lectures and workshops will be presented by ISNIP members and invited guests on Friday and Saturday. A general meeting of the society will be held on Sunday.

Fees : Full Conference : $ 115.00 per person ($125.00 if registering after August 1, 1995)
Single Day : $ 75.00 per person
Banquet : $ 25.00 per person

I (we) will attend the full conference. ..... (number attending) x $ ..... (fee) $.....
I (we) will attend one day of the conference. .....(number attending) x $ 75.00 $.....
I (we) will attend the banquet and dance.....(number attending) x $ 25.00 $.....
Total $.....

Make checks payable to ASNIP
Send this form and check to : Linda Harter
4003 Postgate Terrace # 401
Silver Spring, MD 20906 Telephone (301) 871-2678

If you are registering for more than one person please include names and addresses all attend

TEACHING FELLOW MEETING

April, 28, 1995

Members Attending : Nimet Salem (Switzerland), Jeff Gordon (Germany), Frankie Wiggings (USA), Johan Maertens (Belgium), Inger Johansson (Sweden), Peter Geerlings (The Netherlands), Ron Kissick (USA) and Yetta Lautenschlager-Modifica (USA)

Minutes of the last meeting were read and approved with one change, "Casriel" therapists was changed to "NIP" therapists.

Johan handed out the 1993 conference booklets and said they are available for $ 10.00.

ISNIP as part of EAP
There was a discussion concerning the membership in the European Association of Psychotherapists. It may be a prevention for what happened in Italy where it is very difficult to become a psychotherapist following government policy. Discussion followed on the pros and cons. It was determined that we wait and see how this organisation develops before we make a commitment. The Belgium chapter has decided to become a member, and will keep us up-to-date on the developments.

Name change
There was discussion about changing the name from New Identity Process to Casriel Bonding Therapy. The Europeans find the name New Identity Process not descriptive enough. The Americans do not want the name change due to recognition of the name in the states and the possibility of problems using Casriels name. A decision will be made at the International board meeting.

International Conference
Ron Kissick hand out a flier about the International Conference in Columbia, Maryland USA, in September. He pointed out that we have Candace Pert and Rudolph Bauer, two well-known speakers for the conference. He shared the schedule, and said we may have up to three speakers at the same time. There will also be panel discussions, and asked the Europeans to sign up to speak and be on the panels. The price for the conference will be $ 62.00 per night for the hotel.
The next International Conference will be in the Netherlands in 1997.

International Institute
Johan went over the financial report of ISNIP. He said that there would be a possible loss of $ 1000.00 for the Institute at La Soilette for the five workshops presented. Brainstorming followed with four suggestions emerging.
1. Charge more for participants.
2. Allow other members to come the training workshops as participants, but not trainees. These members would be sponsored by their therapist and followed-up by them.
3. That it would be compulsory for trainees to attend this training.
4. Have other teaching fellows encourage their trainees to attend. Johan is looking for a secretary to overlook the training.

Nimet will check with Doris Störer to see if she could do it.

1996 Training
Feb. 26-March 1
April 28-May 2
July 1-July 5
Nov. 29-Dec. 3

There was a consensus to continue the institute even though we lost money because it is only the first year, and it takes time for new projects to develop. Also, there was a suggestion to do some training in the US in addition.

Networking
Discussion followed on the importance of networking. We could speak at other conferences, write in other journals, and become members of other organisations. Those mentioned were Int. Group needed, notify Johan, and he will get someone.
" A Scream Away From Happiness" will be published in Germany.

Newsletter
Johan asked for suggestions for the Newsletter. He has been printing the contents of the 1993 conference so far. He would like other articles.

Assistant Therapist
There is a need for the assistant therapist category in Europe for those working in institutes. The consensus was that a person may lead groups as an assistant therapist only in a institute where the institute will take full responsibility for their work. It was recommended that assistants not work with their therapists due to counter-transference issues, but work with their trainers.

Videos
There was a discussion about the usefulness of acquiring Dan Casriel' videos. It was consensus that we not pursue them at this time.

Yette Lautenschlager-Modifica