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Theme Issue on TA and Addictions

Positive Payoffs for Destructive Behavior



By Corinne Harrison-Gledhill

At the First Pan American TA Conference some years ago, John James presented a paper on "The Positive Payoff of Games." He recognized that, at the end of a seemingly destructive process, people are able to reach a desired state of being. I rang loud bells for myself as I listened because I had long "known" that all behavior is survival behavior at some level, even if it reaches the point of not being.

In working in Alcoholism Treatment Centers and Vagrancy Units, I have used this awareness as the basis for understanding what clients are doing to and for themselves. I know that, unless their need for survival is met in the contract and treatment program, I may as well "save my breath to cool my porridge."

All behavior is survival behavior at some level, even if it reaches the point of not being.

What, then, is more important to some people than health, sanity and social maturity?

For one thing, people drink to excess and develop addictions in order to regress by means which are resistant to Parent control. Most of the conditions ending in "ic" fall into this category: anorexic, schizophrenic, epileptic, etc. These are designed by Little Professors as sure means of either not growing up and staying retarded, or of regressing psychologically, physically and socially. Attempts to "cure" these "conditions" will not succeed if they address only the social level by attacking the means of regression and if they discount the need to regress, be little and dependent and to keep parent-people around.

When clients in alcoholism treatment units stop drinking, they are often asked to help caretakers by working in the office or even "running groups." This is particularly dangerous, since these clients are likely to escalate their demands for care and control by going on disasterous benders or becoming seriously ill.

Residents in vagrancy units who are "resettled" into flats of their own spend more time in the hospital or jail than in their flats. They often have fires or sell their rent books for drinking money, returning to the unit more regressed than before and highly resistant to repeating the experience. Some are found dead, days after dying alone in their flats.

Alcohol is a means of access to excluded ego states. It is folly to ask someone to stop drinking without having seen him/her drunk. Without seeing the person's behavior and its positive payoffs first hand, we are likely to receive Parent-contaminated reports from clients and their nearest and dearest. When encouraging someone to stop drinking, it is important to build access to their excluded ego state into the contract. Otherwise, they feel like they are giving up their means of being child-like or living without the sense of calm and self-assurance they experience in Parent.

When people drink, they dissolve their Negative Critical Parent. However, alcohol does not discriminate between positive and negative and all their Parent goes. A person without a Parent is a problem. While a small child in a temper tantrum can be managed without too much strain, a six-foot man regressed to four who is having a tantrum is a different matter. Others are forced to exercise care and control for their own protection as well as to protect the regressed person. This passive behavior is at the "incapacitation" level.

Regression promotes the familiar "Laingian Knot:" "I will not control myself, so you try to control me in order to feel in control, but you cannot control me and then you, in your frustration, lose control of yourself and I control you." I win and you lose; I win by losing and you lose by trying to win."

Many people crave a label to satisfy their need for identity and belonging. I frequently experience strong resistance to my suggestion that those wearing "alcoholic," "homosexual," or "epileptic" labels take them off. In fact, clients often beg me to give them this "passport" to the payoffs of security of predictable responses from parent-people and a sense of unity with other "Not OK and determined to stay that way" people.

An important payoff for those who find a means of regression is the very low expectations others have of their performance. Clients who have been stroked for performance rather than being are likely to demand recognition for being in destructive ways. They can punish and embarrass those who discount them with their "incompetent" behavior. There is a strong passive-aggressive element in their insistance on regressing to a level of visible social ineptitude.

By various means, and for a multitude of reasons, there is a large part of our society which is seriously regressed. Using the "Vineland Social Maturity Scale," I assessed a random sample of men at a large (500 bed) vagrancy unit in London. The average life age was 48 years 3 months; the average age of social functioning was 8 years 4 months with the range from 4 years 9 months to 16 years 1 month. Without treatment, these men are no more likely to behave in a "grown-up" responsible manner than actual children of the same age and stage of social development.

Regressed clients and/or those who have retarded themselves make up only half of the picture, however. The other half includes the caretakers, curers and controllers, people who are dealing with their own survival needs by not letting themselves regress. As long as they are surrounded by regressed people, they feel safe in their "grown-up-and-competentness." They enter into the struggle with the regressed person in the same way that they deal with their own need to be cared for and controlled. Wherever the two groups meet — the clinic, courtroom, therapy room and jail — they play the games. The payoff of the games is guaranteed by their "unaware" collusion with each other. They do a "trade off:"

People drink to excess and develop addictions in order to regress by means which are resistant to Parent control.

Caretaker: I will struggle with you to help you to "get better." I will give you my time, energy, and strokes, not allowing myself to be a Child as long as you don't get better and you live out my script ending for me.

Client: I will provide you with excitement and money. I will boost your sense of self-esteem by needing you and I will live out your script ending just as long as you don't ask me to grow up and be a zombie like you. I'd rather die/go crazy than do that.

Caretaker approaches to clients range from "I am so

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Food As Fix

By Anne Waters, BA, Dip. Ed.



In treating adult women who consider themselves to be fat, compulsive eaters or bulimics (who compulsively binge and then purge themselves), I have come to see food addiction, if it can be called that, as sharply different from chemical and alcohol addictions, and correspondingly, in need of a different treatment approach.

When a client says she is going to stop taking drugs or chemicals, I give her full support. However, when she proposes to give up food, we obviously have a completely different situation. While alcohol and addictive drugs are clearly enemies, food, in actuality, is not. It is necessary for our survival and through it we take our place in the natural cycle of growth and decay.

It would be easier if the compulsive eater could give up food as the alcoholic does alcohol. Instead, she daily has to deal with the substance she considers her enemy. Surrounding her at all times and in many forms, food is offered as a symbol of love, caring, strength, energy, sexuality and beauty by people she loves and a culture she longs to be part of. Her real task is to learn to appreciate food and choose it wisely. In fact, she must learn to eat, an often terrifying prospect.

Our culture, through its mass media, bombards women with messages about how they should look. As is common during times of struggle for women's rights, the ideal today more resembles a boy's body than a woman's. For example, the highest paid female models are teen-aged girls who present an ideal that is impossible for most women to achieve. It is no wonder that women experience frustration with their bodies, which, in heavier and bulimic women, amounts to unhealthy stress and anguish.

However, it is important for women to realize, as Kim Chernin notes in *The Obsession: Reflections on the Tyranny of Slenderness*, that fashion is fickle. Movie sex goddesses of only twenty years ago seem fat now. There is a correlation between cultural permission to be sensuous, round and full-bodied with a denial of economic and political power. In addition, this cultural rigidity is less evident in European, black or Hispanic cultures.

As is common during times of struggle for women's rights, the ideal today more resembles a boy's body than a woman's.

In our culture, men are allowed much more leeway to look as they want and to still be considered attractive. They are not urged to "improve upon nature" by shaving their legs or supporting parts of their anatomy in little cups. A larger range of weight and shape is OK for them and there is also the concept of the older, sexy, distinguished man, a concept that is lacking for women.

Knowing how arbitrary and changeable these cultural standards are allows women with eating disorders to own their own power and choose for themselves what they want to look like and how much they want to weigh. Often, when they stop trying to please mommy, men, other women or the fashion industry, they have a good idea of what is healthiest and most comfortable for them. Endurance, strength, muscle tone and flexibility also become part of "beauty."

In a supportive therapy group, women can let in Adult thinking about their bodies, instead of being stuck in Magical Child and feeling that thinness will "fix" everything like some TA commercial solution. This Magical Child position does not act as a motivator; in fact, a client may be hesitant to get thin if she believes it will change everything, a sometimes very scarey idea.

It is important for both therapist and client to see the impulsive/compulsive eating and the bulimic bingeing/purging as protective behavior and to explore its purpose and function. Clients should not, and luckily most will not, give up a protective behavior, whatever its disadvantages, until they have a Parent and Adult they can trust to assess the need for protection and a repertoire of additional protective behaviors. As Susie Orbach says in *Fat is a Feminist Issue*, "Fat is not about lack of social control or lack of will power. Fat is about protection, sex, nurturance, strength, boundaries, mothering, substance, assertion and rage."

A useful exercise with these clients is to have them talk to the fat or the food and then reply from that position. Bulimics need to talk both from the food position (they often have a special relationship with sugar which mirrors their relationship with their mother) and from the position of the vomit. Imagining themselves, at their desired weight, in a social situation with their families will also often uncover what they fear.

The body uses fat as insulation and as a storehouse of nourishment in emergencies. Over-eaters use it in the same way psychologically, which is, of course, minimally effective. Their scripts are usually "loveless" ones and, fearing that their needs are too much, they store up what they can control (food). The food is also used as a sedative when feelings become uncomfortable. In addition, fat is a test of love; only love from those who penetrate the disguise and recognize the attractive Child underneath can be trusted. (I can understand Sleeping Beauty and Snow White feeling grateful, but surely they should have considered whether an over-zealous gardener, who was into breaking and entering, and a wandering necrophiliac would make good life partners!)

The bulimic, on the other hand, is on a teeter-totter, craving nourishment and then rejecting it as if it were poison. She attempts to control the world and her needs by being perfect, reaching for perfection by continually feeling imperfect. She is in the position of the fairy-tale younger son who, by being perfect, gets magical powers which enable him to beat his elders at the appointed task and win the prize.

TA theory helps these clients understand their dilemmas and change their responses. Berne's theory of basic needs, in particular, allows them to both identify their true needs and to understand how they can be unsatisfied after a large meal. It becomes clear how, in certain circumstances, it would be more satisfying to throw a chocolate cake at someone than eat it!

Schiff's passivity theory also offers important clarity to these clients. They will usually admit the problem and its importance, but heavily deny both the solvability of the problem and their own power. A favorite passive behavior is agitation. This includes compulsive eating, which escalates into incapacitation with over-eaters and violence towards themselves with bulimics.

Her real task is to learn to appreciate food and choose it wisely. In fact, she must learn to eat, an often terrifying prospect.

It is also important to decontaminate the Adult in four basic ways. First, there is a large, over-critical and, in the case of bulimics, over-exacting Critical Parent. Second, the contaminated Nurturing Parent, which I call the Idiot Nurturer, says things like, "You have eaten so sensibly today you deserve a chocolate sundae." Third, the Adapted Child contamination is the delusion that fat protects and thinness perfects. Fourth, there is, in the Natural Child, a distrust of body information, especially around hunger and fullness.

As clients begin to use their Adults to think about their culture and their bodies, and to figure out the protection behind their unwanted behaviors, they are gradually able to make better choices about eating and to give up food as a fix.

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Positive Payoffs (continued)

humbly grateful that you allowed me to try to help you" to "there are people like you I just cannot help — you are your own worst enemy." They are likely to send their "failures" to the human scrap heaps and warehouses such as asylums, jails and vagrancy hostels or to keep them on the caretaking circuit of social welfare offices, hospitals and rest homes. All this is done with the passive cooperation of the clients who, like "Custard the Dragon," long for a nice safe cage at any cost.

The approach with which I have had the best results is Re-parenting. So far, there are no facilities in London for parenting, although I have high hopes that I will make this possible in the near future. The next important step for me is to do more research on root causes. I have already recognized that a high proportion of regressed people are children of doctors. Problems of laterality are clearly present in many and dyslexia is so common that it is "normal." Many were brought up in orphanages and have lived on merchant ships and in army barracks for years. Many men regress quickly following the loss of the women in their lives.

All these are beginning points for me. I would welcome any ideas that others might like to share about their experiences with these kinds of clients.

Corinne Harrison-Gledhill, of London, England, is a Provisional Teaching Member in ITAA. Her background includes nursing and psychology.

KEEPING IN TOUCH

Nurses Note: a sub-committee of the Education Committee is collecting information about the use of TA by nurses in education. If you are interested and/or have information to share, contact Sharon Job, RN, MA at 1798 Barlow Lane, Boise, ID 83709.

The Statement of Ethics and the Procedures for Handling Ethics Complaints within the ITAA are available, upon request, from the ITAA office.

The sixth edition of **The Gestalt Directory,** a world-wide guide to therapists using the Gestalt approach, is now being prepared. Those interested in being included may obtain listing forms by writing The Gestalt Directory, PO Box 990, Highland, NY 12528.

Does your Script take a long time to arrive? If you send us the cost of airmail postage ($3.50 US/Canada/Mexico, $10 all others), we will send you a copy of the *Script* by air. Send to Robin Fryer, Managing Editor, c/o ITAA office.

Examinees Passed

Clinical and Special Fields Members - Passed April 13, 1983 in Raleigh, North Carolina and on April 27, 1983 in Caracas, Venezuela

Beverly Arredondo-Olivo, Ph.D., CM, Edo Miranda, Venezuela
Carmen M. De Iranzo, CM, Caracas, Venezuela
Cristina De Narvaez, SFM, Caracas, Venezuela
Amaya de Urresti, SFM, Caracas, Venezuela
Jacqueline M. Doubles, B.A., CM, Hartsville, South Carolina
Ken Knight, M.S.W., CM, Greensboro, North Carolina
Judy Michael, M.S.Ed., CM, Pittsburgh, Pennsylvania
Flor Giner-Rivas, SFM, Caracas, Venezuela
Timothy A. Schnabel, M.Ed., CM, Greensboro, North Carolina
John V. White, C.S.W., CM, Apex, North Carolina

The Education Network Meeting was, unfortunately, not listed in the 1983 Summer Conference Program booklet. It will be held on Friday, August 5, 1983 from 1-2pm and everyone who is interested in TA in Education is invited to attend.

Congratulations to **Robin Maslen,** Clinical Teaching Member, who recently completed a project begun some time ago to teach TA 101's in the capitol cities of all the Australian states. The project, which ended with a 101 given in the isolated, tropical city of Darwin, took Robin through Australia's seven states, which cover an area as big as the United States.

Jean Clarke is interested in finding someone to do Spanish and/or French translation for her trilingual workshop on Educational Model Exchange at the 1983 Summer Conference in Oakland. Emma Zuili, unfortunately, will not be able to attend the conference and act as co-presenter and translator. If you are interested in helping out, contact Jean I. Clarke at 16535 9th Ave., North, Plymouth, MN 55447 or leave a message for her at the conference on the message board.

The Spanish Transactional Analysis Association is holding its second conference on TA in Madrid, May 8-13, 1984. The theme of the conference is "Transactional Analysis: a Method to Help Everyone." For more information, contact the Asociacion Espanola de Analisis Transaccional, Apartado 8.222, Madrid-8, Spain.

1984 Winter Congress

January 23-28, 1984 Santo Domingo, Dominican Republic

"Strategies for Cooperative Change"

We are providing the following information at this time so that you can begin making plans to join us in Santo Domingo for the 1984 ITAA Winter Congress. Additional information about program content and hotel and conference registration forms will be published in later **Scripts,** *so watch for them!*

Pre-congress: January 23-24, 1984
Pre-congress rates include room only

Institutes	$50.00
Hotel Santo Domingo (single, per day)	70.00
Hotel Santo Domingo (double, per day)	35.00
Hotel Hispaniola (single, per day)	45.00
Hotel Hispaniola (double, per day)	22.50
Total Pre-congress:	

Congress: January 25-28, 1984
Congress package includes room and breakfast & lunch daily for four days, plus the welcome dinner, closing banquet and Congress parties.

Hotel Santo Domingo (single, Congress package)	$390.00
Hotel Santo Domingo (double, per person, Congress package)	270.00
Hotel Hispaniola (single, Congress package)	270.00
Hotel Hispaniola (double, per person, Congress package)	200.00

Congress Registration: January 25-28, 1984 ..... $135.00
Note: checks or drafts must be in US funds, drawn on a US bank.

MEMBERS FORUM

Program Committee Requests

Dear ITAA Members:

I want to share a few thoughts about planning conference programs and to make a request of you, the membership. First, it was a delight getting to read all the proposals sent in for the 1983 Summer Conference. We had a large number of them this year and many were of very high quality. It was also a pleasure to meet so many of you over the phone and by letter as we negotiated about which of several workshops you would do or what times would work, etc. ITAA certainly has some of the world's most engaging and interesting people as members.

My request is about honoring the proposal deadlines that have been set up. Forty per cent of the proposals we received this time came in after the deadline. And an additional number were called in after the deadline and given verbally. This makes it impossible for us to get the highly valued opinions of the committee of reviewers and leaves it to one or two people to make hasty decisions about which to select. And, the worst drawback is that this situation makes it very difficult or even impossible for your committee to select the most balanced program possible. Some of the balances we are looking for are in terms of content, level of expertise required by the audience, new versus established presenters, and new versus established material. This balancing act requires that we have all the material in front of us with reviewers' evaluations tallied, and some time to juggle them into the best quality program.

One further request. Please don't feel insulted if we contact you and say we'd like you to do something different from what you've proposed. It may be because of the theme we are trying to keep, or because your proposed topic is being covered by many people or has been covered by you in the recent past, or because we feel that you have expertise in an area not being sufficiently covered. It is all being done with the hope of giving you the best balanced and highest quality program.

I urge you to attend our 1983 Summer Conference in Oakland and enjoy the program we have enjoyed creating for you. Then you can give us feedback (evaluations are going to be taken quite seriously this year) so that we can improve our performance as program planners in the future.

Thanks for your cooperation and looking forward to seeing you in Oakland.

Brenda B. Bary, PhD
Program Proposal Sub-committee Chairperson

Member Services Clarified

Dear *Script:*

I should like the Board to explain the rationale behind keeping the membership fee as high as it is when a major service to the members, namely the maintenance and supervision of contracts has been discontinued, or in any case, has become a moot issue.

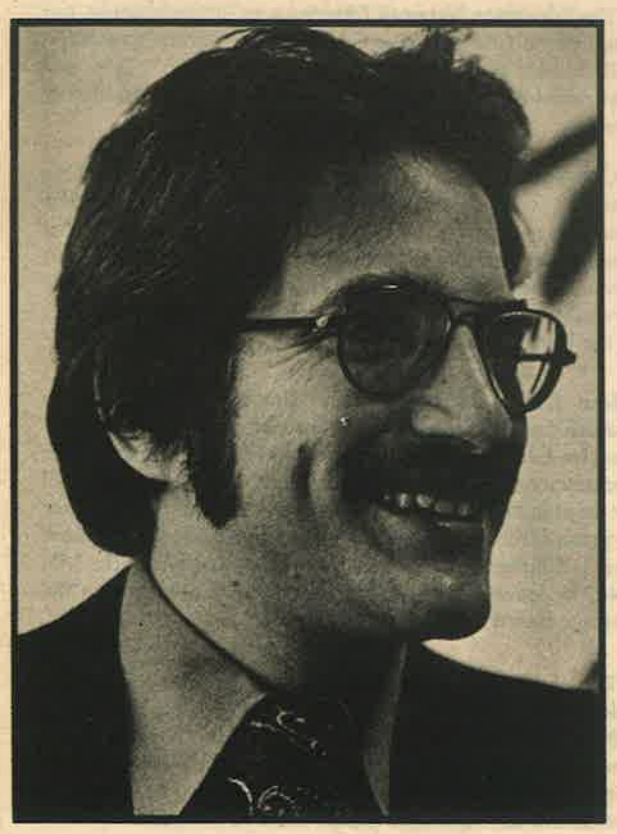
It would have seemed natural to me to budget for the transfer of existing members to the Board of Certification instead of requiring the members to pay an extra fee for something that also involves ITAA's status as a tax-exempt organization.

I am very pleased to belong to ITAA as a professional organization, but would like to have its fees reduced in keeping with its reduced services.

I also think that it would be a good idea to spell out, and soon, the nature of the remaining services of the organization, before I and many other members decide that a subscription to the *Journal* is the more appropriate choice.

Cordially,
Gabor von Varga, CPTM

Editor's Note: *in a special note on contracts in the June 1983* **Script,** *the Training Standards Committee explained that, while the Board of Certification, in its role as a certifying agency, does not require contracts, the ITAA will be continuing to require bilateral contracts between individual candidates-in-training and the ITAA. Membership services, other than contracts, remain the same. These include the* **Script** *newsletter, the* **TA Journal,** *the membership directory, reduced registration at Summer Conferences, eligibility to file a contract for Clinical or Special Fields training, reduced rental rates with Hertz and National Car Rental and, for US members, eligibility for group life insurance, a supplemental in-hospital plan and major medical health insurance.*



Smoking Cessation Program Utilizes TA

By Douglas Kabat, ACSW

Tobacco is the most widely used addictive substance in the world — and the most deadly.[1] Cigarette smoking is highly associated with heart disease, lung cancer, emphysema and other ills. Despite these well-known facts, people continue to smoke. Currently a third of all adult Americans smoke. Quitting is difficult, and many who quit return to smoking within a few weeks or months.[2]

In developing the "Learn To Breathe Free" smoking cessation program, I came across some particularly interesting facts about smoking.

— Nicotine is an extremely addictive substance. Physical addiction is rapidly established and withdrawal discomfort and craving can be quite intense after only a week of regular smoking.[3]

— Information on the dangers of smoking and the benefits of quitting seem to have little impact on cessation rates. Heavy (two packs or more daily) smokers are as equally well-informed regarding health and smoking as are former smokers.

— Behavioral and psychological strategies for quitting are usually only modestly effective. Most smokers will continue to smoke despite hypnosis, aversion, or more traditional support group approaches.[4] It seems that the Child is hard to reach on this subject.

— Psychological profiles of smokers, former smokers and non-smokers reveal few significant differences between the various groups. There is no "addictive personality" in terms of smokers.[5]

TA is an attractive theoretical system for helping people to quit smoking. Most smokers quickly recognize that Parent attitudes and Child feelings are central to successful cessation. When I began working with smokers, I thought TA concepts would be sufficient to help people quit. However, although my clients found Ego State Concepts and Stroke Theory (smokers puff an average of 400 times a day)

Rather than focus on quitting smoking as a unique problem, the emphasis is on life as a normal series of problem-solving encounters, of which this is one.

very helpful, they were often insufficient. I found it necessary to add a number of additional elements, particularly reframing, biofeedback, self-hypnosis, neurological theory and dietary change, so that my clients could succeed in freeing themselves of their nicotine addiction. All these additional elements fit well with TA and are designed to encourage, support and entice the Child.

The "Learn To Breathe Free" workshops begin by reframing the issue. Rather than focus on quitting smoking as a unique problem, the emphasis is on life as a normal series of problem-solving encounters, of which this is one. Quitting smoking is no more or less difficult that making other life changes. Leaving cigarettes behind is like leaving Mom and Dad behind — you lose the home cooking, but gain new freedom. When you quit smoking, you lose the pleasure of tobacco, but gain the pleasure of increased stamina and vitality. Participants are asked to frame the issue in personal, developmental terms, so that smoking, like thumb sucking, becomes a desire whose time is past.

Biofeedback is also helpful in this problem-solving process, not only in speaking to the Child, but in monitoring results. Use of a breath measurement device to report carbon monoxide blood levels provides participants with a graphic example of how smoking affects their blood oxygen level.[6] This personalizes the smoking issue by allowing the participant to see an immediate physiological effect of smoking on his/her body. The machine will commonly report levels of 20-30% carbon monoxide in the blood prior to quitting and 0-2% three days after quitting. Carbon monoxide measurement fascinates the Child and increases motivation.

Another useful tool is self-hypnosis. The Spiegels, in *Trance and Treatment*,[7] emphasize a self-parenting and reframing strategy that many clients find helpful. They suggest a three-part formula for use with self-hypnosis:

"1. For my body smoking is a poison.
2. I need my body to live.
3. I owe my body this respect and protection."[8]

I encourage clients to adapt this formula to fit their own needs as they develop a self-parenting thinking routine. They are instructed to practice, using self-hypnosis, these new messages at least 15-20 times a day. In this way, smoking becomes "inappropriate" to their Parental self-concept, and the issue is reframed from smoking to self-respect and self-protection.

In addition, I have found it useful to introduce my clients to a "key-hole" neurological theory of addictions. I believe that addictions form a "key-hole" in the human brain. The size and shape of the "key-hole" reflects the intensity of the addiction. Each time the addictive substance is introduced, it is as if a key were fitted into the "key-hole" in the brain. When the key fits, the addict feels satisfied and comforted.

The absence of the "key" for any sustained period leads to a feeling of emptiness, usually described as craving. Over time, the "key-hole" shrinks and craving declines, until finally the "key-hole" is just a faint neurological trace and craving is rarely or never experienced. However, if the addictive substance is reintroduced, the "key-hole" rapidly expands to its original size and the addictive pattern returns in full force. This explains the necessity of complete abstinence in successful cessation, and encourages clients in accepting the initial discomforts of a "shrinking key-hole;" i.e., withdrawal.

Diet can also play a significant role in smoking, since nicotine metabolism occurs more rapidly as blood acid levels increase. Certain foods, such as coffee and alcohol, increase blood acid levels, and are thus experienced as "natural" triggers for smoking.[9] Dietary manipulation in the early period of cessation often results in a much reduced smoking rate and a corresponding sense of client accomplishment. Adult information in this area also eliminates Child-Adult contaminations regarding "reasons" for smoking. Finally, the dietary approach emphasizes the physical basis of addiction and discourages over-psychologizing.

The "Learn To Breathe Free" program is 20 hours long, and is usually given over a six-week period. Participants quit after the tenth hour. The first half of the program is given in a marathon format, with a series of second-half, post-quit follow-up weekly sessions to support new client behaviors.

Common areas of difficulty in successful quitting are use of alcohol, severe withdrawal discomfort, and family system conflicts. Alcohol use is significantly associated with return to smoking since it weakens Parent and Adult functioning. Participants are cautioned to avoid drinking during the initial phase of cessation. Rates of alcoholism among smokers are unusually high, and use of a simple questionnaire, such as the Michigan Alcohol Screening Test, can screen out those who must stop drinking before they are likely to successfully quit smoking.[10]

Most smokers quickly recognize that Parent attitudes and Child feelings are central to successful cessation.

Serious withdrawal symptoms are common in 20-30% of all participants in smoking cessation programs. Such symptoms include headaches, muscle aches, dizzyness, nausea, anxiety, and extended craving. These symptoms do not appear related to psychological functioning and may continue for weeks or even months after quitting. Clients should be encouraged to increase their stroke supplies, exercise regularly and remind themselves that the symptoms do eventually disappear.

Family systems conflicts commonly appear when one spouse quits and another continues to smoke. Relationship diagrams and role playing are helpful in encouraging clients to deal effectively with the smoking spouse. This is integrated into "Learn To Breathe Free" by asking all clients to examine their strategies for dealing with smoking co-workers, friends and family members.

"Learn To Breathe Free" is an effective program. Seventy percent of participants quit and 40% remain abstinent at six-month follow-up. Most other programs report six-month abstinence rates of 25-35%.

Background note: the researcher on "Learn To Breathe Free" was Ronald Toseland, PhD, State University of New York at Albany, School of Social Welfare. The program was initially developed as "Breathe Free" with support from the American Lung Association of New York State. It is currently available, as a workshop and training program, from the author.

References

1. Jarvik, Murray E., Et. Al. *Research on Smoking Behavior* (NIDA Research Monograph 17). Washington, DC: US Government Printing Office, 1977.
2. Pechacek, Terry F. "Modification of Smoking Behavior," in *Smoking and Health: A Report of the Surgeon General*. Washington, DC: US Government Printing Office, 1979.
3. Krasnegor, Norman A., ed. *Cigarette Smoking as a Dependence Process* (NIDA Research Monograph 23). Washington, DC: US Government Printing Office, 1979.
4. Pechacek, op. cit.
5. Krasnegor, op. cit.
6. Fix, A. James, et. al., "Immediate Carbon Monoxide Estimates and Self Reported Smoking," *Perceptual and Motor Skills*, 1979, 49, pp. 675-678.
7. Spiegel, Herbert and Spiegel, David. *Trance and Treatment*. New York: Basic Books, 1978, pp. 210-219.
8. Ibid., p. 215
9. Schachter, Stanley. "Regular, Withdrawal and Nicotine Addiction," in Krasnegor, N.A. *Cigarette Smoking*, op. cit.
10. Krasnegor, op. cit.

Douglas Kabat, ACSW, is in Clinical Training in ITAA and currently works as co-director of Al-Care, an outpatient alcoholism clinic, in Albany, New York. He also has a private practice in Albany.

Love Addiction



By Brenda Schaeffer, MA

As a psychotherapist dealing with people's pain and its resolution, I quickly discovered that all clients are dealing with love issues and that they all have addictions.

As defined by Erich Fromm, love is "the expression of productiveness and implies care, respect, responsibility and knowledge; a striving towards growth and happiness of the loved person, rooted in one's own capacity to love." Words often associated with love are: affection, sharing, honesty, trust, valuing, attraction and bonding.

Stanton Peale, author of *Love and Addiction*, defines addiction as "an unstable state of being, marked by a compulsion to deny all that you are or have been in favor of some new and ecstatic experience. It's a malignant out-growth of normal human inclinations." Words associated with addiction are: excess, obsessive, destructive, compulsive, habitual and dependency.

Love addiction is a reliance on someone external to self *in an attempt* to get unmet needs fulfilled, avoid fear, solve problems and maintain balance. The psychological reasons for love addiction are unique to each client. Finding out how love addiction makes sense to the individual is the task of therapy.

Figure 1 Primary Symbiosis-Infancy

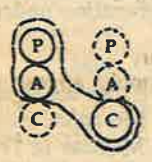


Figure 2: Autonomous Symbiosis-Adulthood



How Love Becomes Addictive

The seeds of love addiction lie in our biology, our social learning, our spiritual questing and our psychological beliefs.

Physiologically, we strive for balance or homeostasis. As infants, our needs were identified through physical sensations and we cried out to the external world to meet them. When the need was met, we felt comfort and balance. When the need was not met, the sensations escalated, leading to anxiety and even, eventually, panic. We have, in our nervous systems, the recollection of these fearful times. We often forget that, as adults, we are now able to meet those needs. Instead, we panic, clinging to another as though we were infants still.

Socially, we are encouraged to be in addictive relationships. Our culture models dependency and drama, evidenced in our music, television and literature. Over and over we hear, "I can't live without you." When we ask a client, "If your mother/father had your relationship problem, how might she/he solve it?", the resulting answers often show that the role models incorporated into the Adult ego state do not provide the necessary data for how to get out of addictive relationships.

Spiritually, we strive for higher experiences, altered states of consciousness and belonging. In a new relationship, there is a sense of euphoria and ecstacy. Love addiction is often a striving for this higher experience because we lack our own unique ways of achieving these states by ourselves. Obsessive, erotic love can be an attempt to fuse or bond with others to end the feelings of isolation created by our prohibitions against intimacy.

Psychologically, love addiction can result from unfulfilled dependency needs and a search to get them met. In healthy parenting, a Primary Symbiosis of dependency (Figure 1) is established. The parent provides adequate nourishment, protection and information assuring that the child will grow and develop into an independent, whole system that can relate autonomously, intimately, spontaneously and interdependently with others. (Figure 2)

Since no one gets everything they need in infancy at exactly the time they need it, the Secondary Symbiotic System (as described by Robert Phillips) develops in an attempt to assure growth and survival. I call this the Grandiose Addictive Dependency System. Within the Child ego state, the Natural Child knows it needs something, the Little Professor figures out "how to" get that thing, and the Parent in the Child carries out the plan of action that will "keep these people around to help me get my needs met so I won't die, get sick or go crazy."

Case Example

After playing happily outside for a while, four-year old Brent returned home for his periodic check-in with Mom to assure that his world was in order. When he walked in the door, he found his mother crying, holding his baby brother, who was also crying. Brent's world suddenly seemed threatened and he felt terror. "What have I done or not done?" he asked himself. Looking for comfort and reassurance, Brent asked, "What's wrong, Mommy? Is everything OK?" Brent's Mom said, "Oh, honey, I'm so glad you're here. Tell Mommy everything will be OK." Brent felt momentary confusion and then quickly acted on his Mom's suggestion. He patted her arm, smiled into her eyes and proudly said, "That's OK Mommy, everything will be alright. I just know it." Mother smiled and said, "You are my wonderful son. I don't know what I'd do without you." Brent's world was in order again.

The tragedy of this story is that Brent needed his Mom to be a big person who would take care of him. Like other children his age, he feared that if something happened to Mom and Dad, his world would not last. Brent felt scared and had a right to information and reassurance; he needed a primary symbiosis. However, instead of Mom taking care of Brent's Child, Brent took care of Mom's Child, stopping his scare in the process. The Grandiose Addictive System was established; "I'm in charge of making people feel good or bad and what I do, say, think or feel will keep them around or make them go away!"

Brent continued this pattern in other relationships. In love addiction, the dependency is Child to Child; the love is always egocentric and designed to meet needs, avoid pain and allow survival. (Figure 3) It was only when, in therapy, Brent was able to look at his unconscious Child fears from a new perspective that he was ready to establish healthy relationships.

Addictive Love Versus Healthy Belonging

In reality, most relationships have elements of addiction. A totally healthy interdependent relationship is an ideal toward which we strive. The important thing is to acknowledge the addictive elements in a relationship so that they can be changed and to build on the healthy aspects of the relationship. (Figure 4)

From Addiction to Love

In therapy, the challenge is to move from addictive love to belonging. The following are stages that I developed to describe what clients go through in the therapeutic process:

I. **Denial** — safe, predictable, closed system. Fear of intimacy and closeness masked by excitement and drama. Relationship often appears to be healthy or normal.

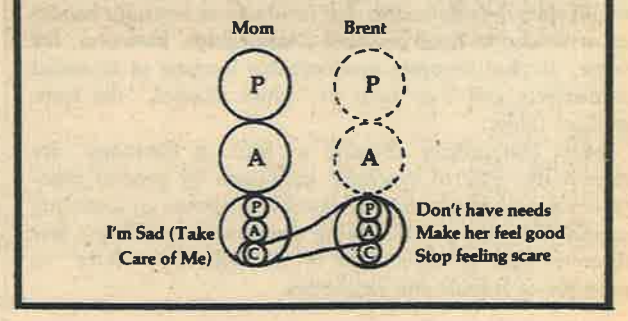
II. **Discomfort** — one or both parties have a sense of something missing. One person usually starts moving out physically or emotionally. May explore outside interests. Some boredom, awareness of repeated patterns.

III. **Confrontation** — relationship or self is confronted by one or both. Escalation of symptoms; scare masked by anger, emphasis on changing the other. May return to previous stages here or separate, divorce prematurely or seek counseling.

IV. **Psychological Separation** — individuals look inward to confront myths, illusions, self-promises that contributed to love addiction. Individual therapy indicated here. Healthy narcissism to discover sense of self and autonomy. Breaking of addictive dependency often results in lack of feelings for other, escalation of scare and resistance to change. May separate from OK position.

V. **Resolution of Self** — sense of healthy detachment and recognition "I am enough alone." Integration of changes, evaluate relationship from a new perspective and decide to continue or not continue. Experience mature aloneness versus borderline aloneness. Important not to stop at this stage or linger too long. The "I" stage.

Figure 3: Grandiose Addictive Dependency



VI. **Belonging** — individuals now have the capacity for developing new and mature love relationships. Focus is on the "We" in therapy. Capacity to experience the being of another. Reaching out, serving, valuing, autonomy, intimacy, spontaneous expression are characteristics of this stage.

VII. **Reaching Out** — move from focus on relationship and self to more universal giving and experiencing. Create or respond to situations that actualize personal uniqueness with support of healthy relationship. Extension of energy to the world in general.

It is important to keep in mind that there are three entities — the two individuals and the relationship — going through these stages, although not necessarily at the same time or in the same way. Movement may be progressive and regressive at the same time.

In summary, love addiction is a process. There is a way in and a way out. By differentiating between addiction and belonging, by having an understanding of the in and out processes, there can be greater acceptance of self and others and higher success ratios in treatment.

Brenda M. Schaeffer, MA, is an ITAA Clinical and Provisional Teaching Member in private practice in Duluth, Minnesota. She has also taught at the university level and consults with numerous mental health agencies, businesses and institutions. As a referral source for people who complete chemical dependency treatment, she has learned about the addictive personality and co-dependency.

Figure 4

Addictive Love	Healthy Belonging
1. Often all-consuming	1. Allows for individuality
2. Boundary problems (other takes over ego)	2. Oneness and separateness experienced
3. Sado-masochistic	3. Values and respects self and other
4. Fear of letting go	4. Accepting of endings
5. Fear of risk, change, unknown	5. Open to change and exploration
6. Stagnation	6. Invites growth
7. Lack of intimacy	7. High level of intimacy
8. Drama to get needs met	8. Freedom to ask and receive directly
9. Giving is to get (ego-centric)	9. Giving and receiving experienced as the same
10. Attempt to change other	10. Accepting of self and others
11. Need other to feel complete	11. Self-sufficient
12. Seeks solutions outside self	12. Accepting of personal reality and limitations
13. Demands and expects unconditional love	13. No longer seeks unconditional love
14. Often is anti-dependent and refuses commitment	14. Interdependent and accepting of commitment
15. Looks to others for affirmation and worth	15. Sense of self-esteem and well-being
16. Fears abandonment upon routine separation	16. Trusts memory of loved one and enjoys aloneness
17. Repetitous feelings-emptiness, rage, guilt, etc.	17. Spontaneous expression of feelings
18. Wants and fears closeness	18. Welcomes need to belong; risks vulnerability
19. Takes care of others feelings	19. Caring detachment

TA and Drug Addiction

By Lothar Sattler, MD

Years ago, Aldous Huxley prophesied in *Brave New World* that, in the future, everyone fifty and older would be given SOMA, a drug that makes you forget that life will soon be over and that, so far, it has been pretty shitty. Today, at least in large cities like Berlin where I live, psychotropic drugs seem to be the only way out of oppression, aggression and meaninglessness for as much as 60% of the adult population.

When idealistic dreams and visions of a world of warmth, love and justice turn out to be cheap lies to deceive the uninitiated and the hopeful, the young often turn to LSD and heroin. The middle-aged primarily use alcohol to alleviate the depression that results from constant hassles at work and in their personal relationships. However, for some, alcohol becomes unacceptable because of its social side-effects and they turn to "white alcohol," the tranquilizer tablet.

Most tranquilizer abusers, at least in Germany, are shown the way to synthetic happiness by general practitioners and internists who lavishly dispense an unending supply from the profit-making drug industry. Only a few discover pills on their own or through the "advice" or example of friends and neighbors.



In this Brave New World of 1984, citizens are granted the right to die the slow, soothing death of the tranquilized for lack of a better, more humane right to life.

It is only after years of such abuse and the cerebral seizures, delirium, dementia, and/or staggering gait that goes along with it, that patients may see a psychiatrist for withdrawal. However, withdrawal is a sidetrack where only a minority of drug abusers are stopped. The majority go through with a "rationed suicide," one that does not require the conscious fatal decision. In this Brave New World of 1984, citizens are granted the right to die the slow, soothing death of the tranquilized for lack of a better, more humane right to life.

I do not believe all these volunteers for early death are moved by a mysterious drive, Thanatos, which starts soon after birth and often overpowers them in their youth. I think the tremendous anxiety engendered by a totally chaotic and alienated human society is at the root of Thanatos, the ubiquitous existential conflict (as taught by Berne) that is closely reflected in the social reality of present, past and future times.

Injunctions like "Don't Be," "Don't Be Close," and "Do Not Expect Anything for You Since There Will Never Be Enough for Everybody," apparently are passed on from generation to generation. We need to be careful not to listen to make-believers who blame parents, parents who themselves had to go through the same hell of annihilating existential anxiety.

Psychotherapy, in my eyes, is humanistic and humane only if it goes beyond the individual "Oedipal" conflict and brings into consciousness the existential conflict that accompanies power-manipulated humanity from the moment of conception.

Transactional Analysis offers a means for making transparent the games power plays and to undercut them. It offers warmth and empathic understanding to those for whom all hope is not yet gone and it does not deny moral values. It thus allows people to get out of the obsessions that drive them into abuse and addiction. We have to accept an imperfect world striving for perfection. We should not accept addiction, suicide and aggression as the only ways out of it.

Treating tablet addicts means decathecting their confused, desolate Child and shifting cathexis to their Adult and Parent. These people are often blatantly devoid of healthy alternatives, and moral values scarcely carry any meaning for them. When cathecting their Natural Child, be aware that, at least with some of them, it is very spoiled.

The results of using TA with drug addicts are very encouraging, both in my experience and the experience of the Berlin Jewish Hospital where I was an affiliate for more than ten years. Deplorably, Berlin Health authorities have a rather suppressing and intolerant attitude towards TA, thus depriving the most needy of dearly required help.

Lothar Sattler, MD, graduated from Berlin University in 1950 and was promoted to Dr. med. in 1951. After some years in surgery, internal medicine, opthamology and other specialties, he did residencies in neurology and psychiatry, leading to Board recognition in 1969. In 1964, he received a Masters in Public Health. He worked in forensic psychiatry until 1982, and is now retired from Civil Service and maintains a private practice. He was affiliated with the Department of Psychosomatic Diseases (alcohol and tablet addicts) from 1970-1981.

Connector Room Schedule 1983 Summer Conference

Monday 1-5pm: open House with Lee Larson
Monday 5-7pm: discussion over wine and cheese with Lee Larson on "Going Back to College to Become a Therapist after Age 45 and Two Decades in the Business World."
Monday 8-Midnight: Al Loeb and all musicians, guitars, singers, instruments of any kind; music lovers and tone deaf people invited.
Tuesday 8-Noon: Lee Larson
Tuesday 2-5pm: Neville Armstrong, "Helpful and Interesting Information about the San Francisco Area."
Tuesday 8pm-Midnight: learn Western dances and other dances with Marcia Rosen
Wednesday 7-8pm: party for new ITAA members (last three years) and first time conference attendees.
Friday 8pm-Midnight: joke night with Alan Jacobs and Abe Wagner (with wall to wall people - this was the high of Snowmass!)

Liz Rutter has graciously volunteered to supply the Connector Room with food, drink and all the other important necessities and luxuries. Thanks, Liz!

We still need more volunteers to lead discussions, play music, or just meet people. It's a fun thing to do! Call or write Barbara Horn at the ITAA office or Natalie Garber, 520 Amherst Rd., Belchertown, MA 01007; phone 413-256-0549, and let us know your time preference. We'll be connecting again soon!

Board of Certification "Grandfathering"

Advanced Members and former Advanced Members who have been certified by the I.T.A.A. will be certified by the Board of Certification without examination under the following conditions:

1. They apply by letter by January 31, 1984.
2. They remit the $25 application fee if they are an active Advanced Member of ITAA or a $50 application fee if they are an inactive Advanced Member of ITAA.
3. They sign a statement that they have not been found at fault in an ethical procedure and have not been found guilty in a criminal proceeding. Exceptions in the above are possible following a review of the relevant details by the BOC.

If they do not apply by the January 31, 1984 deadline and subsequently do want to be certified by the BOC, they will have to take the examination.

Attention Future Examinees

All exam candidates should wait four to six months between taking the written exam and applying for the oral exam. This is to allow the written exam to be graded and the examinee to receive the results.

CALENDAR

August 3-6, 1983 ITAA Summer Conference, Oakland, California
January 23-28, 1984 ITAA Winter Congress, Santo Domingo, Dominican Republic
June 24-July 1, 1984 ITAA Summer Conference, Villars, Switzerland

	Exam Date	Location	Application Deadline
CM/SFM Oral Exams	July 3, 1983 August 3, 1983 November 13, 1983	Rome, Italy Oakland, California Paris, France	April 4, 1983 May 3, 1983 August 15, 1983
TM Oral Exam	August 3, 1983	Oakland, California	May 3, 1983
Written Exam	July 7 & 8, 1983 November 11 & 12, 1983	Location to be announced Location to be announced	April 15, 1983 August 15, 1983

All fees are due by the application deadline. All exam fees are non-refundable, but will be kept as credit in your account (minus $10 fee) if at least 30 days written notice is given for cancellations. Otherwise, fee is forfeited. Fees: Written Exam — $90 US/Canada; $15 all others. Orals application — $75, non-transferable. Oral exam — $50. Contract filing fee — $30.



Ericksonian approaches to psychotherapy

Advanced Clinical Application Intensive Workshop

This five-day advanced training workshop highlights the logic and principles behind Dr. Erickson's approach to diagnosis and treatment of individuals, and families. Stephen and Carol teeach the diagnostic format they use in their Ericksonian work. They discuss, demonstrate and teach Erickson's use of resistance, confusion, conscious/unconscious dissociation, symptom prescription, paradoxical double binds and strategic interventions using complex embedded metaphors, hypnosis and the strategic use of trance phenomena. Workshop eligibility: Masters or Doctorate degree in the helping professions.

by Stephen Lankton, M.S.W., and Carol Lankton, M.A.
authors of *The Answer Within: A Clinical Framework of Ericksonian Hypnotherapy, Brunner/Mazel Publishers, 1983.*

CE credits from University of West Florida are available for psychologists and clinical social workers.

SEPTEMBER 26 - 30, 1983
PENSACOLA BEACH FLORIDA
tuition: $325 (includes lunches)
For information write:

CAROL LANKTON, M.A.
P.O. BOX 958 • GULF BREEZE, FL 32561
904-932-6819

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WESTERN INSTITUTE FOR GROUP & FAMILY THERAPY
SKYLINE SEMINARS BRANCH
BOX 350 STAR ROUTE 2
LA HONDA, CALIFORNIA 94020
(415) 851-4175
FROM OUTSIDE OF THE U.S. (415) 851-8569

WE HAVE RETURNED TO SKYLINE

For the past two years we have been living in Palo Alto, and doing most of our workshops and training away, primarily in Europe. We have now returned to Skyline, our beautiful home overlooking San Francisco Bay, and will begin doing workshops and training here again, as well as in our new Woodside offices, starting in August.

Wednesday Morning Training Program in individual and group psychotherapy. Meeting aproximately three Wednesday mornings a month for eighteen sessions begining November 2, 1983, and ending in May, 1984. A marathon training weekend is included. $875.* Deposit with application: $125.

Monthly Training Program in Psychotherapy. Meeting one Saturday a month for eight months, begining October 1, 1983, and ending in May, 1984. One session will be a two day marathon training program. $875.* Deposit with application: $125.

Weekend Training Workshops. Several workshops covering topics such as Gestalt Therapy, Child Development, Treatment of the Suicidal Client, and Dreamwork, will be held throughout the year. These workshops will be three-days, or four days. the topic. Some are residential and include room and board. Others are not. The first workshop is August 12 and 14, 1983 on TA and Gestalt therapy. *$175. Deposit with application: $50. The second will be in September. Please write or call for more information.

*Application must be made 30 days before the workshop, accompanyed by required deposit. There is a 20% reduction in fee for programs paid in full 30 days before the date of a workshop. Deposits are refundable until 30 days before the start of a workshop.
Please write or call for an announcement showing time, cost, and location of all workshops and training programs.

SKYLINE SEMINARS
George Thomson, Ph. D., CTM, Director
- A BRANCH OF THE WESTERN INSTITUTE FOR GROUP AND FAMILY THERAPY-

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(213) 473-4463

TOM WILSON, M.D., C.P.T.M.
I am a psychiatrist certified by the American Board of Psychiatry and Neurology. I am currently an Assistant Professor at USC and have lectured and taught courses for USC, UCLA and the Los Angeles Group Psychotherapy Society. I am President of the Medical Staff at the Westwood Hospital in West Los Angeles.

Co-Director ROBIN HEIBER, M.A., L.C.S.W., R.M.
I am a Licensed Clinical Social Worker and a Regular Member of ITAA. I have had experience treating individuals and families as well as working with groups. I have assisted with workshops for the Los Angeles Group Psychotherapy Society and UCLA Medical Center.

The West Los Angeles Group Therapy Institute has been in operation since October 1974. Our focus is on training professionals to work with psychosis, especially schizophrenia, and other severe emotional disorders. The faculty works as a team and has been trained in reparenting and regressive techniques. Facilities of a widely known private psychiatric hospital are available for the purposes of training. The West Los Angeles Group Therapy Institute training program includes 101 courses and training towards ITAA CM membership. We also individualize programs for out-of-town trainees interested in psychosis and wishing to spend three days or more in intensive training with us. If you are interested, contact us at the above address.

Self-Esteem: A Family Affair Facilitator Training Workshops.

...Workshops for people who want to learn how to facilitate the ***Self-Esteem: A Family Affair*** parenting model, or how to improve group leadership skills for working with any growth or education groups.



Minneapolis, Minnesota: July 11-15, 1983
-led by Jean Illsley Clarke
Seattle, Washington: August 22-26, 1983
-sponsored by Parent Education Association. led by Jean Illsley Clarke
Cincinnati, Ohio: August 22-26, 1983
-sponsored by A Growing Place. led by Gail Nordeman
Minneapolis, Minnesota: February 13-17, 1984 *-led by Jean Illsley Clarke*

For course credit options and other information, call or write to: Jean Illsley Clarke, 16535 9th Avenue North, Plymouth, MN 55447: (612) 473-1840.

COUNSELING AIDS OR HANDOUTS
by Diane V. Henderson, M.S.W.

"Coping With Grief: A Self Help Booklet"
This booklet incorporates understanding and practical suggestions in a gentle and supportive manner. Topics covered are: stages of grief; grief as a healing process; dealing with depression; handling anger; guilt feelings; reaching acceptance; inner strength.

"Making Stepparenting Easier"
Effective communication, self esteem, myths, unresolved feelings, resistence to change, and developmental stages are covered in this booklet to help families understand the dynamics involved in the blending process. "I have found both booklets to be helpful to me and my clients," **Nancy T. Edwards, M.S.W.** "Well written, clearly conceptualized, and helpful," **Doe Ferrell, M.S.W.**

Cost is $2.25 each. Bulk rates available upon request.
Booklets — B
1308 Gardencrest Circle
Raleigh, NC 27609

Proposal Instructions

Workshops and panels will be 2 or 3 hours in duration; paper presentations will be 50 minutes. If you wish to make a presentation that is longer than 3 hours, or is in two parts on two days, please indicate your preference and the committee will consider all requests.

Presentations in any language are welcomed and encouraged. If you are submitting a proposal for a presentation in a language other than English, please submit abstracts both in English and in the language of the presentation.

A program proposal includes the following items:

1. The **completed identification form** — if making more than one proposal, a separate form is required for each proposal.
2. A **300-word abstract** of the presentation to be reviewed by the committee — please do not include your name in this abstract.
3. A **100-word abstract** of the presentation — to be printed in the program book.

If any of these three items is not included, your proposal will be returned to you by the review committee. All proposals are reviewed in a blind review process.

Come Join Us In Switzerland!

Dear Colleagues:

During the last year, a joint ITAA-EATA committee has already been hard at work preparing for the 1984 Summer Conference in Villars, Switzerland. This conference will be special, not only because of the beauty of the Club Mediterrannee in Villars, but also because it commemorates the tenth anniversary of TA in Europe.

The Program Committee wants to personally invite you to participate in this conference. I encourage each of you to review what new frontiers of therapy and theory you are developing, any perspective about TA development in the last ten years that you might have, and/or any established theory you have not yet shared with the professional community either in the United States or abroad, and then to submit a proposal for a presentation you would like to make in Villars.

If you have not attended an EATA-sponsored convention, you have missed a real treat. My experience of them is one of superb organization, extremely high energy, a warm reception to all participants, and a family-like atmosphere that augments the professional quality of meetings and presentations. I look forward to renewing international friendships and meeting more international friends. I also hope a large contingent of non-European members from ITAA will attend. I invite you to be among us.

Future issues of the *Script* will continue advertising the dates, fees and other pertinent information about the Villars conference. However, **this is the last time the call for proposals will be published and the deadline is October 1, 1983.** So, don't delay! If you have further questions, contact the ITAA office or EATA representatives.

I look forward to sharing with you in Villars.

Warmly,
Laura W. Boyd, PhD
Chairperson, Joint Planning Committee
Summer Conference 1984

Conference Registration

I would like to register now to promote the success of the ITAA-EATA Conference. Therefore, I am sending in this early payment to reserve my place at Villars, Switzerland. I understand that this entitles me to low rates which are guaranteed only through December 31, 1983. Please find my check enclosed. Single fee includes conference registration and room and board (double occupancy).

_____ $400 until December 31, 1983 (Guaranteed)

_____ $425 after January 1, 1984 (Subject to exchange rates)

Please print or type:

_____
Name

_____
Address Phone

Special Note: those living in Europe should send their registrations and fees to Jenni Hine, Chemin de Neyruaz, 1297 Founex, Vaud, Switzerland; all others send registrations and fees to ITAA, 1772 Vallejo St., San Francisco, CA 94123.

Call for Proposals

ITAA-EATA 1984 Summer Conference

Villars, Switzerland

June 24-July 1 at the Club Mediterrannee

Transactional Analysis: Origins and Development

Deadline: proposals must be received by October 1, 1983. Please print or type.

Non-European members of ITAA may submit conference presentation proposals to the Program Committee Summer Conference 1984, 1772 Vallejo St., San Francisco, CA 94123. European ITAA members or EATA members may submit proposals to the 1984 Summer Conference program Committee, c/o Eleanor Fawaz-Kamber, President of the Swiss Association for TA, La Rochette Case PO 39, 1462 Yvonand, Switzerland.

Identification Form

_____
Name (as you want it to appear on program) Highest Academic Degree Attained

_____
Address

_____
Phone Category of ITAA Membership

_____
Organizational Affiliation (for program)

I want to present a (check one or more): _____ paper _____ panel _____ workshop _____ film

entitled: _____

Room Specifications, if any, required for your presentation (size, soundproofing, floor covering, etc.): _____

_____

Papers are 50 mins. If workshop or panel, I prefer ____ 2 hrs. ____ 3 hrs.

Circle any or all appropriate categories: theory, treatment, relationships, education, business/OD, religion, social issues, training, research, youth program, family program, non-English (specify which language) _____

Number of Participants: limited to _____ unlimited _____

This presentation is for TA (circle one): beginners advanced highly skilled

Co-presenters (if any, give names, addresses and highest academic degree attained). **YOU ARE RESPONSIBLE FOR CONTACTING CO-PRESENTERS AND INSURING THEIR ATTENDANCE OR REPLACEMENT.**

_____

_____

On two separate sheets, enclose a 300-word abstract describing your presentation for review by the selection committee, and a 100-word abstract which will be printed in the program book, if accepted.

I understand that, if this proposal is accepted, I am committing myself to participation in the 1984 Summer Conference and that a cancellation on my part is a discount of the Program Committee and to those who register to attend my presentation.

Signature _____

For Regular Members and Non-Members Submitting Proposals

(except those who presented at the 1982 or 1983 Summer Conferences)

The following statement must be completed and signed by an Advanced Member and returned with your program proposal.

Name of Submitter _____

Name and Membership Status of Endorser _____

I have known the above-named submitter since (year) _____. I have read his/her proposal for the 1984 Summer Conference, and I believe he/she is capable of conducting the workshop as described and providing adequate protection for participants.

Signature of Advanced Member _____ Date _____