RITES OF PASSAGE

SUBSTANCE DEPENDENCE AND THE NEGOTIATION OF DEVELOPMENTAL TASKS

A CASE STUDY

Catharina Roux

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ABSTRACT

This thesis is an attempt to provide an understanding of drug addiction in its relation to the tasks and arrests which take place during the developmental process. Current theories of drug addiction are situated within the parameters of developmental theory; Object Relations Theory, Lacanian Structuralism and Freud's concept of the Oedipus Complex are drawn on. The dual regressive and progressive function of drugs as it relates to developmental tasks and arrests is illustrated, the argument being that a very specific relationship exists between the compulsive use of drugs and the developmental tasks which need to be avoided as well as those which need to be negotiated.

The case study research method is made use of in the attempt to illustrate the links between drug addiction and specific developmental tasks. I present an in-depth analysis of the developmental history of Rafiq Jaffer, an inpatient at the drug unit at Lentegeur Psychiatric Hospital, drawing on the material which was collected during nine months of individual therapy.

As Borderline Personality Disorder is the primary diagnosis in the case of Rafiq Jaffer, the emphasis is by necessity put on borderline pathology. The primary aim of the thesis is, however, to highlight the need to understand the compulsive use of drugs within the context of the developmental process, thereby developing a conceptualisation against which further cases may be tested.

TABLE OF CONTENTS

CHAPTER 1

AIMS AND RATIONALE

The aim of this study is to come closer to an understanding of the psychodynamic structure which constitutes the compulsive use of drugs. In the course of nine months of therapy with a twenty-six year old compulsive drug user who has been diagnosed borderline personality disorder, I came to understand his addiction within the context of the tasks and arrests which take place during the developmental process. This case study is an attempt to formalise the unstructured process of therapy into a coherent theory of drug addiction as it applies to this specific case. The aim is to develop a conceptualisation to open up the essential qualities of a specific case, but I hope to show that the assumptions and principles derived from this case are also valid in other cases concerning drug addiction. That is, although the emphasis in this case is on borderline pathology, I believe that the categories and constructs employed to illustrate the importance of developmental theory in the understanding of drug addiction apply to the compulsive use of drugs in general.

Addiction literature is at present in a conflicting and controversial state of affairs. There is little agreement as to the etiology of addiction and even less consensus as to the course of proper treatment. Psychoanalytic theories of drug abuse have developed from a rather limited perspective which focused almost exclusively on the euphoric, regressive aspects of drug use to the belief that drug addiction is ego defensive and may well be progressive. Even the latter theories, however, fail to provide an understanding of the dynamic interaction between the developing ego of the child and the pathologic family structure which would eventually give rise to the compulsive use of drugs. The analysis of the psychodynamics of drug addiction on the whole takes place outside the parameters of developmental theory.

The aim of this case study is to provide an understanding of drug addiction within the framework of developmental theory. I draw on Object Relations Theory, Lacanian Structuralism and Freud's concept of the Oedipus Complex in order to contextualise theories of drug addiction within the parameters of the tasks and arrests which occur during the developmental process. The aim of this is two fold: 1) to illustrate a very specific connection between the developmental tasks that the compulsive drug user is unable to negotiate and his/her addiction, and 2) to illustrate that drug addiction serves both a regressive and progressive function and that the dual function can only be separated at the cost of negating the specific developmental tasks that need to be mastered.

The emphasis in this case study is not on the process of therapy but on the psychodynamic structure of drug addiction as it was revealed during therapy. As the hypotheses employed in the case study are based on the material gained from therapy, I furnish detailed process notes on the nine months of therapy which took place at Lentegeur Psychiatric Hospital where Rafiq Jaffer* was an inpatient at the drug unit (see appendix 2). Little, if any emphasis is however put on the therapeutic relationship and the process of therapy itself. The scope of the study is limited to the attempt to develop an understanding of the psychodynamic structure of drug addiction within the parameters of developmental theory as it was revealed during the therapeutic process.

* Since the study is based on confidential material, every effort has been made to keep the identity of the patient anonymous.

CHAPTER 2

METHODOLOGY

2.1 The Case Study Method

Freud's development of psychoanalytic theory took place in conjunction with the detailed description and discussion of case material. He thereby paved the way for later generations of psychotherapists to develop the theory and practice of psychotherapy on the basis of the case study method. As Edwards however points out, the steps whereby theory is developed in dialogue with case material, have largely been implicit (Edwards, 1989). This has given rise to serious reservations concerning the case study method, which are succinctly expressed by Janis (1958). He observes:

> An obvious weakness of the single case study - is that it can provide no indication as to whether the relationship applies to all other, many other, a few other, or no other human beings. Thus, even when a casual sequence is repeatedly found in a given person, the investigator cannot be sure that his findings can be generalised to any broad class of persons because the relationship may occur only in unspecifiable, restricted class of persons sharing a unique constellation of complex predispositional attributes (in Wallerstein, 1971).

Wallerstein (1971) further points out that the basic observations made and theoretical conclusions reached during the therapeutic process, are not available to independent concurrent observers. As Kvale (1986) points out, interpretation is thus not an objective matter, but rather arbitrary as it is open to multiple meanings. Kvale further observes that observations are not objectively reproducible, a point which is elaborated on by Bromley (1986) who observes that in the non-experimental method conclusions,

solutions, decisions and recommendations are arrived at on the basis of rational argument about the relevant evidence. The danger in this method is that facts may be badly constructed and misinterpreted. However, as Bolgar (1965) points out in her discussion of case study method:

> It is pretty generally accepted that experimentation is mainly concerned with proof and rarely leads to discovery, and that in the rigid attention to hypothesis testing the researcher often overlooks unexpected outcomes which might be discoveries. On the other hand ... the case study method is the ideal way to generate hunches, hypotheses and important discoveries (in Edwards, 1989:3)

The advantage of the case study seems to lie in this potential to "generate hunches, hypotheses and important discoveries". Giorgi (1985) calls the descriptive science, on which the case study method is based the "cornerstone of the process of discovery" (Edwards, 1989:3) and asserts that without this process the machinery of verification is meaningless. Edwards, in support of this claim, observes that the case study researcher needs to develop a conceptualisation aimed at "opening up the essential qualities" (ibid:4) of the case being investigated. Although the case study is, compared to the experiment, a relatively ineffective method when used for the specific purpose of testing general causal relationships, this method may be the most effective if the purpose is to describe the experience of a single person, to develop interpretations or explanations of that experience, or to develop courses of action appropriate for this person (Laskov 1987). Bromley moreover observes that the case study method offers a more comprehensive form of understanding than other methods of inquiry and that it can reveal social structures and processes. He maintains that contextual elements are revealed by the case study which are not revealed by the more closely controlled studies. This observation is supported by Kazdin (1981) in his assertion that the

case study method occupies an important role in clinical work in that it serves to develop hypotheses about clinical problems and explore treatment methods. The particular strength of the case study method, which lies in its capacity to generate discoveries and explore hypotheses, is further commented on by Bromley. He observes that the aim of the case study is not to find correct or 'true' interpretations of the facts; it rather strives to eliminate erroneous conclusions in order to explore the best possible interpretations.

Edwards formulates a continuum from description to theory testing which can be employed to locate any individual case study. He observes that the context at the descriptive pole consists largely of discovery, while verification constitutes the theory-testing pole. He distinguishes four points on this continuum although individual studies may have aspects of more than one category. The four points are:

a) Exploratory-descriptive case study

The emphasis in this type of case study is on an articulated description of an individual case. The aim is the exploration of an aspect or area in psychology about which little is known. Little emphasis is put on interpretation, as the objective of the case study is to furnish readers with an in-depth understanding of the circumstances which constitute a specific person's life.

b) Descriptive-dialogic case study

In this type of case study a theoretical framework is employed in order to adequately articulate and make sense of the description. Hypotheses may be formulated for testing in later studies, and an attempt may be made to informally test the content and adequacy of the conceptualisation in existing theories.

c) Theoretical-heuristic case study

This type of case study is concerned with the development and

testing of existing theory. Since the aim of the study is to test specific principles, generalisations or hypotheses, cases are selected on the basis of their suitability to specific theoretical principles.

d) Crucial or test case-study

A case is carefully chosen in order to test a particular theoretical proposition which is well developed and operationalised (Edwards, 1989:8).

Laskov (1986) suggests that the case study should leave the reader with the following:

a) Insight into the person, making the meaningless comprehensible

b) A feel for the person, conveying the experience of having met him/her

c) An understanding of the inner or subjective world of the person

d) A deepening of our sympathy or empathy for the subject

e) A portrayal of the social and historical world of the subject

f) The illumination of causes and meaning of relevant events, experiences and conditions.

In conclusion Wallerstein, in support of the case study research method, points out that shareability and agreement are the crucial test of reality. The essence of objectivity is achieved in the perception and comparison of one's own and other's awareness.

2.2 Reasons for Using the Case Study Method in this Case

The aim of this study is to provide an understanding of the pathological interactions which constitute the family dynamics of the compulsive drug user. Emphasis is put on the interactions and the conflicting demands and expectations which take place in the

family of the prospective drug addict in order to gain an understanding of the psychodynamic structure of drug addiction. The length and intensity of the therapy with Rafiq Jaffer, as well as the nature of the information on family dynamics which emerged during therapy, made an explication of these dynamics possible.

The case study method is considered appropriate with the above material. In terms of Edwards' continuum from description to theory testing, this case study can be located as having aspects of both the exploratory-descriptive and the descriptive-dialogic case study. The aim is to help readers to understand the subjective world of the compulsive drug user and to provide insight into what often seems like the meaningless destruction of the self. A second, equally important aim is, however, the search for a framework to make sense of the description, and the formulation of hypotheses for testing in studies concerning drug addiction.

2.3 The Procedure Involved in Using this Case

I present an in-depth analysis of the psychodynamic structure of drug addiction. The analysis is contextualised within the parameters of developmental theory and is based on the developmental history of Rafiq Jaffer as it emerged during nine months of therapy. Stress is put on the developmental tasks and the difficulties caused by the arrests of these tasks. The aim is to provide an understanding of the function of drugs in the arrested developmental process. The discussion dialogues the description of the specific developmental history with a criticism of addiction literature within the context of developmental theory.

The psychodynamics of drug addiction when borderline pathology is present, is presented in three separate but related sections which are based on the three main themes which emerged during therapy. They are:

1) The symbiotic, ambivalent relationship with the mother

2) The absent father

3) The sense of self.

The function of drugs, as articulated by the patient, is throughout related to these three main themes.

The emerging themes and subsequent dynamic understanding of the function of drug addiction in the arrested developmental sequence are used to illustrate the importance of understanding drug addiction within the framework of developmental theory.

The intention has been to adhere to the guidelines described for the case study research method, particularly in terms of the following:

a) Using as full process notes as possible which are included in Appendix 2.

b) In addition to the process notes, other information is used, including feedback from the drug unit and psychological testing. Relevant material is included in Appendix 1 and 3.

2.4 Ethical Considerations

On admission to the drug unit the patient signed release forms, which permit the professionals involved in the case to discuss the material arising from assessments and therapy, and to utilize it in clinical settings and research, with due consideration for preserving the anonymity of the patient and his family.

CHAPTER 3

ADDICTION LITERATURE

At present addiction literature is in a conflicting and controversial state of affairs. There is little agreement as to the etiology of addiction and even less consensus as to the course of proper treatment. Early psychoanalytic formulations emphasised the regressive and pleasurable function of drugs, whereas more recent psychoanalytic theories stress the interaction between the individual's ego-psychological organisation, including drives and affects, and addictive drugs.

3.1 The Regressive Function and Satisfaction Producing Effects of Drugs

In the first attempts to formulate a psychodynamic understanding of drug addiction the role of libidinal factors took central place. Abraham (in Lowinson, J.H.and Ruiz, P.M (eds), 1981) observed that alcohol and morphine have a special effect on repression in that both overcome sexual inhibition. Wesson and Smith (ibid) noted that intoxication with sedative-hypnotics is qualitatively similar to intoxication with alcohol. Like alcohol intoxication, the effects may vary from time to time, even with the same individual, depending on the set and setting. Generally the desired effect of intoxication is " disinhibition euphoria" (p.188) in which mood is elevated, self-criticism, anxiety and guilt are reduced, and energy and self-confidence are increased.However, the emphasis on libido obscured the different effects that various substances produced. This oversight slowed down the process of understanding the function of drug addiction considerably. Rado (1933) stressed the pleasurable aspects of taking drugs as the main reason for addiction, and maintained that the quest to experience euphoria eventually overrides all other considerations. He believed that it was the desire to use the drug that was of importance, the

substance used was irrelevant to this understanding.

Wikler and Rasor (ibid:467) observed a relationship between aggression and the use of narcotics but failed to explore this relationship in any depth.This failure is probably once again due to the minimisation of the differences between drugs such as alcohol, morphine and cocaine, as well as the emphasis, in the Rado tradition, on the pleasure-and-satisfaction-producing effects of narcotics. They went a step further than Rado though and argued that neurotics and psychopaths use narcotics differentially; narcotics have the function of relieving anxiety for neurotics, whereas psychopaths crave the euphoria associated with narcotics. However, as pointed out by Khantzian and Shaffer, the clinical evidence offered to support this distinction is not convincing (ibid:467). Wilker and Rasor also made the observation that narcotics stabilise behaviour in as far as they reduce the anxieties associated with aggressive and sexual impulses and behaviour, but failed to develop this conclusion into a theory that explained adequately how an individual's damaged ego-organisation interacts with addictive drugs.

The notion that relief of tension and distress may be a motive for taking narcotics was taken further in the formulations of Fenichel, Savit (ibid) and Wieder and Kaplan (Wieder et al, 1969). However, Wieder, Kaplan and Savit all associated the distress that the addict seeks to alleviate, with addiction and viewed the compulsive taking of drugs as a means of inducing a pleasurable regressive state that would minimise the psychic pain caused by addiction. This is a rather circular argument which does little to further an understanding of the factors underlying drug addiction. Savit (in Lowinson et al, 1981) attempted an understanding of the psychodynamics of drug dependence by putting forth the theory that the intravenous use of drugs is symbolically linked to a primitive state of fusion and regression. The drug addict strives for a parasitic fetal relationship via the umbilicus through the

intravenous use of drugs. Although this rather abstract argument has little validity in itself and lacks clinical evidence to support the main hypothesis, it is at least an attempt to understand the significance of different drugs or groups of drugs.

3.2 A Progressive rather than Regressive Adaptation

In contrast Glover (1956) believed that the pharmacological effects produced by various drugs were of little significance. His focus was primarily on aggression and sadism as the causative factors in producing addiction; according to him drugs symbolise a substance onto which conflicts are projected as a defence against regression to a more psychotic state. Drugs could thus be viewed as a primitive defense mechanism.

Glover viewed drug addiction as a fixation to a transitional system. This transitional system is more advanced than the paranoid-schizoid position but more primitive than the obsessional neurosis. The function of addiction is to defend against sadistic charges which are not as violent as those associated with paranoia but more severe than the sadistic charges dealt with in obsessional formations.

Glover equated paranoid-schizoid tendencies and psychosis with unconscious homosexual fantasy systems and came to the conclusion that drug addiction functions as a progressive and successful defense against the overwhelmingly threatening nature of these sadistic charges. As Khantzian (in Lowinson et al, 1981:468) points out, Glover's understanding of addiction as a progressive rather than regressive adaptation heralded the onset of a new paradigm in the psychodynamic formulation of addiction. However, his de-emphasis on the difference between the variety of addicting drugs led him to compress the dynamics of drug addiction into a rather abstract theory in which aggression and sadism are viewed as the root cause of compulsive drug use. Although he attempted to

understand the unconscious, instrumental use of drugs, his understanding was hampered by the prejudices and limitations of psychoanalytic theory during the first half of this century.

3.2.1. The Adaptive and Functional Use of Drugs

Chein et al (1964) took Glover's thesis further and asserted that addiction is adaptive and functional; a way of coping with unpleasant emotions and of managing interpersonal relations. They were the first to point out that addiction cannot be separated from severe personality disturbance and maladjustment which encompass ego and superego pathology and sexual identification. They put emphasis on the addict's inability to sustain constructive relationships and his/her limited insight into the consequences of destructive or careless behaviour. Chein et al threw a new light on the defensive function and behavioral patterns of drug addiction but, although they examined the sociological, economic and personality variables associated with compulsive drug use in depth, undue emphasis was still placed on the euphoric effects of narcotics. Besides, the addictive personality is understood in terms of shortcomings and handicaps, with the result that a theory of the development of the addictive personality structure is eclipsed by a description of impaired interpersonal and intrapersonal modes and functions.

Khantzian and Wurmser (in Lowinson et al, 1981) published two papers in the 1970's in which they almost simultaneously but independently came to the conclusion that drugs are used as a defense against threatening and dysphoric feelings associated with unmitigated aggression. The emphasis here was placed on drug use as a way of counteracting the disorganising influences of rage and aggression, the theory being that these were affects with which addicts have particular difficulty. Although the papers were important contributors to a comprehensive theory of addiction, important affects, such as shame, humiliation, guilt, etc., were

not addressed; this was an oversight which limited the usefulness and scope of the theory.

Hartmann (ibid), working along similar theoretical lines to Khantzian and Wurmser, offered an understanding of adolescent drug abuse which pointed to a need to avoid active mastery of developmental challenges. According to Hartmann, the prospect of facing adult role expectations with inadequate preparation or models is too daunting for certain adolescents. The intrapsychic conflicts derived from inadequate preparation for adult responsibilities are severe and are often solved through the use of narcotics. Hartmann's thesis lacked, however a developmental perspective, failing thus to explain why only some adolescents are prone to this passive solution to interpsychic conflicts.

Wieder and Kaplan (ibid) took up this challenge and developed Hartmann's perspective further by observing that, as a result of preadolescent conflict certain individuals are more vulnerable to problems of anxiety, depression and physical discomfort during adolescence. In these cases, drugs seem to induce a desirable ego regression. Wieder and Kaplan were also the first to draw up a coherent theory that linked specific drugs to stage-specific developmental conflicts. They hypothesised that the selection of a drug is a function of a specific type of personality organisation and ego impairment. For example, opiates were considered to produce a state that simulate the fusion with the mother. This drug would thus be selected in order to avoid the separation anxiety caused by the adolescent dependency crisis.

Milkman and Frosch (ibid) examined and elaborated on the hypothesis that choice in drugs is related to a specific defensive style. They used a Bellack and Hurvich interview and rating scale for ego functioning to compare heroin and amphetamine addicts in drugged and non-drugged conditions. It was found that heroin addicts need the calming effects of opiates; opiates strengthen the addict's

fragile defences, while simultaneously reinforcing their tendency toward withdrawal and isolation. Amphetamine addicts, on the other hand, need the stimulating action of these drugs to boost their tenuous sense of self-worth; amphetamines also induce a defensive style which make active confrontation of their environment possible. Hendin (ibid) used psychological tests and interview data to examine Milkman and Frosch's findings. He concluded that heroin as well as barbiturates function as a defense against overwhelming destructive impulses, as both drugs assist the addict in withdrawing and avoiding intimacy.

Wurmser and Khantzian (ibid) however question the emphasis on the regressive effects of narcotics. They put forward the hypothesis that the specific pharmacological action of opiates has a progressive effect which may actually reverse regressive states.

Khantzian (ibid) suggests that narcotic addiction functions as a drive defense; that is, the direct anti-aggression action of opiates reverse regressive state; it serves to counteract the disintegrative influences of rage and aggression on the ego. Both Khantzian and Wurmser suggest that the psychopharmacological effects of drugs can serve as a substitution for defective or nonexistent ego mechanisms of defense.

The works of Hartmann, Wieder and Kaplan, Milkman and Frosch and Hendin differ in emphasis but share a common stress on opiate use as a prosthetic which functions as a correction to impaired or defective ego functions, thereby assisting the individual in coping. The controversy between the progressive and regressive effects of opiate - use is studied further by Krystal and Raslin (ibid) who suggest that opiates may be used either to permit or prevent ego regression. Krystal and Raskin's work stress the relationship between the affects of pain, anxiety and depression and drug and placebo effects. The difficulty addicts have in recognising and tolerating painful affect is examined and they came

to the conclusion that addicts tend to sanitise depression and anxiety; these affects remain unverbalised and undifferentiated, resulting in a defective stimulus-barrier which leaves such individuals ill-equipped to deal with their feelings. This inability to verbalise and integrate unpleasant feelings predisposes such individuals to drug abuse. They further examined the major problems addicts experience with negative as well as positive feelings about themselves and others, concluding that rigid and massive defences, for example splitting and denial, are used in their interactions with others and in their feelings about themselves. They suggested that addicts prefer and utilise short acting drugs to: a) "assist the ego in defending against painful affect, and b) allow them to experience briefly and therefore, safely, feelings like fusion (oneness) with loved objects" (ibid:470). These positive affects are, in addicts, suppressed by the defences that are needed to protect the ego against the painful affects of rage or aggression. Krystal and Raskin put little, if any stress on the specific effects of different drugs.

Zinberg (ibid) approaches the question of ego regression among narcotics addicts from a very different perspective. He maintains that the role psychopathology plays in the regressive appearance and behaviour of drug addicts is less important than the enforced social isolation and deviant status which is the result of drug addiction. Central to Zinberg's thesis is the concept that the ego is relatively autonomous; the social stigma under which the illicit drug - user lives results in a significant reduction of balanced input from the environment. It is this deficit that undermines the ego's relative autonomy from the id. At the same time the deficit also chips away at the superego structures that are maintained by social support systems. Zinberg asserts that:

> the perpetual nature of addiction, in which the user continuously cycles from high to low and back again, serves to keep drive tension high, which results in increasing dependence on the environment for obtaining

> drugs and for whatever is left of coherent social relations, thus weakening relative autonomy from the environment. Under these conditions, the ego could be expected to undergo a regressive process that results in the typical impulse ridden, psychopathic junkie who is the subject of most clinical studies. (ibid:471)

Psychoanalytic theories of drug abuse have developed from the rather limited perspective which focused almost exclusively on the euphoric, regressive aspects of drug use to the belief that drug addiction is ego defensive and may well be progressive. Leon Wurmser's classic study on the psychodynamics of drug addiction offers perhaps the most coherent and structured theory of how narcotics and similar substances are used adaptively by individuals to cope with their impulses, aggressive drives and their environment (in Lowinson et al., 1981). His thesis will be discussed in depth.

3.3 The Psychodynamics of Drug Addiction

Wurmser maintains that drug addiction can only be understood and treated when viewed in terms of a triple layering of dynamic interaction. Drug addiction is the superficial layer and an attempt at self medicating. The drug in itself does not offer pleasure, it is not a shortcut to gratify hedonistic cravings, as earlier writers believed it to be. Instead the drug defends against unwanted emotions, it numbs and it blocks. This layer is in itself fraught with problems which are self-perpetuating, such as physical addiction, mental damage, interpersonal disaster, illegality and derivative criminality. In this sense, substance abuse is a disease and needs to be treated.

However, once the disease is examined psychodynamically, it becomes clear that the disease is simply a symptom. Thus, on the next, deeper level, compulsive drug use has to be seen as a symptom that

functions as a defense against feelings which threaten to overwhelm the addict when not anaethetised. The drug induces artificial affect which provides relief from " a vague, diffuse, but pervasive mood of anxiousness, tension, uneasiness and unhappiness" (ibid:66).

Wurmser believes that if these diffused and pervasive feelings of discomfort are probed, quite specific affect states from which surcease is sought, start emerging. Moreover, that the choice of drugs is specifically related to the affect which needs to remain hidden. He maintains that narcotics and hypnotics defend against rage, shame, jealousy, and the often panicky anxiety attacks derived from these partly repressed affects. Stimulants are arranged against feelings of depression, weakness, inner emptiness and helplessness. Psychedelics are deployed against boredom, disillusionment, apathy, a sense of meaninglessness, painful isolation and detachment. Alcohol wards off intense guilt and self-punishment, loneliness and longing. (Ibid:66). Features common to all types of drug use include overwhelming anxiety, and the experience of the self as wounded, injured and vulnerable. Whenever the affect that needs to be hidden and unfelt is triggered, and threatens to surface, drugs are used to impose an artificial affect that will take the place of the ones that cannot be allowed. The precipitant is frequently and most typically linked to intense disappointment, either in the self or in others. Disappointment in the self and in others cannot be separated from the overvaluation which is typically placed on people/events or the self, an overvaluation which is inevitably the function of the exaggerated expectations and hopes behind which the negative affects remain hidden. However, the opposite also holds: potential good almost always needs to be warded off, spoiled, lest the disappointment and rejection they expect are overwhelming. Wurmser maintains that these specific affect states from which surcease is sought quickly tend to become " global, undifferentiated, resomatized and deverbalised" (ibid:66) and calls this process the process of

"affect regression" (ibid: 67).

Underneath this regressive affect state is found the third layer, which Wurmser calls the infantile neurosis, and he stresses that the conflicts of the infantile neurosis are very intense, usually of both an Oedipal and preoedipal nature, and that the defences are widespread and archaic. Wurmser maintains that pathogenesis and etiology are not limited to one phase of development but that it usually encompasses all of childhood and adolescence. Later damage perpetuates and reinforces the infantile neurosis. He questions the extensive use of the "borderline" concept as essentially coextensive with serious, strongly preoedipally determined pathology, and wants to reserve the diagnosis "borderline" as a clinical diagnosis limited to uncertainty about whether or not a patient had been overtly psychotic or may become so again. He prefers the term infantile neurosis which can be clearly defined as fundamentally phobic, a definition that corresponds with the psychodynamic structure of the compulsive drug user. The phobic structure of the infantile neurosis is surrounded by "multiform conversion hysterical, paranoid, depressive, masochistic, impulsive and depersonalising features" (ibid:70). The anxiety that lies at the core of this structure may be bound up in a variety of objects and situations but can, in a great number of cases be specified as claustrophobic, the fear of being captured or trapped, closed in. He stresses that for drug addicts limitations mean confinement; closeness and commitment stifle and they continuously need to escape the constrictions and constraints they feel are imposed on them. This observation is based on Fenichel's assertion that:

> any state of anxiety is physiologically accompanied by feelings of being closed in; and thus, reversely, an external closeness (or idea of it) facilitates the mobilisation of the entire anxiety syndrome (ibid:67).

To Wurmser this means that every intense affect has become fused with a tension that is not only global and undifferentiated but over which all control has been lost. Because the individual feels

that the tension cannot be controlled, (s)he feels helpless and overwhelmed, and an original traumatic state is re-awakened.

Wurmser suggests that, as even the word anxiety itself expresses a physical constriction (being derived from "angustia", meaning a narrow boxed-in place), it is plausible to assume that not only can claustrophobia be found at the core of all other phobias, it may even underlie all other symptomatic neuroses. Moreover, that the need to burst free of the restrictions that hem in, is at one and the same time the fear of "bursting asunder" (ibid:67).

He maintains that this basic anxiety, which is initially all pervasive, generalised and internal, transforms itself into a more localised one which is at first bodily experienced and then displaced onto surrounding objects and structures. This sequence is accompanied by a series of actions (usually aggressive) geared toward liberating the self from the various concentric bonds. However, the struggle for liberation has its own inevitable consequences:

> condemnation in form of guilt and shame, aloness because of the separation from the protective, shielding claustrum, ultimately ... the fear of the most radical bursting: that into small fragments of body and mind (ibid:67).

This state of anxiety, which is experienced as confusion and loss of felt controls, a pervasive but nameless tension, leads to a paradox that cannot be resolved. Anxiety is equated to the experience of confinement and entrapment and projected onto all external structures, with the result that the threat of encroachment and enclosure is all pervasive. Relief from such anxiety needs to be sought in the form of protection against it, yet this protection could only be found in external structures. It would have to be sought primarily in outside constraints and boundaries because the search is for an outside control that would

take responsibility for and protect against the dark, overwhelming part inside. The paradox is that all such protection against the overwhelming anxiety will inevitably become once more a new claustrum and therefore a renewed source of terror.

Wurmser works here towards a dialectic counterpoint, asserting that whenever a phobic system exists, its antithesis, a protective system in the form of protective figures and protective fantasies, can be found. He believes that drugs, as substances, and the drug culture itself, constitute the protective system which is as compulsively sought as the phobic object is compulsively avoided. The direct counterpart to the phobia is thus a countervailing fantasy of a protective object. This protective figure or object functions in the service of denial and repression; it is split off from the hated and feared anxiety object but derives it power from the same source. It is in this sense that Wurmser correlates the addictions to phobic neuroses. He states:

> Whereas the phobic neurotic compulsively avoids the condensed and projected symbol for his anxiety on the outside, the toxico-manic equally compulsively seeks the condensed and projected symbol of protection against uncontrollable, overwhelming affects, again on the outside. Its protective efficacy is proven by the introduction of the magically powerful means from the outside and the ensuing mobilisation with its help of a transient and lastly spurious counterforce (ibid:68).

Wurmser maintains that the drug effect itself is a type of counterphobic fantasy that protects against the phobic fears by denying the main anxieties. Through stimulants the addict is able to deny his/her vulnerability, through narcotics and sedatives his/her anger, with alcohol his/her isolation and overwhelming feelings of guilt.

Wurmser sees this dialectic counterpoint as the convergence from

which yet deeper levels of disturbance may be uncovered. In a brief synopsis, they are: 1) the duality of phobic and protective systems entail a juxtaposition of closeness and dependency as both feared and sought after claustra. This conflicting emotional constellation is derived from very early object relationships and conflicts about them; 2) the phobic objects are perceived as menacing; they thus have to be understood as projections of the subject's own aggression and of oral and anal libido; 3) the traumatic quality of the anxiety is of such a pronounced nature that massive early and ongoing traumatisation as a probable causative agent must be presupposed.

He asserts that the conflicts underlying the infantile neurosis are predominantly preoedipal in nature. He specifies these conflicts as pertaining to the triad of early separation anxiety and real object loss, castration anxiety and castration shame, and anal-sadistic conflicts. They speak for early damage and traumatisation in the middle or late second year of life (Mahler's "rapprochement phase"), thereby explaining the prevalence of inward-turned aggression and of narcissistic expectations.

Wurmser offers two alternative but complementary explanations (from an intrapsychic as well as interpersonal point of view) for the centrality and severity of the anxiety that needs to remain hidden. He postulates that the anxiety has to be traced back to the rapprochement phase during which time the child's wishes for love and/or security and his/her aggression were excited and encouraged to a degree that was unmanageable for his/her age. Alternatively or complementary, the focus may be placed on the unmanageable degree of outside violence and/or exposure to sexual actions or seductions.

Wurmser's hypothesis of a triple layering of dynamic interaction which constitutes the personality structure of the compulsive drug user makes an extremely useful contribution to the understanding of

the driving force behind drug addiction. He ultimately limits himself however to a description of a personality structure through his insistence that the pathogenesis and etiology of drug abuse can only be understood within the framework of a claustrophobia rooted in infantile neurosis. He therefore fails to a significant degree in his attempt to analyse the psychodynamics of drug addiction. Although he describes the family dynamics of the compulsive drug user, he fails to provide an understanding of the dynamic interaction between the developing ego of the child and the pathologic family structure that would eventually give rise to the compulsive use of drugs.

A brief review of a developmental object relations theory is presented below, as it provides a framework to understand aspects of the normal development of self-expression and the difficulties caused by arrests of this development. The review is mostly based on the works of Klein (1948, 1952, 1955, 1963, 1975), and Segal (1964, 1979). Reference is made to Freud (1973, 1977, 1984) and Lacan (1977) in an overview of the Oedipus complex.

CHAPTER 4

DEVELOPMENTAL OBJECT RELATIONS THEORY

The theoretical foundations of object relations theory rest on the belief that the infant experiences anxiety from internal and external sources from the beginning of post natal life (Klein, 1948). The first external source of anxiety can be found in the experience of birth, when the pain and discomfort suffered, as well as the loss of the intra-uterine state are experienced as a persecution by hostile forces. Klein describes two positions in the oral phase, the paranoid-schizoid and the depressive positions and describes two types of ego and object relation organisation in these two positions.

4.1 The Paranoid-Schizoid Position

During this position, which is during the first three-four months of life, the infant's initial feeding experiences and the mother's presence initiates an object relation for the child. This relation is initially a relation to a part-object, for both oral-libidinal and oral-destructive impulses are directed from the beginning of life toward the mother's breast in particular. At this stage the infant is pre-ambivalent, that is, his/her object is split into an ideal one and a persecutory one and the prevalent anxiety is persecutory: the fear is that persecutors may invade and destroy the self and the ideal object. Hatred and persecutory anxiety attach themselves to the frustrating bad object and love and reassurance to the gratifying good breast. The primary aim is to acquire, possess and identify with the ideal object and to protect and ward off both the bad object and the infant's own destructive impulses.

Klein believed that anxiety arises from the operation of the death instinct within the organism. It is felt as a fear of annihilation

and takes the form of fear of persecution. When faced with the anxiety produced by the death instinct, the immature ego deflects it. This deflection of the death instinct, described by Freud (1973), in Klein's view, consists partly of projection and partly of the death instinct into aggression.

The ego splits itself and projects the part of the self containing this death instinct into aggression, and also projects the part outwards onto the breast (external object). The breast is now felt to contain a great part of the infant's death instinct. It is therefore experienced as bad or threatening to the ego and, in this way, gives rise to a feeling of persecution.

Klein differs from Freud on two issues dealing with the nature of the early ego and primitive anxiety. Freud believed that threatened by the death instinct, anxiety is deflected outwards.He uses the term organism in preference to ego to illustrate that he considers it a biological and not yet a psychological entity (Freud, 1973). Klein maintains there is enough ego at birth to experience anxiety and the primitive ego projects the death instinct (Klein, 1948).

Klein's belief that an ego exists at this stage influences her view of anxiety. Freud believes that the unconscious infant and even small child have no notion of death and that the fear of death is a derivation of castration anxiety (Freud 1973). Klein holds that the operation of the death instinct gives rise to a fear of annihilation, and it is this fear which leads to the defensive projection of the death instinct. The ego projects the death instinct as a defence against fear of annihilation and it is this basic fear which leads to the defensive projection of the death instinct (Klein, 1948).

The early ego is weak and defenceless, and under the impact of anxiety it tends to fragment and disintegrate. The deepest fear stirred by the operation of the death instinct is the terror of

disintegrational annihilation (Segal, 1979).

It is characteristic of the emotions of the very young infant that they are of an extreme and powerful nature. "The frustrating (bad) object is felt to be a terrifying persecutor, the good breast tends to turn into the 'ideal' breast which should fulfil the greedy desire for unlimited, immediate and everlasting gratification" (Klein, 1975:65). Another factor making for the idealisation of the good breast is the strength of the infant's persecutory fear, which creates the need to be protected from persecutors, and therefore increases the power of an all gratifying object.

The ego, according to Freud, is the organised part of the self,constantly influenced by instinctual impulses, but keeping them under control by repression. Furthermore, it directs all activities and establishes and maintains the relation to the external world (Freud, 1973). According to Klein, the ego exists and operates from birth onwards. It is disorganised, but has from the beginning a tendency toward integration. The ego initiates a number of processes, eg. introjection, projection and splitting (Klein, 1975).

Introjection means that the outer world, its impact, the situations the infant lives through and the objects (s)he encounters, are not only experienced as external but are taken into the self and become part of the inner life. This is an ongoing process (Klein, 1975). Projection implies that there is a capacity in the child to attribute to other people around him/her feelings of various kinds which are predominantly love and hate.

These are not merely infantile processes, even though rooted in infancy. They are part of the infant's phantasies, which operate from the beginning and help mould his/her impressions of the surroundings. By introjection this changed picture of the external world influences the understanding and experience of the world; an

inner world which is partly a reflection of the external world, is built up. These two processes become modified in the course of maturation but they never lose their importance in the individual's relation to the world around him/her. Even in the adult, therefore, the judgement of reality is never quite free from the influence of the internal world.

Persecutory anxiety reinforces the need to keep separate the loved objects from the dangerous ones. Splitting is linked with increasing idealisation of the ideal object in order to keep it far apart from the persecutory object and protect it from being harmed. It can be considered a defence against psychic anxiety for, by denying the split off persecution and by idealising and identifying with the split off good object, fears of destruction are allayed. Salzberger-Wittenberg (1970) identifies the idealisation of the breast and mother as a defence against envy. Devaluation of the desirable object by the child reduces anxiety felt in attacks made on the object and is thus also viewed as a defence. By continually questioning the worth of a desirable object, thereby maintaining feelings of confusion and doubt, the child reduces feelings of envy.

4.2 The Depressive Position

The successful negotiation of the anxieties experienced in the early months of the infant's development leads to a gradual organisation of his/her universe.

If the conditions of development are favourable, the infant will increasingly feel that her/his ideal object and own libidinal impulses are stronger than the bad object and own bad impulses; (s)he will increasingly be able to identify with her/his ideal object; (s)he will feel that her/his ego is becoming stronger and better able to defend itself and the ideal object.

The depressive position is that phase of development in which the infant recognises a whole object and relates her/himself to this object.

The infant begins to recognise his/her mother when through normal maturation processes and psychological drive there is sufficient integration for whole object relating. As such, the infant can love her as a whole person and identify with her in a different way. The child turns to the whole loved person to relieve his/her persecutory fears; (s)he wishes to introject her as she may protect him/her from inner and outer persecution. Yet, if this loved mother is felt to be protecting the infant from danger, she is now also exposed to danger. As the mother is now felt to be a whole object, this not only contrasts the previous position in which she was felt to be a part object, but also in the sense of not being split into a persecutory and an ideal object; she is felt to be the source both of the infant's gratification and of his/her frustrations, pain and anger.

The infant's love for the mother is, therefore, very ambivalent and easily turns to hatred, so the mother is in danger of being destroyed, not only by the "phantasised persecutors but also by the infant's own hatred and love" (Segal, 1979:79). The mother is constantly introjected, the destruction is at the same time an internal one and the infant's inner world is in "ruin and chaos". "Through this step the ego arrives at a new position, which forms the foundation of the situation called the loss of the loved object. Not until the object is loved as a whole can this loss be felt as a whole (ibid:82).

The lessening of projective processes and the greater integration of the ego means that the perception of objects is less distorted, so that the bad and ideal objects are brought closer together. At the same time, introjection of an increasingly whole object promotes integration of the ego.

The prevalent anxiety is thus now depressive. It has changed from fear of being destroyed by persecutors to fear of the infant's own aggression which will destroy his/her ambivalently loved object. Since the infant's fantasies are felt to be omnipotent, mother's absence is experienced as a death, leaving in its wake feelings of guilt, irretrievable loss and mourning.

Another important feature of the depressive position, is the superego. According to Freud the superego develops at approximately age five. Klein however believes the superego develops in the fifth or sixth month of life. At this stage the child becomes afraid of the harm that his/her destructive impulses and greed may do, or might have done to his/her loved objects as (s)he cannot yet distinguish between his/her desires and impulses and their effects. The infant experiences feelings of guilt and wishes to preserve these objects and make reparation to them for the harm done. The working through of the depressive position depends on the capacity to make reparation. When the infant feels that his/her hatred has destroyed his/her good internal and external object, the subsequent feelings of guilt and loss and the longing to restore and recreate the lost harmony and well-being, inspires the infant to mobilise all his/her love and creativity toward reparation. The reparative drive is thus the most important source of mental growth and creativity. With the repeated experience of loss and recovery of his/her object, the infant feel confident in the strength of his/her good object and also of his/her own love and creativity.

The defences evident in the depressive position are classified under two headings: reparation and manic defences. Manic defences include mechanisms which were already evident in the paranoid-schizoid position: splitting, idealisation, projection, identification and denial. What distinguishes the later use of these defences is that they are highly organised in keeping with the more integrated state of the ego, and that they are specifically directed against the experience of depressive anxiety

and guilt. This experience is dependent on the fact that the ego has achieved a new relation to reality.

4.3 The Oedipus Complex

Klein believed that the Oedipus complex begins at the same time as the depressive position, i.e. when the infant becomes aware of his mother as a whole, separate, other-relating person, (s)he is immediately exposed to sexual jealousy. The infant's omnipotent fantasies increase his/her jealousy, as the emotional tie (s)he sees between the parents means they give to one another what the infant desires for him/herself. The jealousy, although in oral terms, gives rise to a triangulation of the intensity described by Freud in the Oedipus complex. The expression of the Oedipal situation is dictated by the child's stage of libidinal development, and the earlier the stage, the more it will be dominated by omnipotent projections. Klein believed, in accordance with Freud, that the Oedipus complex manifests it self differently between the two sexes. Whereas the boy, during genital development, returns to his original object, the mother, thereby seeking female objects in competition with the father, the girl turns away from mother and finds in the father the object of her desires.

As much importance will be placed on the role and place of the father in the development of the ego in the case study presented below, I will give an in-depth overview of Freud and Lacan's understanding of the development and resolution of the Oedipus complex. As the patient presented is male, only the masculine Oedipus complex will be discussed.

4.3.1 The Drive Theory

One of the most revolutionary theories in psychology, was Freud's insistence that the infant was born with a sexual drive. This sexual drive can have diverse aims and can be active or passive in

its direction. Initially, these sexual urges are satisfied auto-erotically, or from the mother's body, which is experienced as an extension of the infant. Realisation of the infant's incompleteness and separateness is forced on it by the discovery that satisfaction of the drive is dependent on outside forces. From that discovery onwards, the sexuality of the child is more actively defined and linked to objects and people. The mouth, anus and genitals are particularly associated with libidinous satisfaction. From the moment of birth onwards interest in them develops in a definite sequence. For the new born child the mouth is the primary organ of pleasure through which she makes contact with her first object of desire, the mother's breast. The oral phase is overlapped and succeeded by the anal phase which is characterised initially by the aim to expel aggressively and later to control. Pregenital sexuality as a stage of development ends towards the end of the third year when the early genital or phallic interest begins to centre on the penis. Freud defined the sexual object as the phallus specifically and not the genitals, because this stage knows only the male genital. This stage deserves special focus.

4.3.2 The Phallic Phase

The phallic phase begins toward the end of the third year when the boy's interest becomes centred on his penis. This interest arouses sexual attraction for the mother which is accompanied by feelings of jealousy and resentment directed towards the father who has become the boy's rival for his mother's affections. The boy here experiences the Oedipal situation which comes to an end primarily because he fears that his father might castrate him as punishment for his illicit desires. The masculine Oedipus complex is thus resolved by the castration complex (Freud, 1977).

The third phase, the phallic phase, is initially, according to Freud, as impervious to gender differences as the oral and anal phase. It is within this phase that the recognition of the phallic

power of another, as being bigger and better than one's own, occurs. The boy compares himself with his father and the trauma of castration anxiety results. Castration, or the threat thereof, was for Freud the high point of the psychological fear of loss and hence of danger. He saw the Oedipal sequence in the following terms: the boy desires the mother and fears the father, because it is in the omnipotent father's power to deny him the mother. Castration is linked with loss as well as with danger, because the boy feels himself threatened by the superior strength of the father. He eventually does give up the mother, only to realise that the loss precedes a gain. The boy has now moved into manhood, and is ready to take over the omnipotent penis of the father. By realising that one day he will be the father in his own right, that is, by submitting to the symbolic role of castration, the boy resolves the fear of castration (Jones, 1956).

Death and castration are also closely linked. The child internalises the father because of his fear of castration, and this process gives birth to the superego. Fear of castration then leads the boy to identify with the castrating agent. With the aid of his own aggressive drives, the boy incorporates the castrating agent into his own personality as an internal authority figure, a judging superego. The ego experiences hatred from its own superego and fears death. As the ego once feared castration from the father, it now experiences an equivalent threat from the superego that was formed out of an identification with the father. The fear of death then, as the fear of conscience, is a development of the fear of castration (ibid).

The implication here is that the boy enters manhood and achieves normality through the fear and repression exerted on him to resolve his Oedipus complex. Normality is achieved at a cost but, however high the price is the boy has to pay, the promise, implicit in Freud's theory, is that submission to symbolic castration makes it possible for him to enter into his phallic heritage.

4.4 Lacanian Structuralism

Lacan's understanding of the child's entrance into the world differs, but at the same time compliments and builds on to Freud and Klein's theories of development. His theoretical ideas are articulated in terms of how different kinds of relationships of signification, which are established almost from birth, are built up (Lacan, 1977).

Lacan differentiates between two orders of signification. The first order is called the imaginary order, and refers to the time of the first signification when the infant signifies to be what the mother most desires. The infant wants to complete the mother, to be what she lacks and wants to be above all else: the phallus. He does not represent the phallus as being the penis. It stands for the infant's desire to be part of the mother, to be what she most desires. Most importantly, it stands for the kind of desire that can never be satisfied. The child's relationship with the mother is fusional, dual and immediate, dominated by the desire to lose self in other. Lacan places great emphasis on a mirror phase of development which can be located in the imaginary order. During the mirror phase the child recognises its body in the mirror as a whole which is him/her. The infant relates to this image in the mirror in the same way as (s)he relates to the mother's body or the bodies of other children, that is, in an immediate one-to-one fashion. The image of the body is still inferior to the image of the mother, or rather, inferior to the desire to be the mother's desire. Lacan views this kind of unmediated, one-to-one relationship as alienating. However, this process of identification is paradigmatic. The self continues to identify with others in a fusional direct way and thus the self is lost in other. Thus the ego is created, an alienated ego which is the bearer of all neuroses.

The child's desire to fuse with the mother is repressed by the

understanding of the father's presence and the father's name. The child assimilates the father's name and the father's no to his desire to be the mother's desire and he identifies with the father. In Freudian terms, the child's desire for the mother has been repressed but Lacan represents the Freudian act of repression in linguistic terms as metaphor formation. That is, one signifier, the desire for the mother, is substituted for another, the father's name. Thus the child enters the symbolic order because now (s)he no longer relates to what is being signified; that is, he no longer relates to the phallus in a direct, unmediated fashion. The relationship between signifier and being signified is now mediated, they are more distanced from one another. The old signifier, the desire for the mother, is now pushed down to a deeper level. A chain of signification is now established of which the original signifier is just one link which is unconscious. In the course of a lifetime the individual builds up many chains of signification, always substituting new terms for old and always increasing the distance between the signifier that is most accessible and visible and all those that are invisible, including of course the original signifier. The forgotten link in the chain of signification, the desire for the mother, or other, can never be satisfied, as the chain of signification can never be completed back to an accessible reality.

4.5 The Sense of Self

The common denominator in the three developmental theories discussed above, is that a sequence of object relations, differing in nature and quality, is required for normal development. Klein's paranoid schizoid position, Lacan's imaginary order and Freud's concept of early sexual urges being satisfied auto-erotically by the mother's body which is experienced as an extension of the self, all describe an early relationship which is fusional and enmeshed, where self and other blend and mingle to the extent where the infant cannot perceive her/himself as a separate being in the

world. The infant exists in the mother's regard or disregard, in the mother's love or anger: the self exists in the mother's giving or the mother's withholding. In order for the infant to acquire an identity, a sense of self, a separation from the mother must be negotiated; the unconscious one-to-one fusion must be mediated in order for the child to enter the world of conscious, symbolic speech and for society to enter the child. In Lacan's words: "the conscious presentation comprises the presentation of the thing plus the presentation of the world belonging to it, while the unconscious presentation is the presentation of the thing alone" (Lacan, 1977:43). In the Lacanian structuralist paradigm the unconscious is structured as a language; the studies of the laws of language and the laws of the unconscious are one and the same. If the unconscious is structured, it has to be structured through the relationship between two signifiers, and the signifiers thus take dominance over the signified. Important here is that meaning is derived from the relationship between the signifiers, not from the signified. The alienated ego is born in the imaginary order where the ego does not signify back to itself, but in a fusional relationship to others. When the child enters the symbolic order, that is, society, law, the place of the self in the family system of names, language itself, (s)he experiences her/his relationship with others through the mediation of an increasing number of signifiers. The child now lives within an order of symbols which mediate her/his relationships and which removes her/him further and further from her/his immediately lived first signification.

The father's no to the desire of the child for the mother, and the acceptance of the no, thus marks the child's entry into the symbolic order, and this prohibition denotes the structure underlying the apparent organisation of societies. A prerequisite for entrance into the symbolic order is then the resolution of the Oedipal complex and the acquisition of language which turns the child away from her/his fusional relationship. By entering this order, the child becomes fully conscious of her/his autonomy as a

subject and a member of society (Lacan, 1977).

In order for the child to negotiate this developmental sequence, (s)he needs the support of a third person to introduce him/her to the world of language and law, to a world that continually evolves into new forms. Or, if a third person is not available, (s)he needs to develop a basic trust created by a mother who is capable of helping him through separations and crises, thereby inspiring a faith that he can enter a manageable world as an autonomous being. Of this process Bernd Jager says:

> We generally have the impression that basic trust originates in the loving, sustaining, nourishing embrace of the mother. Yet trust inevitable refers to transitions, to perilous moments, to times of vulnerability and attack. We may think of basic trust as originating in the warm unfolding presence of a maternal and paternal figure, but we cannot complete our understanding within that fetching image. The word 'trust' maintains links to the older concepts of loyalty and faithfulness, to a pact in which each party promises to assist the other in times of need. The word 'trust' is related to 'troth' which we find back in 'betrothal' and in such traditional formulations as 'I plight my troth to thee'. Central to the pledge of troth and betrothal is the realisation of the inevitability of discontinuity, of the fateful aspects of life, of the relentless course of developments and history. Giving and accepting trust, betrothal, makes sense only within a full or growing sense of our vulnerability, of the constantly changing aspects of our lives. The mother becomes a trusted figure to the child, not because she manages to smooth out or even camouflage the difficulties inherent in transitions, but rather because of her role in helping the child face and manage these transitions. Trust is not a force opposed to history but rather is an effective force

> within history. The question of the trust inspired by the mother is decided by how she will guide the child through weaning, past the attempts to master the bowels, through the first real separations imposed by the kindergarten. Trust can only come from a constant metamorphosis of love. An unchanging love of the mother fixated on cuddling, feeding and protecting does not generally inspire trust and is more likely to result in insecurity and neurosis (in Kruger, (ed), 1988:159).

An arrest in this developmental sequence results in a lack in selfhood, an incompleteness which is frequently perceived as non-being or non-identity. Eva Seligman (1982) describes the inner world of patients who present and describe themselves as 'half-alive' (ibid:1), and asserts that the common denominator in her 'half-alive' patients is the absence of the father. Absence in this case refers to fathers who are experienced as unavailable both by the mother and the child, even though he may be physically present at least until the child's puberty or beyond. He either excludes himself or is excluded by the mother-child dyad. She states:

> I have evidence that there is an unconscious collusion between mother and child to maintain and prolong their mutually interdependent omnipotence and dependency in a dyad to satisfy one another's needs and wishes, thus postponing the more difficult and conflict - ridden subsequent phase of the triad, the phase of sharing and conflict (ibid:3).

Secondly, the father may not make himself available because of his own unresolved psychological problems, or he may be physically, verbally and/or sexually abusive, thereby representing the bad object that is hated and/or feared and must be avoided. In either case, the father does not support the child in his/her attempt to emancipate from the mother.

Seligman observes that the impression of the mother that emerges in the analyses of the 'half-alive' patients, points to a mother who is essentially "ego-damaging" (ibid:3). These mothers may be withdrawn and self-absorbed, or efficient but affectionless; they may be anxious and over-solicitous and over-protective or controlling, domineering and intrusive. Others may be experienced as seductive and castrating, puritanical, thereby creating a guilt-ridden conscience in their children, or controlling their children by martyrdom and illness. She describes jealous mothers who vacillate between hostility and remorse, and mothers who cannot release their children, exploit or scapegoat them (ibid:3). She concludes that the more unconsciously destructive the mother is, the less possible it is for the child to achieve his/her emancipation from her. Separation from the mother in this kind of relationship is perceived as damaging to the mother and is resisted by both child and mother. The extent and intensity of this relationship, which is nourished by guilt and fear, leaves no possibility for a relationship with another. Seligman states:

> The non-existent father is indeed the most noteworthy common denominator in the personal history of these patients. It is the father, nevertheless, who plays a specific and essential role as the mediator of the difficult transition from the womb to the world. Without the father's emotional support, it seems to me that it becomes almost insurmountably difficult for a child to be properly born and confirmed in his own identity, and to negotiate the unavoidable separation from the mother, a prerequisite to a satisfactory adult heterosexual commitment. The 'absent father' syndrome encourages a mutually collusive 'embrace' with the mother, nourishing a shared illusion of 'oneness', from which the developing child cannot extricate himself, leaving him neither in, nor out, of the womb, but wedged, so to speak, half-way, half-alive, half-born(ibid:10).

It is with the concept of being 'half-alive', 'half-born, without support in a world that is perceived as alien and hostile, that this thesis concerns itself. Ultimately it is the sense of self, or the lack of such a sense, that needs to be understood. The question then is firstly, how is that sense of self built up in the individual, and secondly, what kind of interaction causes the sense of self to be atrophied. Winnicott (1988) states:

> the sense of self comes on the basis of an unintegrated state which, however, by definition, is not observed and remembered by the individual, and which is lost unless observed and mirrored back by someone who is trusted and who justifies the trust and meets the dependence (p.71).

He maintains that creativity emerges only in playing and that it is only in being creative that the individual uses the whole personality and discovers the self. The basis for a sense of self rests on a) relaxation in conditions of trust based on experience, and b) creative, physical and mental activity manifested in play (ibid: 66). The search for the self takes place in the unintegrated state of the personality which functions formlessly, simulating the rudimentary playing of the child. It is in this formless state that creativity emerges and becomes part of the organised individual personality if reflected back. Only if the moment of creativity is reflected back does it become possible for the individual to postulate the existence of the self.

4.5.1 The Mirror-role of Mother and Family in Child Development

"In individual emotional development the precursor of the mirror is the mother's face" (Winnicott, 1988:130).

As observed above by Klein and Segal, the environment, in the figure of the mother who has the function of holding, handling and object-presenting, plays a vital role in the early stages of the emotional development of the infant while it is not yet able to

separate itself off from the environment. Winnicott maintains that when an infant is held and handled satisfactorily and presented with an object in such a way that his/her legitimate experience of omnipotence is not violated, (s)he will be able to use the object, perceiving it as a subjective object, created by him/herself (ibid: 131). Gradually the infant develops the ability to separate itself off from the environment, the pace varying according to the infant and according to the environment. The major changes take place in the separating-out of the mother as an objectively perceived environmental feature. However, even though the separating-off of the not-me from the me has taken place, the baby can still only see him/herself in the environment; that is, the environment personified in the mother, reflects the self back to the baby. In Winnicott's words: "the mother is looking at the baby and what she looks like is related to what she sees there" (ibid:131). The baby thus sees him/herself. But the baby may also look and not see him/herself but the mother's mood or the rigidity of her defences. In this case the mother's face is not a mirror. The consequences of looking and not getting back that which is given are: 1) that the baby's own creative capacity begins to atrophy, and 2) that the baby searches for other ways of getting something of him/herself back from the environment. Winnicott observes that, when the mother's face is not a mirror, "perception takes the place of apperception" (ibid:132); what could have been the beginning of a significant exchange with the world, turns into a watchful observation of the world.

There are half-way stages in this scheme of things. Some babies continue to study the mother's face, hoping to see the meaning that ought to be there. Others continue to study the mother's face in an attempt to predict her mood, and quickly learn the meaning of her expressions. This makes it possible to risk the expression of personal needs at times. Beyond this, in the direction of pathology, is predictability, which makes it almost impossible for the baby to allow spontaneity, either in himself or in the

environment. In such a case the baby will withdraw or only look in order to prepare him/herself for defence.

This lack of a firm sense of identity, of not knowing who and what one is, of looking in the mirror and not finding oneself there, is supremely manifested in the borderline personality.

As the case study discussed below concerns a compulsive drug user who has been diagnosed borderline personality disorder, the rest of the literature review will focus on an in-depth discussion of the borderline personality disorder. The review of borderline literature will incorporate the issues discussed above.

CHAPTER 5

CONCEPTS OF THE BORDERLINE PERSONALITY

> To be a borderline might imply a personality that does not belong to any claimed territory; that functions as a divider, separating this from that; that is frozen in time and direction and cannot move; that does not exist in the world of three, or four dimensions (in Schwartz-Salant, 1988:44).

> (The borderline is) a person alone with a difficult, almost unmanageable task; the existence of a multilayered, false self none to easy to remove; excessive dirt and shame; an invasion or infection; a deeply wounded instinctual body; the portrayal of an innocent; and the experience of bloody suffering upon confrontation with the problem (ibid:49).

> The borderline personality is unique not in the vertically split nature of his identity...but in a psyche splintered into multiple components and dominated by bi-polar affect images of a victim-aggressor complex which attacks the relationship between a weak ego and the self (ibid:52).

5.1 Current Theories and Diagnostic Criteria of the Borderline Personality

Kernberg (1967), representing ego psychology - object relations theory, understands the borderline as an organisational malfunction of the personality which is stable and specific over time. This organisational malfunction of the personality is characterised by identity diffusion, difficulties in reality testing and the employment of primitive defences to guard against the emergence of

unwanted and unbearable affects. Narcissistic, masochistic and self-destructive character disorders are thus all encompass by the term borderline - personality organisation.

Goldstein (1989), modifies and expands the ego-psychological diagnostic approach and attempts to provide a current, generally accepted psychodynamic framework.

In accordance with Kernberg, Goldstein understands the borderline personality in terms of a specific "stable pathological personality organisation" (ibid:322) which is characterised by a specific kind of underlying structural configuration. This structural configuration encompasses a distinct kind of ego and superego functioning and a specific pattern of instinctual drive organisation. Goldstein distinguishes (in accordance with Kernberg) between three structural configurations, within which all of the patient population can be classified diagnostically. The first level or supraordinate structural diagnoses under which all descriptive diagnoses fall are envisaged as a continuum registering normal-neurotic, borderline and psychotic. The possibility of a fourth structural configuration, the narcissistic, between the neurotic and the borderline, is considered. The structural configuration includes a specific kind of ego and superego functioning as well as a distinct pattern of instinctual drive organisation. However, Goldstein's focus is largely on the ego. The borderline person's ego is viewed in accordance with the various ego functions; a particular ego structure, consisting of a distinct pattern of relative ego strengths and underlying ego weaknesses, is described.

The relative ego strengths lie in 1) reality testing which is basically intact, 2) thought processes which are predominantly secondary process, 3) seemingly adequate interpersonal relations, and 4) adaptation to reality which is often superficially intact. Goldstein stresses that these four strengths are only relative and

easily break down to various degrees in stressful situations. However, these relative strengths make it possible for the borderline to present him/herself in such a way that 'normality' is not questioned.

The underlying ego weaknesses are as follow: 1) poor impulse control and poor frustration tolerance, 2) the proclivity to use primitive ego defences, 3) identity diffusion, and 4) affective instability. These weaknesses lie beneath the surface and are thus not easily detected. They however most clearly differentiate the borderline from the more neurotic individual.

The ego psychological diagnostic approach is divided into a broad and a narrow classification of the borderline patient. The distinction is based on how many and which of the ego weaknesses are required to make the diagnosis. A narrow classification specifies an inclusion of identity diffusion, the proclivity to use primitive ego defences, and the propensity to regress in reality testing, whereas a broad classification fits the patient into the large grouping (normal-neurotic, narcissistic, borderline or psychotic) which best reflects the overall pattern of ego-strengths and weaknesses.

Goldstein queries the concepts of broad and narrow. He points out that Kernberg's classification is viewed as broad because identity diffusion, for most dimensions, include even mild problems in identity. The associated premise is that the miscellaneous use of borderline defences is sufficient to qualify for a weakness in the area of defences. In accordance with Kernberg, he considers identity diffusion to be present only when there is a "clear lack of an integrated and stable self-concept, and a corresponding lack of a stable concept of objects" (ibid:327). He further points out that the occasional use of borderline defences, such as splitting and denial, does not necessarily indicate weakness in this area. An ego weakness in defences is specified as either a clearly increased

use of primitive defences in the normal course of interaction, or a pronounced tendency to depend on these defences under stress. This, as well as severe identity diffusion, indicate significant psychopathology, and Goldstein proposes that, as such, it does not constitute a broad classification of the borderline personality. Conversely, the narrow classification and the DSM -111 - R overlap with many of the other DSM-111-R personality disorders, especially histrionic, antisocial, narcissistic and schizotypal personality disorders.

Goldstein attempts to resolve this debate by distinguishing between the "core borderline personality" and the "depressive impulse-ridden character" (ibid). Both these types fit into the borderline group, but the core borderline personality is the borderline patient Kernberg describes. This type of personality is characterised by identity diffusion, the proclivity to use borderline defences, and sometimes the vulnerability to regress in reality testing. Goldstein differs from Kernberg in that Kernberg places emphasis on the relative ability to maintain reality testing, while Goldstein stresses the vulnerability to regress rather than the relative intactness.

In contrast to the core borderline personality, the depressive impulse-ridden character always maintains the ability for reality testing, has a relatively more sophisticated pattern of defense organisation and has an identity based on a "bad" self instead of identity diffusion (ibid:328). This group of people experience problems in frustration tolerance and impulse control, and suffer from affective instability and generalised irritability. Various acting-out behaviours are common, and severe impairment in interpersonal relations is experienced. The depressive impulse-ridden character is clearly less pathological than the core borderline personality but still meets the DSM-111-R criteria for borderline personality disorder.

Goldstein introduces a third term, "impulse-ridden affectively unstable character" to describe an even broader group of people, of which the depressive impulse-ridden character is a subgroup. This group is identical to the depressive impulse-ridden character, except that the person's identity is not necessarily based on a 'bad' self. Goldstein believes that the term borderline is increasingly used to describe this group, which does meet the DSM-111-R criteria for borderline personality disorder.

Meissner introduces a borderline spectrum which registers a degree of emotional expressivity and defensive style, with hysterical tendencies at one end of the continuum and schizoid tendencies at the other end. He suggests eight categories which define the breadth of the borderline spectrum, namely: 1) instinctual defects of excessive aggression, 2) failures in the maturity of the ego's defensive functions, 3) defects in the ego's organisation and integrating functions, 4) a variety of failures of the normal developmental process, 5) the type of narcissistic defects described by self psychology, 6) faulty object relations, 7) a false self organisation, and 8) aspects of identity diffusion (Schwartz-Salant et al, 1988:57).

Common elements exist across all the views discussed above. They all stress the interrelationship between a child and his/her earliest caretaking environment; they all understand the borderline categorisation in terms of the first internalisation process, the formation of a sense of self, and the consequences of a damaged, split or conflicted identity. The various different theories all converge on the implicit assumption that a distinction exists between the postoedipal, neurotic personality and the borderline personality. The postoedipal neurotic personality deals in whole objects whereas the borderline personality deals in preoedipal relationships which are composed of unintegrated, split objects. The neurotic personality possesses a sense of self which has achieved a cohesive and functional stability, whereas the

borderline personality struggles with a splintered, vulnerable identity, which, because of its lack of cohesion, divides into various self and object complexes.

5.2 Developmental Theories of the Borderline Personality

Charlton (in Schwartz-Salant et al, 1988) asserts that the prospective borderline person's earliest nurturing and mirroring environment fails him/her in a very fundamental way, giving rise to an inner world which is defective in quality and internal cohesion. Failures in the earliest nurturing and mirroring environment are constituted of significant inconsistencies and deficits in holding, feeding and loving. Parents are either physically and/or emotionally unavailable or overinvolved, unable to separate their own needs and those of the infant. Physical and/or sexual cruelty is often present. Reward for regressive behaviour and abandonment/punishment for developmental strivings are commonly found. The response to the inadequate or appalling conditions which the child lives with, is a rage that rises to unmanageable levels and "the experience of victim and aggressor is entrenched within the evolving psychic world " (ibid:58). As a result of the lack of empathic good-enough parenting, the child is unable to develop adequate self-caring and soothing abilities. This, in turn, leads to an inability for integrated conflicting interpersonal relationships, and leaves the internal state fragmented. Early object relations are reflected by "kaleidoscopic movement from almost-annihilated victim to enraged aggressor, from the depths of inferiority to extreme inflation" (ibid:58).

From the striving to obtain love from hostile or indifferent parents, emerge patterns of primitive masochistic self and object interaction and become part of the developing identity. These children learn to be extremely sensitive to the feelings of those around them in order to maintain a connection and manage their anxiety. At the same time they learn to deny feelings emerging from

within. They learn to cope with the contempt, depression, deadness, dismissal, anger and blame expressed by others by accepting roles as the object of such feelings. Charlton contends that:

> this masochistic orientation protects the parent from facing inner conflict by taking one pole of it away, thus preserving for the child a connection to a less conflicted, partially mollified object (ibid:59).

In other words, in order for the child to attain the security of a bond to loved ones, (s)he has to carry or live the conflicts and/or the feelings the parents themselves cannot own.

The co-existence of primitive victim and aggressor identifications counteracts the potential for the emergence of a normal pattern of integration of identity. Any signs of independence, success, innate talent or perception of self as whole or integrated, are met with an internal assault. Because so much energy is spent on fruitless attempts to manage an unmanageable situation, distortions in perception arise, leaving the child vulnerable to confusion between interior and exterior, self and other. The child's inner world, which is constantly threatened by conflict in the most vital relationships, becomes more and more confused, and eventually detaches itself from the sense of identity which is normally unfolded in the unconscious, autonomous development of a maturational pattern. A relatively secure sense of self never develops; instead a "fragmented, endangered multiplicity of self-images" are created which constantly compete with each other and with "primitive, internalised object-images of rejecting and punishing figures" (ibid:60); this exhausting battle leaves little room for an emerging sense of self.

The father of a prospective borderline person has often physically abandoned the family or been emotionally absent, physically and/or sexually and/or verbally abusive, alcoholic or a drug addict. Charlton observes that the father is usually remembered by the borderline adult in extreme terms, and in experience and memory he

is often fused with memories and feelings displaced from the early mother.

The father thus either represents danger or an inability to protect against danger. In either case he fails to provide a place of safety which would make separation from the mother possible. The child thus does not develop a sense of him/herself as being independently secure in space and time, but continues to cling to the mother because separation may cause damage or annihilation. Charlton observes that this leads to a "transitional relationship, in which connection to another offers magical protection from the threat of dissolution of the self" (ibid:60). Aggression, inevitable in the process of separation-individuation, becomes threatening. Perceptions which involve the ideal self image in feelings of hurt, anger or disappointment, are disavowed and aggressive impulses are suppressed, masochistically turned into provocative behaviour and/or turned against the self. The need for the presence of the other in order to guard against dissolution of the self leads to the desire or fear of being swallowed up, a fear which, ironically, reinforces the risk of loss of the self.

The defences that are necessary to manage the child's intolerable anxiety and painful affect are multiple and rigid. At this level of development, repression, the defense mechanism of the neurotic personality, is not strong enough; the multiplicity of good and bad affect-images have to be kept apart and this can only be done through the splitting of the self and object complexes, alternating projection of one pole and identification with the other.

The personality remains, on the whole, involved with dyadic relations, but features of triadic, oedipal and other more developed conflicts emerge. A conscience which is rigid and punitive, and which is based primarily upon "talion-organised victim-aggressor dyads" (ibid:61) emerges and forms its own set of multiple compromises. More mature defences are sporadically

discovered by the fragile and threatened ego, and as these fuse into early compromises, primitive conflict and a fragile self merge and coalesce within areas of structuralised conflict.

In relationships such as work, friendship, marriage, parenthood or analysis, the vulnerability for regression becomes pronounced, and higher level compromises become unravelled. The ability to think rationally and symbolically become impaired and both the inner and outer world lose stability and familiarity. A sense of imminent annihilation reemerges; the fragile self vacillates between intense bouts of depression and states of primitive, presexual masochism.

Masterson's (1981) integrated developmental approach to the borderline personality disorder compliments and adds to Charlton's views on the borderline. However, as Masterson provides an extensive analysis of the developing borderline personality, his thesis will be discussed in depth.

5.2.1 The Rapprochement Crisis

Masterson (ibid) bases his analysis of the developing borderline personality on Mahler's concept of a rapprochement crisis in normal development. One of the functions of the rapprochement crisis during the separation-individuation phase of development, is to bring the grandiose self and the omnipotent object into accord with reality. In normal development this is done by phase appropriate disappointment and frustration. The main feature of the practising period is the child's great narcissistic investment in her/his own functions, body and the objects of her/his expanding surroundings. (S)he seems relatively indifferent to the frustrations and disappointment which (s)he encounters in the exploration of her/his environment.

The rapprochement suphase (15-22 months approximately) begins with the mastery of upright locomotion. This is a period of increasing

differentiation of the child's emotional life which develops alongside the growth of cognitive faculties. However, the previous indifference to frustration, as well as the relative obliviousness to the mother's presence now change, and an increased separation anxiety can be observed alongside an awareness that (s)he is not the centre of the universe. That is, toward the end of the practising period, at the height of mastery, there is increasingly clear differentiation between the self-representation and the object-representation. The toddler now starts to lose his/her prior sense of grandiosity and omnipotence and realises his/her own frailty and relative helplessness in the world. At this stage there is an attempt to return to an earlier relationship with the mother, a relationship which was characterised by a direct, fusional quality. However, the self-representation and object-representation are already too far on the road to differentiation, and the erstwhile relationships does not satisfy anymore. In this way the infantile fantasies of grandiosity and omnipotence are brought into accord with reality.

Self-expression starts with "the self-representation that emerges from the fused symbiotic self-object representation of the mother-child unit as the child passes through the symbiotic phase (3-18 months)" (ibid:102). It continues to develop through the stages of separation-individuation (18-36 months) and the first tentative developments of the ability for object constance (36 months plus). Masterson maintains that this emergence of the self occurs under the influence of: 1) genetic drives, 2) pleasure in the mastery of new functions, and 3) mother's appropriate cuing and matching to the child's individuation (ibid:102). At the height of mastery the toddler develops the capacity to separate from the mother and during the time of separation-individuation the child develops an image of him/herself as separate from the mother. This image emerges first as two part-images: a good-self and a bad-self representation. The two part images then fuse into a whole self-representation, both good and bad. The child loses the grandiose

image of self and the omnipotent image of the object during the rapprochement stage of this process, and then moves toward whole self and whole-object representations:

> In the course of this evolution towards an autonomous self, the child develops a whole self-image (both good and bad) about which he feels adequate esteem, which is based for the most part on the achievement of the capacity to utilize self-assertion, to identify and activate in reality his own individuative thoughts, wishes and feelings (ibid:103).

According to Masterson the developmental arrest of the narcissistic personality disorder occurs before the rapprochement suphase, because the narcissistic personality disordered person continues to behave as if the object representation and the self-representation were an omnipotent, dual unity. Those perceptions of reality which do not resonate with this narcissistic, grandiose self-projection must be sealed off by avoidance, denial and devaluation. The rapprochement crisis, on the other hand, is crucial to the borderline, whose pathology can be seen as a reflection of her/his immersion in and inability to resolve it. Masterson observes that the borderline personality clinically behaves as "if all life were one long unresolvable rapprochement crisis" (ibid:29). The borderline child is thus extremely vulnerable to the normal developmental vicissitudes of the rapprochmemnt suphase. The surge of individuation which accompanies the acquisition of speech, as well as the increased awareness of the separateness from the mother, brings with it a greater need for the mother's support. It is during this vital process that the mother's support is withdrawn. The process is thus arrested and the abandonment depression born.

The borderline's greatest need is to defend against the abandonment depression and (s)he thus has to avoid identifying and activating individual thoughts and wishes, as these presupposes separation and

thus triggers the abandonment depression. Self-expression is thus sacrificed to defense and the operation of the withdrawing object relations part-unit advances the already negative self part-image.

The intrapsychic structure of the borderline is thus of self-and object representations which are separate and split into rewarding and withdrawing part-units. The pathological ego forms alliances with the rewarding object relations part-unit as well as with the withdrawing part-unit. The purpose of these alliances is primarily to defend against feelings of abandonment. The alliances may alternate but one usually tends to predominate (ibid:133). The projections of these two part units alternate, calling for passive-regressive behaviour which requires that the true self is denied, and cannot be asserted. The borderline has no access to self-esteem because the assertion of the self is threatened by the maternal withdrawal projection. The borderline vacillates between clinging to and distancing from the object, continuously defending against the maternal withdrawal projection, in the process foregoing the true self (ibid:29).

In his earlier works Masterson asserted that he had conclusive evidence, based on the observation of many borderline adolescents and their mothers in psychoanalytic therapy for several years, that the mother of the borderline child is borderline herself. Because of her own separation anxiety she requires the child to resonate with her projections through regressive behaviour, thereby defending against her own abandonment depression. The child's development becomes fixed at the separation-individuation stage because she withdraws her supplies at this stage in order to prevent the individuation, which would expose her to separation anxiety, thereby producing the abandonment depression in the child (ibid:130).

In his later works he however came to the conclusion that he had drawn the concept of the borderline mother as an etiologic and

psychodynamic force too narrowly, and restated the original hypothesis in a different form. He now hypothesises that the mother of the borderline may have a disorder even more serious than a borderline syndrome, which may even include psychosis. Mothers who are depressed and empty, or who are ill and/or physically absent during this crucial period, contribute to the etiology.

The key issue is the mother's "libidinal unavailability" (ibid: 132) for the child's separation-individuation needs. Unavailability may be due to any number of reasons. For example: the mother may cling and reward regressive behaviour and withdraw or punish separation-individuation behaviour; she may be neutral to regressive behaviour and prematurely rewards and/or inappropriately promotes individuation because the child's dependence is intolerable to her. In both cases, the failure to respond appropriately to the child's unique separation-individuation needs will be introjected as a withdrawing object-relations maternal part-unit (ibid: 133).

5.2.2 Later Development of the Borderline

Masterson asserts that the borderline child emerges from the separation-individuation phase with a fixed intrapsychic structure that will persist and dominate her/his adaptation. Her/his entrance into the phallic-Oedipal phase is marked by a condensation of pregenital and genital conflicts which result generally in some form of sado-masochistic sexual adaptation. This particular type of adaptation reflects the overriding influence of the earlier level of aggression and conflict: the earlier separation-individuation conflict has now possibly been reshaped by the efforts at resolution of the condensed Oedipal conflict which overlaps it. The latency stage is characterised by failure to sublimate and learn the necessary adaptive skills, and adolescence as a developmental stage is regressively avoided or often produces a symptomatic episode through the person's inability to free herself from the

infantile object (ibid:135).

Masterson observes that in his work with borderline adolescence, borderline pathology is almost always expressed in terms of difficulties with the self. These difficulties are experienced and expressed as difficulties with self-regulation, self-esteem and self-expression. He asks the following questions in his discussion of the concept of self: 1) What is the self? 2) What are its function? 3) What are its constituents and its development? 4) What is the difference between the experiential and the theoretical self?

5.3 The Psychopathology of the Self in the Borderline: A Review of the Theories of Kohut, Winnicott and Masterson on the Concept of Self

Kohut's theory on the psychology of the self has to be distinguished from his observations of defects in the structure of the self, or the psychopathology of the self (Kohut,1977).

Kohut includes the type of disorders described as borderline by Masterson and Kernberg in his assertion that the key pathology of the narcissistic disorder is a primary defect in the structure of the self. He uses the term borderline to refer only to patients with borderline psychosis or schizophrenia. He describes the defects in the structure of the self as being expressed clinically by defensive and compensatory structures which hide a low self-esteem, depression, a profound sense of worthlessness and rejection, and a deep need for response and reassurance (ibid:63). In his observations of the psychopathology of the self, he stresses a number of points which include the following: 1) he distinguishes, on a developmental level between the psychopathology of the self and the psychopathology of the Oedipal conflict; 2) a distinction is made between normal aggression and excess aggression. In this he differs from Klein in that he views normal

aggression as imperative to the evolution and self-assertive function of the self, whereas excess aggression derives from early trauma; 3) he stresses the need to explore serious and latent, but denied parental pathology in the history of patients who exhibit a primary defect in the structure of the self (ibid).

His theory of a psychology of the self focuses on an understanding of the self as being on the one hand the centre of its own psychological universe, while on the other hand part of an overall mental structure. As the centre of its own psychological universe, the self has its own functions in terms of the regulation of self-esteem, its own development and its own psychopathology. Self-esteem is regulated through the actualisation of ambitions and ideals, while development is linked to the mother's mirroring and the father's idealising functions. The psychopathology of the self relates to failures in both mother's and father's functions.

Masterson questions this view as it "competes with, rather than complements, both object relations theory and the findings of child observation research (Masterson, 1981:18). He further points out that Kohut's theory of a psychology of the self conceptually obscures: 1) the distinction between the self and the object as part of the self, and 2) the differences between the various phases of the early development of the self-and-objects representation. The theory further fudges the degree to which the mother's mirroring and the father's idealising functions is important during the different phases of development of the self (ibid:19).

Kohut (1977) argues that drive experience is subordinated to the child's experience of self and self-objects, and stresses narcissism as a separate line of development of the bipolar self. The object is thus joined to the self, implying that the self cannot be separated from the object. Growth thus takes place in terms of maturation from archaic to more mature forms. This view excludes an understanding of development in terms of symbiosis and

separation-individuation, thereby also excluding the need for separation of the self from the object. Masterson strongly questions this argument, and using clinical material of borderline and narcissistic patients in analytic therapy as examples for his argument against the notion of the perpetuation of self-objects, comes to the conclusion that:

> Patients who are working through their abandonment depression/separation of the self from the maternal object report that the mother's withdrawal is experienced as a loss of a vital part of the self, thus relating self to object. When patients whose principal defense is clinging to the object improve, one observes a slow, gradual decrease in the cathexis of the object representation, simultaneously with a parallel slow and gradual increase in the cathexis of the self-representation. ...the emotional investment is being transferred from the object representation to the self-representation, thereby providing further evidence that self and object are initially linked and then separate. This separation is followed by progressive, separate, parallel maturation of both self-and-object representations, each mutually influencing each other (Masterson, 1981:20).

Kohut thus seems to ignore the transfer of investment and consequent maturation. This obscures the distinctive functions the father and mother fulfil in the development of self-representations, and thus the phase of influence of each parent. Masterson points out that Kohut seemingly equates the influence of the mother's mirroring function on the grandiose self between the ages of one and three with the father's idealising influence on the idealised parent image between the ages of four and six (ibid:20). Kohut states:

> If the mother had failed to establish a firmly cohesive self in the child, the father may yet

> succeed in doing so. If the exhibitionistic component of the nuclear self cannot become consolidated, then its voyeuristic component may yet give it form and structure (quoted in Masterson, 1981:20).

Masterson points out that the child only becomes intrapsychically available to the full impact of the father once (s)he had individuated and separated from the mother. Once individuation has taken place, the child's relationship with the father is mediated through a "separate self-representation in a triadic intrapsychic structure" (ibid:21). The relationship with the father cannot be mediated through a fused symbiotic self-object representation in a dyadic structure.

Because Kohut ignores the specific tasks that have to be negotiated in each phase and equates the mother's mirroring and the father's idealising, he is logically lead to the conclusion that the identification with the father compensates for the deficiencies in the mother/child relationship. The implication is thus that the Oedipal conflict can be negotiated and the compensatory mechanisms released without the conflict with the mother being resolved.

Masterson observes that Kohut in fact describes a situation in which a clinging symbiotic relationship is transferred from the mother to the father. The father is then, in an intrapsychic sense, not a father in his own right but mainly a symbol for the mother (ibid:22).

Kohut (1977:63) understands the mother's defective mirroring functioning mainly in terms of her lack of empathy for the child's grandiose exhibitionistic self. She is not able to understand or empathically respond to the child for any number of reasons, which may include depression, narcissism, psychosis, or a variety of other reasons. Masterson (1981) however observes that in his

experience the mother's defective mirroring derives from an emotional withdrawal which is specifically related to the unique way the grandiose exhibitionistic self is expressed by a specific child. That is, the specific mode of self-expression interrupts or frustrates resonating with the projections the mother had placed on the child in order to "shape him/her for use as an object essential to maintain her own intrapsychic equilibrium" (ibid:23). He also notes that it is of the utmost importance to understand that the mother rewards those regressive behaviours that fulfil her projections, thereby blocking not only phallic-genital needs, but also the primitive and fundamental need for individuation.

Masterson (1981) describes a false self, similar to the concept described by Winnicott, which is frequently observed in borderline patients. However, he views this false expression of self as only one of a broader spectrum of clinical difficulties with individuation and self-expression.

He observes that many borderline patients express complaints that can be collated into problems related to self-expression. Some cannot articulate these problems as they are submerged in their pathological behaviour. The complaints that are expressed fall in two categories. The first category comprises the various instances in which they are unable to identify their own individuative thoughts, wishes and feelings. The second category has to do with the inability to initiate, activate and implement the individuative thoughts and wishes that can be identified. A defect or inhibition of self-assertion, and a distortion of self-image, related to an inability to autonomously regulate self-esteem, are always associated with these difficulties with self-expression (ibid:99).

A clinical spectrum of the degree of self-image distortion can be devised, with no self-image at the one end, through the false self-image in the middle to the poor self-image at the other end.

a) No- self Image

Motivations and behaviour are so completely dominated by the need to suppress individuation that few individuative stimuli are allowed to break through. The need to cling to the object dominates all other needs, so that the individuative stimuli that manage to break through cause great anxiety (ibid:100).

b) The False Self

This is less serious in degree than the no-self image. Masterson observes that "it represents a collection of behaviours, thoughts and feelings that are motivated by the need to cling to the object, with avoidance and suppression of individuative stimuli" (ibid:101).

Freud (1950) divided the self into a part that is central and energised by the instincts, and a part that is turned outward, relating to the world in a normative way. The part which is empowered by the instincts can be called the true self, whereas the part that is subservient to the norms of the environment is presumably the false self. This definition is based on structural theory and, as Masterson (1981) points out, poses a false dichotomy. He holds that the true self reflects the individuation process as well as the norms and customs of the environment which is internalised alongside the instincts.

Winnicott's theory of true and false self relies on Freud's division of the self into two parts. However, his perception of the true self favours an understanding of the true self as an entity. For example:

> The true self is the theoretical position from which comes the spontaneous gesture and personal idea. The spontaneous gesture is the true self in action. Only the true self can be creative and feel real. (Winnicott, 1965:142).

He further states:

> There is a compliant aspect to the true self and healthy living, an ability of the infant to comply and not to be exposed, an ability to compromise ... The equivalent of the false self in normal development is that which can develop in the child into a social manner, something that is adaptive (ibid:145).

Masterson (1981) however points out that the separate individuated self, what Winnicott calls the true self, constructively engages with the environment, forming adaptations and compliancies because of its sense of being alive, alert and creative. If the creativity and the sense of being alive were absent, its interactions would be maladjusted.

Winnicott believes that the development of the false self is a function of the need of the true self to remain hidden and be protected. Masterson however observes that, as the true self is a function of individuation, it does not exist if individuation has not taken place. The two selves thus cannot exist side by side; no true self exists, only the potential of one is present. The false self does not protect the true self but those regressive, compulsive behaviours which are the function of the alliance between the rewarding object relations unit and the pathologic ego. As this alliance is called into being in order to defend against the abandonment depression, the defensive function of the false self is to rationalise and provide a false sense of identity that would protect against exposure to the abandonment depression (ibid).

Winnicott believed that a true self emerges only if the mother is able to meet the omnipotence of the infant; that is, when the infant's ego is sufficiently strengthened to give life to a true self "through the mother's implementation of the infant's omnipotent expressions" (quoted in Masterson, 1981:103). Masterson re-phrases this, stressing once again the process of individuation

as crucial in the development of the true self:

> the true self begins to have life through the mother's provision of reward and approval for steps toward separation-individuation. This spurs individuation and gives a sense of true self as the infant begins to separate from the mother (ibid:105).

Winnicott asserted that the mother who is not good enough is not able to implement the infant's omnipotence, and so she repeatedly fails to meet the infant's gesture, substituting her own, which is to be given sense by the compliance of the infant. This compliance on the part of the infant is the earliest stage of the false self and belongs to the mother's inability to sense her infant's needs (Winnicott, 1965).

Masterson translates this observation into the language of object relations, understanding it in terms of the mother's libidinal unavailability which gives rise to the failure of separation-individuation. That is, the mother withdraws approval for separation-individuation behaviour. This withdrawal produces the abandonment depression against which the child defends him/herself by regressive compliance with the mother's projections. As the mother rewards regressive clinging, a system of regressive, pathologic defense mechanisms is set up, constituted of avoidance, denial, clinging, acting-out, splitting and projection.

One part of the split object relations unit which characterises the borderline, is thus constituted of the internalised image of the rewarding mother. This, the rewarding unit, forms an alliance with the regressive defense mechanisms to form a defense against the withdrawing unit, which constitutes the other part of the split object relations. This alliance, whose function it is to defend against the abandonment depression, becomes the basis for the false self. Masterson states:

> Neither of the part-self images of the two units is the

> true self since the latter, a developmental achievement, only comes about through separation of the self-image from the maternal-image, based on growth and development through the mode of self-assertion, facilitated by the mother's mirroring and matching responses (ibid:106).

The development of the false self is thus not a function of the need to protect or hide the true self, since the true self has not emerged. The function of the false self is to rationalise the adaptive function of the regressive defences against the abandonment depression, and this depression is created by the attempt to develop a true self in the first place. The intrapsychic system which results from the compliant response to the mother's projections is then internalised and projected onto the environment. The parallel and complimentary set of pathologic defense mechanisms which, through the false self, react to the mother's projections with compliance, is constantly re-activated so that the false self which the infant develops, relates to external reality on the same basis as it relates to the mother. (ibid).

We have come full circle. Wurmser (in Lowinson, 1981) poses a theory of a phobic system with its antithesis, a protective system between which the compulsive drug user vacillates in order to cope with unbearable anxiety. Wurmser's description of the drug addict is of a person who has no firm ground under his/her feet, who lives with a need for vigilance, whose world is constantly on the verge of collapse, who can only find sanctuary in drugs and the drug culture. This is also the person that Charlton describes, the man or woman who is "frozen in time and direction"; it is Seligman's "half-alive ones", who is "neither in nor out of the womb, but wedged half-way, half-alive, half-born". Ultimately it is Masterson's borderline child who is described here: the child who fights against abandonment in the only way (s)he knows: by forgoing the self, by living in a nether world, in the mother's image and in the mother's need.

CHAPTER 6

INTRODUCTION TO CASE STUDY

Rafiq Jaffer is a twenty-six year old Muslim male. He is a frail looking, attractive person, intelligent and articulate, with eyes which always seem to be searching for an answer to a question which remains unspoken; maybe the search is for a question only, one which could structure his scattered thoughts and confused dreams into a single, manageable quest. When I first met him, he talked in riddles and metaphors, in a coded language which no-one, least of all himself, could decipher. Alienated thought and denied emotion fused in an endless stream of words in which vivid impressions mingled with disconnected memories.

Disgraced member of a wealthy and upright extended family, peopled with confident successful men and timid women, he is a man without a family and without a religion. He drifts and dreams, collects imaginary and real slights like a miser and weaves fantasies of glory, terrible revenge and instant success. Son of an alcoholic father, he carries his father's shame with him like a leper carries his bell. In his dreams he is a saviour; in his dreams he gives his mother a new life and wipes out her sad past. In reality he is a drug addict; a man who lives outside his culture, without faith or hope.

I was first introduced to Rafiq during a ward round in the drug unit (Ward 4) at Lentegeur Psychiatric Hospital. It was his second admission to Ward 4, and Chris Robinson, the Unit Manager, was worried about his continuing depression. His diagnosis at the time was: Axis 1: (a) Polysubstance Dependence (cannabis, mandrax, obex, vesprex, and prohypnol as the drug of choice); (b) Dysthymia; Axis 2: Dependent Traits. He started experimenting with cannabis at the age of 14. By the time he was 16, he was smoking two-three "white pipes" (a cannabis and mandrax mixture), taken with rum and brandy.

He started experimenting with pills at the age of 19. At the time of admission, his daily drug intake consisted of 10-15 vesprex or obex tablets, at least three prohypnol, and two-three "white pipes".

During the ward round, at which a consultant psychiatrist was present, it became clear that Rafiq was not only suffering from depression but from a generalised anxiety disorder as well. We were all struck by his pleasant and forthright presence, and his willingness to answer questions. In a ward characterised by anti-social and narcissistic personality disorders, Rafiq's friendliness and politeness and his refusal to get involved in community conflicts and factions, set him apart. Chris Robinson, who has had many years of experience with personality disordered drug addicts and who believes that drug addiction almost inevitably goes with a personality disorder, felt convinced that Rafiq was an exception to the rule and did not have a personality disorder. He decided that Rafiq would do well in individual therapy (only group therapy is used in the ward). It was decided that projective tests would be administered and that I would take him for individual therapy.

Initially Rafiq was an extremely co-operative and pleasant patient. He valued therapy and said at last he felt he could be "saved". He was well liked and respected by both staff and patients; in fact, he was a firm favourite in the ward and established friendships with many of the psychiatric nurses and students.

When I left the ward at the end of April for another placement, I made arrangements to continue seeing Rafiq for therapy. We had what I perceived as a successful, and even moving last session before I left for a week's vacation, and we made an appointment for two weeks later.

While on vacation, I was contacted by the ward psychologist who told me that Rafiq drugged in the ward and had been discharged (see

appendix 3 for Ward 4 rules). He apparently got hold of pills immediately after our last session and gave some to other patients as well. He swore at the staff, denied having taken drugs and refused to go to the seclusion ward. When discharged, he was dishevelled and disorientated. He flung abuse at the staff and swore never to set foot in ward 4 again. He was back the next day, shivering and crying and pleading to be taken back. The staff refused. He had not only broken the most important rule in the ward but had also caused the discharge of other patients. Moreover, he had disappointed them deeply. He had turned from star patient to abusive junkie: alternating between threats and pleas he followed them around the ward, weeping and wringing his hands, causing distress to staff and patients alike. He looked and smelled offensive and his face was very swollen. The staff thought his behaviour was manipulative. They now suspected anti-social traits. It was eventually decided that he would be accepted back into the ward after a month's attendance at the Outpatients Clinic.

Rafiq stayed with the family of an ex-Ward 4 patient during this month. He found the living arrangements and lack of privacy extremely difficult to cope with and felt guilty about not being able to make any financial contribution to the household. He was, however, the perfect guest. He made himself responsible for the shopping and cleaning of the house and frequently did the cooking as well. He also managed to stay off drugs. The family liked and respected him and repeatedly told him that he was welcome to stay as long as he wished.

The weekend before re-admission he went on a drugging spree which cost him dearly, both financially and emotionally. He was mugged in his drugged state and his father's ring was stolen. He lost the respect and affection of the family with whom he stayed and returned to Ward 4 with a swollen nose and eyes, a bruised face and a great deal of sadness and shame.

Although the staff were now sceptical about him, he relatively quickly re-established himself in their affection. After he had completed his three months programme, the multi-disciplinary team decided to allow him to stay on in the ward whilst looking for employment and accommodation. He received very encouraging and positive feedback in his termination group and emerged glowing with confidence and pride. The glow only lasted a few days before severe depression and devaluation of the ward and therapy set in. He was resentful about having to take part in community meetings and activities, broke ward rules time and again, and drank heavily over the weekends. After repeated warnings he was discharged once again.

Rafiq found employment in October 1990 and we arranged to see one another on Sunday mornings. However he seldom kept his appointments. At the time of writing we are still seeing one another but on an ad hoc basis, as he works long hours and has little money for transport. He has been drug-free since May 1990 but at times drinks heavily over weekends.

In the course of therapy I slowly realised that the initial diagnosis needed reconsideration. Rafiq's fluctuating moods, his inability to sustain relationships, his self-destructive behaviour and his complaints of feeling "dead and empty", all pointed to a personality disorder. I eventually changed the original diagnosis to borderline personality disorder as primary diagnosis.

6.1 Rafiq's Relationship with his father

Rafiq grew up as part of an influential and wealthy extended Muslim family. Both his paternal and maternal uncles are well established in businesses scattered all over this country and the Transkei; his family on the maternal side has, however, a slight edge over the paternal side: the maternal side is somehow more respectable; strictly keeping to the rules of their faith they are confident in

their righteousness and freely dispense advice to nephews and cousins less fortunate than them. Rafiq's father was the only one of this large family who did not make good: he was an alcoholic, suffered from severe depressions and failed dismally in his sporadic attempts to provide for his family. He was frequently committed to the local psychiatric hospital from which he as frequently would escape to his parental home where he was not welcome. Eventually, leaving a trail of debts and promises, still clad in his hospital clothes, and sobbing and drunk, he would end up on the pavement in front of the block of flats where his family lived. His bouts of depression lasted for months, during which time he would sit on his bed for days on end, staring at the wall. The young Rafiq would sit next to him, telling him over and over that things could still turn out well: they all just had to pray very hard and work very hard and look on the bright side and everything would be fine. Or he would ask: "Why are you so sad, Daddy? Did we hurt you? Did I hurt you?" There was never any response.

When drunk, his father would be full of bonhomie and clumsy generosity, promising his silent wife and child unheard of riches. Or, when very drunk he would become verbally abusive and sometimes, but rarely, physically abusive; he would vomit and fall over his wife's polished furniture, turn mean and sly and resist all their attempts to get him to his room and bed; sometimes he would turn on them violently. Rafiq remembers coming home from Mosque on Friday afternoons and seeing his father weave his unsteady way from lamppost to lamppost. Then Rafiq would turn into a clown, jump and shout and grab a friend's satchel and run away with it, leading his friends across the street and round the block, away from his father. Years later Rafiq repeated his father's performance and weaved his drugged way through his town's streets. Now it was his young cousins who turned away from him.

Religious festivals, family birthdays, weddings and anniversaries all filled Rafiq with dread. His father always refused to attend:

he would either be drunk, recovering from a hangover or in a depression. Whatever the case may have been, his wife and sons attended these occasions without him. In his father's absence, Rafiq was the head of the family and it was to him that his uncles and aunts came with their veiled questions: "Is your father not here today?" they would ask with feigned surprise. "I hope he is not ill?" "Yes", Rafiq would say, "he does not feel very well today". "Perhaps he is working too hard?" they would ask and snicker and Rafiq would smile back weakly, knowing that they knew that his father was unemployed. Rafiq recalls that it always felt as if he was falling during those occasions - there was nothing to hold on to, he was all alone and he was falling. He could feel all of them looking at him and his mother, whispering and scandalmongering behind their hands. His mother would stand meekly beside him, listening with downcast eyes to the questions, waiting for him to provide the answers.

In 1981, when Rafiq was 17, his father joined Alcoholics Anonymous and remained sober till his death in 1988. During this sober period he tried very hard to win his son's love and friendship, but Rafiq could neither forgive him, nor love him. By this time he was already heavily dependent on drugs and his father wooed him with cannabis and money. Rafiq smoked with him and took the money but refused the love. His father went with him on leadership courses, tried to share his memories and own youthful ideals and plans for the future. Rafiq wished his father would stop pretending they were friends. They were not: Rafiq could not, nor did he want to, forget the past.

One night in 1988 his father came home after an AA meeting and went up the back stairs to smoke his daily dagga cigarette. He had a cardiac arrest and died. Rafiq and his mother waited up for him most of the night, sitting together with their old memories of waiting for him to come home drunk and violent. Early the next morning a neighbour called. He pointed to Rafiq's father, sprawled

on the stairs below and said: "I see he has gone back to the drink then". Rafiq remembers thinking: "The fucking shit, he has gone and done it again. I knew he would". His mother ran downstairs and he followed. When they reached his father, he knew almost immediately that he was dead. He now says that he felt a sense of loss then, a sadness at having lost someone he had known all his life. He did not feel grief for the loss of a father. Yet, in Ward 4, in an evocative group session in which he was asked to write a letter to someone he had lost, he chose to write to his father. "Dear Dad", he wrote, "I never thought I would say this to you, but I miss you very much".

As eldest son, Rafiq was now head of his family and was expected to provide financially as well as fulfil the religious and traditional duties of the father. Members of his extended clan congregated in his hometown from all over the country for the funeral; many solemn speeches were made, each reminding Rafiq of his honourable duties. At this stage Rafiq had been off drugs for five months following two months spent on a mission. He now went back on drugs. On the last afternoon of the days of mourning, when the flat was packed with respectable uncles and aunts and the narrow street outside was clogged up with Mercedes Benzes', Rafiq stumbled in and loudly denounced the family. In the scandalised silence that followed, he demanded money, swore when none was forthcoming and stumbled out. He found money somewhere, he cannot remember where and for the next few months lived his life in a nether world of uppers and downers; sometimes when the streets were dry he turned to alcohol, and, heaving with distaste for the smell and taste, drank himself unconscious.

6.2 Rafiq's Relationship with his Mother

Rafiq's mother is a timid, gentle and very religious woman. She remained loyal to her husband during his years of drinking and now remains loyal to her son. She works hard and seldom, if ever,

complains. She gently and frequently tells her son that she does not blame him for anything, that she accepts everything which has happened in her hard, sad life: she understands that Allah is punishing her for her sins; sometimes, however, she wonders why her punishment must be so very hard.

Rafiq speaks of his mother with great love. His memories of her are all sad, heavy with guilt and anxiety. As a child he used to sit up with her and wait for his father to come home. He remembers her sad, tense figure on the couch, waiting motionless and silently deep into the night. Sometimes he would fall asleep and wake up out of a dream and see her still sitting there. Then he would chide himself for failing her and sit up with her. When his father came home, he would be the one to wipe up the vomit and settle him for the night. His mother never complained but he was always aware of how sad and difficult her life was, and as a child he promised himself that he would be very rich one day and make her happy. He once told an uncle of this dream, and his uncle said that Rafiq's mother was a good woman and deserved such a good, caring son. Many years later the uncle called the family together and told them about the promise Rafiq made to him as a child. "Look at him now", he said, "look how much his promises meant". Rafiq and his mother sat side by side on the couch, surrounded by their successful and respectable family. His mother sat with her eyes downcast. Rafiq smiled sadly when he told the story: his mother had never defended him against his uncles and aunts. Not once. But she is a timid woman, she allows herself to be dominated. She has always been the most timid one in the family.

She was an anxious mother when he was a child. There was a wild, noisy bunch of children in the block of flats where he lived and he often got hurt in the street games: a torn toenail, a finger slammed in a door, a knee that gushed blood. Once he fell out of a tree on the tarmac below and broke an arm. Another time he fell from a swing and suffered mild concussion. Every time the injury

turned into a catastrophe, a wild race to the hospital, with his mother weeping and blaming herself, his grandmother lamenting and scolding the other boys for their wild ways: they were hooligans and skollies and Rafiq was different. He was accident-prone and sensitive and did not belong with them. If only they could move to another neighbourhood, if only there was some money, if only life was not so hard. When it was pointed out to him in therapy that all little boys break arms and tear toenails and have to be stitched together time and again, he remembered, with uncharacteristic bitterness that indeed, his friends also sustained injuries of various kinds and no fuss was ever made about it. During a therapy session he remembered a favourite aunt with whom he had spent one glorious summer holiday. She had five sons and they were as wild as they come. The six of them terrorised the neighbourhood that summer, got into scrapes and trouble, broke legs and arms, once almost drowned, went on long hikes and slept in the veld. When the neighbours complained, the aunt would stand at her gate, arms akimbo, and shout abuse back at them. 'Boys will be boys', she repeated ten times a day, over the phone, to irate neighbours, once even to the police. She bandaged their various injuries, provided huge meals and left them alone. Now her sons were respectable and very rich businessmen, Rafiq said with bitterness. When he is with them he feels such confidence, as if everything is possible. The world seems such an easy place when he is with them - one can just go out and get a job and make good and get married and buy a house and a car and have a family. But it is only when he is with them that these things seem possible.

Rafiq seldom speaks about his mother. He feels he has hurt and disappointed her, and made her life even more difficult. To him she is all goodness - she is almost saintly. She never raises her voice; she has suffered so much but she has never spoken a harsh word against her husband. Rafiq has a distant family member who is also an alcoholic. His son hates him and often assaults him when he is drunk. Rafiq's mother often refers to this family when she

reminisces about her own husband and she never fails to tell Rafiq she is very grateful that he never assaulted his father. Once, however, when Rafiq was about fourteen and working in his uncle's shop over weekends, his father stole his little hoard of money and got very drunk. When his father came back that night, he was in a particularly mean mood, and refused to allow Rafiq to settle him for the night. He struggled and swore and vomited and Rafiq kicked him, only once but very hard. His mother also never fails to remind him of that incident. "Do you remember the time you kicked your father?" she would say and her eyes would fill with tears. Rafiq would watch helplessly, trying to feel guilty, trying to apologise but the emotion would be faked and the apology meaningless. Rafiq was never allowed to feel anger, certainly never to express it. They were a happy family; life was hard but they were blessed in many ways and they had to make the best of things. The anxious waiting, the drunken violence, the misery that pervaded the house like a bad smell, was never spoken of. It was the secret everyone knew, but no-one told.

Life is still hard now but Rafiq's mother still does not complain. She has now realised that she is on her own, and that no-one will look after her. Life will remain hard and she must accept it as such. She writes to her son every week, telling him that she expects nothing from him, she only wants his happiness. She prays night and day that he will find happiness, and that he will become a man. She also prays that he will find a woman to look after him. She wants him to be married, and to be looked after by someone else now because life is hard and she is tired. She tells him what his uncles and aunts are saying about him and assures him she does not agree with them: she does not expect him to come home and look after her - her only wish is that he would become a man. She says she does not want to hold the past against him, there are no recriminations from her, she does not want to "nag" him: she would rather say nothing.

After his first discharge from Ward 4 Rafiq spent three weeks at home with her. He sat with her every night and she told him stories from her past, her hopes for the future when she was a young girl. She shared dreams and memories with him and he listened. In a family therapy session during his second admission, she told the therapist that those three weeks were amongst the happiest in her life. Rafiq said nothing then but later told me that it was a time of utter misery for him: he felt suffocated, sometimes he could not breathe and feared that he was dying. He went back to drugging because he felt as if he was dying - drugging was the only way he had to reclaim his life.

But he feels guilt like a sore tooth worried by a tongue. He would so much like to make it possible for her to stop working, he would so much like to make her life better.

6.3 Employment History

Rafiq circles in remorse and shame. In an individual therapy session seemingly disconnected memories from his childhood mingle with anxiety about the future, hopes about the present and yearnings for a friend, a lover, a brother - someone to support him. His anxiety about a job is intense. He has never been able to hold down a job or even go for an interview when not drugged or drunk. When talking about leaving the hospital and finding a job, he frequently speaks about nine months he spent in the Transkei, working in his uncle's shop. This uncle was a harsh, impatient man, loud and critical, with explosive outbursts of anger. There was no prohypnol available in the little Transkeian village, and mandrax and cannabis hard to get hold of. So Rafiq drank. He hated the smell and taste of brandy but would keep a bottle in the toilet and slip out every half hour or so to have a few sips. After a few hours of drinking, the shop and the village and his uncle would become bearable again, the day's edges softened, he would stop heaving from the smell of the brandy; the day would pass. He speaks

of interviews in which he was high on obex, drunk on brandy, floating on prohypnol. Jobs would last a few months, sometimes only a few weeks or days. With every new job there would first be the anxiety, then prohypnol and the feeling of having come home; the future would be bright, the work a challenge and a promise. He would be creative and enthusiastic and happy. Then something would happen: a harsh or impatient word spoken by someone, a feeling that he was not trusted or appreciated. His drugging would increase because now the workplace was a prison and his colleagues enemies. Eventually he would be dismissed or resign or just walk out. These patterns have repeated themselves so often he now has no belief in his ability to hold down a job. Nor does he believe it is possible to go for an interview without the support of some kind of drug.

And so Rafiq circles in despair and love. His tasks are clear- cut, the rites of passage laid down before his birth by his culture and religion, by myth and legend: he has to enter man's estate, take his place in the long line of men who care for mothers and wives and children, run their businesses with confidence and aplomb and congregate at their mosques to confirm that they are the chosen, that they have earned their place in the "Light". But Rafiq dwells in darkness and doubt. How to take his place in the family hierarchy when his memories are heavy with shame and waiting, when he has been taught he is too weak to compete in the street games. His mother is timid and shame-faced, his father escaped from mental institutions and weaved drunken patterns in the streets on Fridays, Mosque days. His uncles are loud, confident men; they know no doubt, and no respect for the privacy , the "otherness" of another. They judge and do business harshly and acknowledge only the reality they find in money and Allah. Rafiq's reality is different: like a hothouse plant it flowered in the nights he waited with his mother for his father to come home, watching her eyes, absorbing sorrow, responding to her every mood and need. Rafiq's youthful models of masculinity were his frighteningly loud, verbally abusive uncles and his weak, pathetic father. The boy who resonated with his

mother's every sigh could not identify with his uncles who lived in a powerful male world, far removed from the cloistered female world. No bridge existed between the world of power and money and the world of patient waiting and suffering which his mother inhabited. Nor could he identify with his father, the pathetic drunk, the depressive who feared his uncles' world as much as he did. Rafiq could neither internalise the castrating maleness of his uncles nor the impotent maleness of his father; it has thus not been possible to enter the symbolic order (see section 4.4.), to live the story, live under the law and talk the language of the symbolic order. It has not been possible to re-formulate the relational structures of his early history. He has no 'own' story to tell. Rafiq can only circle in the imaginary order in which self is lost in other, he can only use the fusional, dual and immediate language of the imaginary order in his struggle to define a self which can take its place in the world of men. And thus he fails: he lives in his mother's image of him, he lives in a language that cannot provide access to the separation of self from other.

CHAPTER 7

DRUG ADDICTION AND BORDERLINE PATHOLOGY

> We tend to think of the father too one-sidedly as the castrating figure, a kind of bad mother image in the preoedipal period ... against the threat of the maternal engulfment, the paternal position is not another threat or danger, but a support of powerful force (Mahler, 1976:142).

The hypothesis that I want to put forward here and that will be developed in the course of this chapter, is that drugs could serve a regressive as well as a progressive function in psychodynamic development. In order to illustrate this theory, I will present an in-depth analysis of the psychodynamic structure, encompassing the developmental tasks and the developmental arrests that necessitate the compulsive use of drugs for Rafiq Jaffer. The discussion will include a dialogue with and criticism of addiction literature within the context of developmental theory. I will extensively draw on Masterson's analysis of the dynamics of borderline pathology in order to illustrate the relationship between the borderline personality structure and the compulsive use of drugs. Because of the limited nature of this study, it has to be kept in mind that no attempt is made to generalise these observations into a comprehensive theory of drug addiction and borderline pathology. My observations are limited to one case only. It is, however, an attempt towards understanding the psychodynamics of drug addiction as such within the framework of developmental theory.

I believe that drugs serve a progressive function in Rafiq's interpersonal relationships, that they serve as a mediator between him and the world. His addiction makes the attempt to find a place and role in the world possible. To some extent his addiction serves as the 'signifier' that creates a separation in the fusional,

direct relationship between mother and son; it embodies, so to speak, the role of the father: in the absence of the father, drugs introduced him to and support him in the world; in his case they stand in for the absent father, and in this sense his addiction serves a progressive function: it saves him from engulfment, from losing self in other. However, while drugging can be viewed as the attempt to anchor himself to the world, to overcome the fear of the world, Rafiq's compulsive use of drugs also prevents entry into the world, it ensures the continuity of the bond between mother and son that is kept alive by his dependency. In this sense his addiction serves a regressive function.

Stanton (in Boszormenyi-Nagy, 1974) stresses the importance of understanding the contradictions that constitute the family dynamics of the compulsive drug user. He observes that while the compulsive drug user flaunts the family rules and values, thereby putting himself outside the family group, he attains the reverse: he reinforces his dependency on the family and saves the family cohesion. Should he become healthy and well, the dissolution of the family would be risked: "He is the loyal son who denies himself and rescues his family. He is a saviour" (ibid:64).

Although it would be possible to argue that Rafiq's addiction originated in the need to hold the family together by carrying their unacknowledged illness, this is not a point I wish to explore. What is important, though, is Stanton's understanding of the contradictions that are inherent in the compulsive use of drugs: it allows the addict breathing space, it allows him to step outside the family group. At the same time his inability to look after himself, to hold down a job, to achieve financial and emotional independence, ensures and reinforces the dependency on the parents, thereby prolonging the position and status of child far beyond childhood. The implication is that the regressive behaviour is needed and subtly encouraged by the parents in order to meet their own needs for this type of relationship.

Stanton's focus is specifically on family dynamics. As he works within the tradition of addiction theorists who, while acknowledging the prominence of personality disorders among compulsive drug users, ignore the specific dynamics of the borderline and narcissistic disorders, he, with Wurmser and Chein et al, ultimately merely describe behavioral patterns in the family, but fail to explain the dynamics that prevent separation and individuation. The debate as to whether the compulsive use of drugs serves a regressive or progressive function thus continues; the underlying implication being that substance abuse is a discreet problem, independent of the specific dynamics of the borderline and narcissistic condition. Although it is widely accepted that substance abuse may be present in up to two thirds of patients with borderline pathology (Dulit et al, 1990), substance abuse in borderline patients is still viewed as a pathology with its own autonomous features, course and outcome. Although it is accepted that drugs serve as a temporary replacement for defects in psychic structure and as such regulate drives, specify defences and control affect, the specific function of drugs in substituting for the developmental arrests that take place in the different personality disorders, is largely ignored.

I want to put forward the argument that drug addiction cannot be understood outside the parameters of developmental theory; the compulsive use of drugs is inextricably bound up with the developmental tasks that the person who seeks support and surcease for his anxiety in substances, fails to negotiate. Rafiq Jaffer has all his life been dismayed and overwhelmed by these tasks; it is ultimately the sense of dismay, the knowledge that he is alone with an unmanageable task, that makes a world without drugs untenable for Rafiq.

The psychodynamics of drug addiction when borderline pathology is present, is presented below. The presentation will be structured into three separate but related sections. They are:

1) Relationship with mother: This section will focus on the following themes that emerged in therapy:

a) individuation/separation;
b) abandonment depression;
c) the inability to leave home.

The emphasis in this discussion will largely be on the regressive function of substance abuse and will be explored within the context of developmental theory. Stress will be put on Melanie Klein's concept of the paranoid-schizoid position and Margaret Mahler's understanding of a rapprochement crisis in normal development.

2) Relationship with father: This section will emphasise the following themes that emerged in therapy:

a) the absent or inadequate father;
b) the male representatives of the family;
c) the developmental tasks that are perceived as too difficult to negotiate without the support of substances.

The discussion around these themes will focus on the progressive use of drugs. Emphasis will be placed on the negotiation of the Oedipus Complex and Jacques Lacan's linguistic understanding of the Freudian act of repression as a process of metaphor formation.

3) The Sense of Self: The lack of a firm sense of self will be discussed within the framework of the following themes that emerged in therapy:

a) being homeless;
b) the support that is derived from the use of substances.

The discussion in this section will be based on Donald Winnicott and Masterson's views of the self as a sense of wholeness, emerging out of the mother's mirroring and the successful negotiation of the normal developmental tasks. In the concluding section the above themes will be synthesised in a discussion of the dual function of

substance abuse.

7.1 The Phobic Structure

> I knew when I took that beer that I would not be able to stop. But I could not not take it, I had to, everything was unbearable. It was at a party, you know, and everyone was happy and dancing and laughing and I felt ... it felt ... as if I was falling, you know. There was nothing to hold on to. There was no way to be without it. I had to take it (Rafiq Jaffer).

Rafiq grew up in a house where his father was an alcoholic and his mother was preoccupied with the behaviour of her alcoholic spouse. She was wrapped up in the patterns and consequences of her husband's drinking to the extent that it amounted to co-alcoholism on her part (Black 1981); I would hypothesise that the combination of alcoholism and co-alcoholism resulted in neither parent being available on a consistent, predictable basis to meet Rafiq's emotional needs in infancy and early childhood. During the paranoid-schizoid position when relationships are experienced in terms of part-objects and emotions towards these objects are split into absolutes of hatred and persecutory anxiety towards the frustrating bad object and love and reassurance towards the gratifying good breast, the lack of predictability and consistency intensified and pathologised the normal developmental fear that persecutors may invade and destroy the self and the ideal object. As Bernd Jager (in Kruger (ed), 1984) points out, the oral sphere is essentially one of trust and the urge to oral contact, the urge to be held and supported. The unpredictability of support and availability derived from the combination of alcoholism and co-alcoholism led to a fundamental but unacknowledged distrust in the strength of both the ideal object and his own libidinal impulses during this phase; it would thus not have been possible for Rafiq to fully identify with his ideal object and to feel increasingly

able to defend both himself and his ideal object against the bad object and his own bad impulses, i.e. to reach the depressive position. In this preambivalent phase the degree of persecutory anxiety is intense, and I believe that this is the anxiety Wurmser (in Lowinson, 1981) describes in his observation of an anxiety that lies at the core of the phobic structure that defines the infantile neurosis. Although Wurmser specifies the conflicts underlying the infantile neurosis as pertaining to the triad of early separation anxiety and real object loss, castration anxiety and castration shame, and anal-sadistic conflicts, he fails to analyse the system of interactions between mother and child that give rise to the intensity of the anxiety. He therefore has to rely on the assumption, which remains clinically unsubstantiated, that the traumatic quality of the anxiety presupposes massive early and ongoing traumatisation. Moreover, both Wurmser and Masterson (1981) emphasise a relatively late stage in development as the focal point for the unconscious fear of abandonment and/or annihilation, which both agree is what the anxiety represents. Wurmser explains the prevalence of inward-turned aggression and narcissistic expectations in compulsive drug users by rather vaguely referring to the rapprochement phase, the phase of early separation anxiety, whereas Masterson isolates the inability to resolve the rapprochement crisis as the crux of the fear of abandonment. Although I agree with Wurmser and Masterson that the developmental phase that is represented by the rapprochement crisis is of dominant importance in both borderline pathology and the compulsive use of substances, I believe that insufficient attention is payed to the persecutory and annihilatory anxiety that dominates the paranoid-schizoid position. The fear of "bursting asunder" that lies at the core of the anxiety that Wurmser describes (in Lowinson, 1981:67), speaks of a very early mismatch between mother and infant, an inability on the mother's part to provide reassurance that the good object could be kept safe against the bad object and the infant's destructive impulses. The concept of "bursting asunder" seems to describe a subterranean awareness of a

continuous threat that the world may collapse at the unforeseen whim of an unknown force. I want to propose that this threat during the early months of life, at the time of the oral stage when the persecutory anxiety of the paranoid-schizoid position is dominant, constitutes the core of an anxiety which is perpetuated and reinforced by later damage. Bernd Jager says of this stage:

> at the time of the oral stage when the mouth rules all, we are supported by the mother in the most complete sense. Not only do we drink the substance of our life from her breast, but at the same time, while drinking and caressing with the mouth, we are held in the mother's arms and thereby find intensified the relationship of nourishment and support (in Kruger (ed), 1984: 151).

Jager further points out that our relationship with food, which has its foundations in the oral phase, cannot be separated from our relationship to the world in its dimension of "offering support, of giving us a legitimate place, of holding us securely, of delimiting us in a way that makes possible measure, satisfaction, legitimacy, security, sociability" (ibid:156).

I want to argue here that the need for vigilance which characterises Rafiq's interactions with others, the anxiety which points to an expectation of imminent catastrophe, the depression which is described as a feeling of falling, a knowledge that there is nothing to hold on to (see appendix 2, session 31), is derived from the lack of consistent hospitality during the oral phase, a lack which intensified the normal persecutory anxiety of the paranoid-schizoid position, and makes it so difficult for the child and subsequent adult to work through the depressive position, a working through which depends on the capacity to make reparation. As Segal (1979) points out, the early ego is weak and defenceless and tends to fragment and disintegrate under the impact of anxiety; the terror of disintegrational annihilation lies at the core of the anxiety which Wurmser describes as the "fear of the most radical

bursting: that into small fragments of body and mind" (in Lowinson, 1981:67). Klein (1975) observes that the emotions of the very young are characterised by their extreme and powerful nature, so that the bad object becomes a "terrifying persecutor", while the good object needs to be turned into an ideal object which would protect and safeguard the infant against the danger of internal and external destruction. In the paranoid-schizoid position ambivalence cannot be tolerated because the danger is too overwhelming. The dormant anxiety of "bursting asunder" becomes intolerable when anger, or even ambivalence toward the ideal object is experienced. I would hypothesise that it is this anxiety, which makes the preservation of the ideal object a matter of life and death, that lies at the core of Rafiq's inability to express, or even experience anger toward his mother (see appendix 2, sessions 11 and 14) and which makes the expression of anger in general something which is fraught with danger (see appendix 2, sessions 7, 10, 17, 21, 24). The only expression of anger which is admissible and tolerable is the violent emotions expressed toward his father (see appendix 2, sessions 10, 14, 28). As his father had never offered hospitality, had never provided legitimacy and security, nothing could be lost by the expression of anger; in fact anger toward his father protects the ideal object, as it keeps separate the loved object from the dangerous one and thus keeps it untarnished by his own destructive impulses, thereby providing a semblance of protection for himself.

In summary: my argument here centres on Wurmser's contention that underneath the regressive affect states that characterise the personality of the compulsive drug user, there lies a phobic structure which is of such a traumatic quality that massive early and ongoing traumatisation must be presupposed. Wurmser's failure to systematically analyse the self-destructive process of drug addiction within the framework of the developmental process leads to an apocalyptic presupposition which throws little light on the psychodynamics of the compulsive use of substances. I am

challenging the trauma theory here (although I agree that it is certainly an important factor in the histories of many drug addicts) by arguing that a mismatch in early infancy may well lie at the core of the phobic structure that Wurmser speaks of. I am arguing that massive trauma in all probability did not occur in Rafiq's history, but rather a slow, insidious erosion of the potential of finding a valid ground, a legitimate place, a faith in his right to his inheritance. Furthermore, that the anxiety which is caused by the emotional conviction of being homeless and without right to a legitimate place, the fear of falling and fragmentation, is not necessarily derived from abuse and trauma but could well be traced back to what Jager calls "the loss of an original welcome" (in Kruger, (ed), 1984:157). I am arguing that the dependence on the holding of a mother who is anxiously wrapped up in her relationship with an alcoholic husband, must lead to a sharpened vigilance, an awareness that the world, of which the infant is still an extension, is eminently fragile. The quality of the care of such a mother must of necessity be unpredictable and inconsistent because it is influenced not by her relationship with the infant but the relationship with her husband. In this situation it is not possible for the infant to allow himself ambivalence towards the mother who is sometimes available and often not, because he is too precariously posed between survival and destruction. The annihilatory anxiety dominant during the paranoid-schizoid position now has the potential of becoming a permanent feature of his mental life, forming the foundation of the anxiety that colours and shapes the subsequent incompetence in negotiating the necessary developmental tasks.

7.1.1 The Ever-Present Mother

> It felt like ... as if I was dying, you know. Sitting there with my mum every night ... it made her so happy. She was like a young girl, it was so nice to see her like that. But I felt ... I had to get my life back, man.

> Drugging was like the only way I had ... it was the only way I could, you know, feel alive again (Rafiq Jaffer).

> They used to flame in the window in the March sunshine as he sat on the sofa chattering to his mother. The two knitted together in perfect intimacy. Mrs Morel's life now rooted itself in Paul (D.H. Lawrence, 1973:176).

Rafiq's mother was the wife of an alcoholic and verbally, sometimes physically abusive husband. He shamed her in front of her family and disgraced the name of his own family. He not only failed to provide financially for her and her two sons but, most importantly, failed to give her a place and a role in the strict Muslim hierarchy of wives, mothers and sisters. Moreover, wrapped up in his alcoholism and depression, he failed to meet her needs for sustenance and intimacy. She therefore turned to her eldest son to have these needs met. He was going to be the saviour of the family, her lifelong companion, the mediator between her and her disapproving, sometimes hostile brothers and sisters-in-law (see appendix 2, sessions 3 and 8). Dependent on her son for affection and validation, she was unable to combine a relationship which simultaneously contained togetherness and separateness. The intensity of her need thus bound the two of them in an inner relationship of symbiosis in which boundaries were fluid and sometimes non-existent; her son had never been given the opportunity to distinguish between his needs and hers because he was never allowed to negotiate the transition from their shared world to a world he could inhabit as an individual with his own name and a legitimate place. The intimate, shared world of mother and son became her haven and his prison from which no escape was possible. Even when he was given the keys to the prison doors in group-and-individual therapy he could not take them: their shared world is too fragile: it can splinter from a disloyal thought, a harsh word and the world outside that intimate relationship is foreign territory, an alien landscape in which he cannot survive.

Although Rafiq speaks of his tasks in terms of mastery and control, the psychic task that takes dominance in his life and prevents him from making the direct and vigorous attempts that would relate him to the world, is the protection of the world he shares with his mother, the protection of himself from the world.

Masterson's contention that the mother of the borderline child herself suffers from a serious psychological disorder, is of importance here (Masterson 1981). Once again, an overstatement of the pathology of the mother may be possible. However, I do not want to argue against this assertion. In Rafiq's case though, I would like to point out that the problems facing the Muslim wife of an alcoholic are severe. Not only is alcohol seriously prohibited by the Muslim religion, the material failure of the alcoholic has far-reaching cultural consequences in terms of family hierarchy and respectability. A serious pathology does not necessarily underlie such a mother's dependence on her son: the norms of her culture and religion narrows down her possibilities for success and status; she only has access to these through the male members of her family, she can only achieve a role and a place through a husband or a son, and these channels are culturally approved. This puts the burden of achievement squarely on the shoulders of the eldest son if the father fails in providing a place for the family in the extended family hierarchy. As can be seen in the therapy notes (appendix 2), the burden of provider, as eldest son of the family, rests heavily on Rafiq (see especially sessions 3 and 28). He needs to take his own place in the family hierarchy, and he has to reclaim his mother's rightful place. Moreover, and most important, is the unspoken message he has throughout his life received from his mother: that he has to make her life better, give her a new life and wipe out the sad past. His role and place have been determined before birth, and neither his culture and religion nor his mother's plight provides an exploration of his own potential. Ultimately, the failure of individuation has to be understood in terms of both his mother's libidinal unavailability to her son's separation-

individuation needs as well as the constraints his culture and religion place on the sense of personal selfhood.

The failure to individuate and the role that drugs play in the defence against the abandonment depression will be discussed in this section in terms of Masterson's concept of the intrapsychic structure of the borderline, which consists of separate self-and-object representations, split into rewarding and withdrawing part-units. However, I want to argue that sole emphasis in this case should not be put on the mother-son unit; the religious norms which punish any exploration of the self which transcends cultural boundaries, need to be taken into account in order to understand the full extent of the fear of the abandonment depression and the anxiety associated with the search for a legitimate place in the world. I am arguing thus that the fear of abandonment by the extended family, rejection by the religious and cultural community, perpetuates and reinforces the fear that no accessible place exists outside the closed, intimate circle of mother and son.

My hypothesis here would be that the anxiety that took a pathologic shape in the oral phase because of inconsistent mothering, developed into the phobic system that Wurmser speaks of during the rapprochement crisis. Although no information of this time is available, Rafiq's mother's extreme anxiety about her son's safety (see appendix 2, session 15) indicates an unwillingness on her part to allow her young son to explore his world outside the parameters of her maternal protection. Direct punishment or withdrawal of affection might not have accompanied his thrusts at independence but the consequences were always traumatic: the mad race to the hospital for the smallest injury, his mother's tears, blaming herself for his every misfortune, his grandmother's scolding of his friends; the litany that thematised his efforts to join his peers in their rough-and-tumble world: he was different, he was sensitive, he did not belong (see the Introduction). The message

that was internalised was not necessarily that he was bad, but that he was weak and inadequate. During a therapy hour he confessed that his anxiety about being with people is because they may find out that he is basically an inadequate person, a non-person (see appendix 2, session 19). People may respect him and like him, but this makes him even more anxious because then he has to work so much harder at hiding his inadequacy. Of importance here is that the unspoken acknowledgement of this inadequacy, acting upon the non-verbal assumption that he was unable to survive without the mother's protection, prevented the trauma of his mother's tears, the catastrophical consequences that followed attempts at independence. Rafiq describes his mother as a timid person, someone who trembled when she had to explain her husband's absence at family gatherings, someone who sat with downcast eyes when her son was confronted by her brother. It seems safe to assume that Rafiq's mother found the world an unmanageable place filled with danger; ultimately a place that could take her son away from her. Masterson (1981) observes that the mother of the borderline child requires the child, because of her own separation anxiety, to resonate with her projections through regressive behaviour. Rafiq's mother's fear that her son would be taken away from her through his participation in peer activities outside the maternal embrace, led to a subtle but insidious punishment of individuation behaviour: his punishment was her tears and despair and the only way he could prevent the tears and succeed in making her life easier was to remain within the sheltered circle of women.

The regressive function of the use of drugs is of importance in this context. Wieder and Kaplan (in Lowinson, 1981) maintain that opiates produce a state that simulate the fusion with the mother, thereby avoiding the separation anxiety caused by the adolescent dependency crisis. I want to argue here that Rafiq's drug addiction is to a significant extent related to the fear of separation from that protective maternal embrace. The earliest message that he internalised was that the world was unpredictable and that the good

object was unable to provide safety against the world and his own destructive impulses. In order to protect himself and to increase the power of the good object, he had to idealise it, and all doubt concerning the strength and goodness of the object had to be denied. During the rapprochement crisis, at the time of separation-individuation, the image of himself as separate from his mother, emerged as two part-images: a good-self and a bad-self representation which, together with the pathologic ego, formed alliances with the rewarding object relations part-unit as well as with the withdrawing part-unit. The good self, in Rafiq's case, was the inadequate, sensitive "different" part-image and centred on behaviour that pleased the mother: staying at home, staying close to the mother, giving up the attempts at mastery, control and competition that are tested and achieved in the games with peers. Correspondingly, the bad-self representation was connected with attempts at independence and separation from the closed family circle which centred on the father's alcoholism. These attempts caused disruptions and havoc and was met with despair for the damage done to an already beleaguered family. The good self is the inadequate self, the self that does not cause fear and despair for the mother, and it is this part-unit that is still brought into operation in Rafiq's interactions with others. In session 19 (see appendix 2) he came to the realisation that he has to diminish himself in order to be accepted by others; his style of interaction is wholly characterised by an obsequious diminishment of himself as a person. If he did not diminish himself he would be "too harsh, too much", he would "push people away" (appendix 2, session 19). In other words, he would cause the withdrawal of affection, he would cause pain and damage, and, as he states so sadly in session 21 (appendix 2), he would rather carry the humiliation and hurt than be responsible for other people experiencing these feelings. However, the cost of keeping the mother reassured is the failure of mastery and competence. The self is felt to be small, weak and inadequate; correspondingly the world appears unmanageable and overwhelming, so that the protective maternal embrace is actively

sought in order to protect himself from the alieness of the world. The good self is then also at one and the same time the bad self, because despite his best attempts at pretending that he can participate as a whole human being in a world he has mastered, the fear remains that he would be "found out", that his basic inadequacy would be revealed to a mocking and unforgiving audience (see appendix 2, session 19). The point is of course that the world has to remain uninhabitable in order to spare the mother the fear of losing him. It is in this context that the regressive function of drug addiction has to be understood. The compulsive use of drugs reinforces the concentric bonds that ties Rafiq to his mother, it prevents the aloness that separation from the "protective, shielding claustrum" (in Lowinson, 1981:67) would entail. Ultimately, it is Masterson's concept of the abandonment depression that is of relevance here. Masterson (1981) asserts that if the mother's support is withdrawn during the process of individuation/separation, the process is arrested and the abandonment depression born. The great need to defend against the abandonment depression, entails the avoidance of identification and activation of individual thoughts and wishes, as these presuppose separation and thus trigger the mother's withdrawal of affection or availability. Self-expression is thus sacrificed to defence; the child sacrifices himself to the mother's need. In this case, Rafiq's manhood is sacrificed: in order to protect the mother against her fears of losing him to the world, and in order to protect himself against a world which is perceived as alien and hostile, he continues to inhabit the dependent realm of childhood. His drug addiction provides the assurance that he will not leave home; he will remain the eternal child, dependent on the mother for his needs, even if those needs are only material in the sense of money, shelter and food.

This inability to resolve the rapprochement suphase is tied up with Wurmser's concept of a phobic structure that is fundamental to the infantile neurosis. I want to argue that the anxiety that lies at

the core of this structure is bound up with the inability to assert and confirm an own identity, to negotiate the unavoidable separation from the mother. Trapped between the world and the womb, the child moves in a nether world that is encircled and defined by the maternal embrace, an embrace which eventually does not protect but suffocates. Wurmser stresses that for drug addicts limitations mean confinement, that closeness and commitment stifle and that they continuously need to escape the constrictions and constraints they feel are imposed on them. As Wurmser does not analyse the phobic structure within the framework of developmental tasks and arrests, the reason for the claustrophobia, the fear of being captured or trapped, remained largely unexplained. I believe that the fear for confinement can only be properly understood as the fear of losing self in other, of being overwhelmed, suffocated by the mother's inability to combine a relationship which simultaneously contains togetherness and separateness. However, as Wurmser (in Lowinson, 1981) points out, the struggle for liberation leaves chaos and ruin in its wake. Not only is there self-condemnation in the form of guilt and shame and a devastating aloness, but the most radical fear, that of "bursting ... into small fragments of body and mind" (ibid:67) accompany every attempt at liberation. The attempts at liberation are thus doomed to failure. The addiction to drugs rationalises the passive-regressive behaviour which requires that the true self is denied and provides a sense of identity, that of the dependent drug addict, that would protect against exposure against the abandonment depression.

This pattern of interaction that is born in the rapprochement suphase is of course carried over into adult relationships and situations. In Rafiq's case it clearly emerged in his impatience concerning the inflexibility of group therapy, and the ward rules and regulations that placed severe limitations on how and where time could be spent. However, when the programme ended, he went into a depression. He had achieved liberation but at the cost of feelings of emptiness, of feeling dead. A crippling anxiety that no

amount of medication could counter accompanied his liberation from the group, and it was only in alcohol that he could find a degree of reassurance, a way of coping with a reality that he found intolerable (see appendix 2, sessions 26-33).

7.1.2 The Witness

Paradoxically, however, the passive-regressive behaviour needed as a safeguard against the abandonment depression, makes it impossible to meet the mother's equally important needs of being saved by her son. All avenues towards reparation were blocked and this failure gave rise to a different but related anxiety: anxiety doubled back on itself, and the phobic structure was intensified by its own attempts at resolution.

Rafiq's mother's timidity and fear of losing him to the world made her unavailable to his individuation needs. The message Rafiq internalised was thus that the world was a hostile and alien place and that he was too weak and inadequate to make it on his own. At the same time, however, his mother's timidity and despair at her life defined his role as a saviour: his mother was fearful and in need of protection - she could not make it on her own either. He not only had to protect her but save her and this message was codified in his religion, and sanctified by his culture. This was a task that he could not escape, but one that his mother's ambivalent needs and expectations made impossible to perform. He was required to witness her distress (see appendix 2, session 9) and the message he received from his mother and uncles was that he, as the eldest son, had to change the nuclear family's life situation. At the same time, however, his mother needed him to keep the myth of a normal, happy family intact. She needed him to show respect toward his father, to lie to his uncles in order to keep up appearances, to keep silent about the emotional and physical violence in the house. His father's alcoholism was never spoken of: it was the secret everyone knew but no-one told. She had never

forgiven him for the one time he transgressed the unspoken rule she had laid down. She still tearfully reminds him of the night he kicked his father (appendix 2, session 10), thereby negating and punishing the one honest emotion he expressed throughout all those silent, miserable years. Required to be a witness, but denied permission to speak or take action in defence of either himself or his mother, Rafiq was forced into the role of eternal, watchful but helpless child. The response to his anger was catastrophic, similar to the response to his attempts at individuation. The message he internalised was thus that his anger and hatred could destroy his good internal and external object, and all his love and creativity could not repair the lost harmony and well-being. The expression of anger could not be forgiven, and the possibility of losing the good object thus became a permanent threat in his mental life. Of importance is that the recovery of the good object, if he should give free reign to his anger, was threatened to such a severe extent that the ability to make reparation must be eternally doubted; the working through of the depressive position thus becomes a heroic but unmanageable task. Rafiq cannot repair his mother's life because she requires him only to witness her distress. Her demand that the reality of her life is disguised and hidden, condemns him to impotence so that instead of directly and vigorously relating himself to and mastering the world, thereby improving the family's financial situation and status in the community, the main part of his efforts are diverted towards making the lie bearable and avoiding the feelings that would damage and cause separation from the "protective, shielding claustrum" (in Lowinson:67). This can only be done through the compulsive use of drugs. Dulit et al (1990) observe that most of their inpatients with borderline personality disorders who abuse substances, prefer sedative-hypnotics or alcohol as the drugs of choice. They speculate that borderline patients use these substances because they "rapidly modulate the frantic anxiety that is associated with dysphoria and anger" (ibid:1006). As Rafiq never expressed any feelings of anger toward his mother, it is only possible to

speculate about the extent of the anger and despair that was felt (and denied) at the role of passive witness that was forced upon him. Krystal and Raskin (in Lowinson, 1981) observe that addicts have difficulty in recognising and tolerating painful affect, that these affects remain unverbalised and undifferentiated, and that it is this inability to verbalise and integrate unpleasant feelings that predisposes such individuals to drug abuse (see chapter 3). They however refrain from speculating on the dynamics present in the nuclear family that may give rise to such an inability; the underlying implication in their statement is that drug addicts, for some unspecified reason, lack a fundamental mechanism of emotional survival, almost a moral courage that would enable them to identify and act upon unpleasant emotions. They thus have to turn to drugs in order to cope with the emotions non-addicts manage to live with. Rafiq Jaffer's history makes it clear though that, far from being a moral coward, he sacrificed himself to the need and expectations of a significant other. He had no other choice: in order to survive at all emotionally, he had to deny not only his anger but his vitality, his potential as an active human being who is in touch with and in command of his emotions and his environment. Rafiq did not choose the easy way out. The importance of his choice did not lie in the use of drugs in order to avoid the unpleasant emotions other, more courageous people live with, but in the choice of responding to his mother's conflicting needs and expectations at the cost of his own vitality and manhood.

The regressive function of drugs in Rafiq's addiction is once again of importance here. Krystal and Raskin suggest that addicts prefer and utilise short acting drugs to "assist the ego in defending against painful affect, and to allow them to experience briefly and therefore, safely, feelings like fusion (oneness) with love objects" (ibid:470). We have seen that the expression of painful affect needed to be denied, because the expression of these feelings could permanently damage the only good, protective object in Rafiq's life, leaving him alone in a world that he was prevented

from mastering through the needs of his good object. As he was denied entrance into and mastery of the world, the maternal embrace remained his only option and his sanctuary. However, the nether world in which he was forced to live as passive witness, did not only constitute the structure of claustrophobia, in the sense that Wurmser uses the concept, but, by necessity, had to create the rage and aggression that Khantzian and Wurmser (in Lowinson, 1981) observe as underlying the compulsive use of drugs. The rage and aggression at the mother for stunting his emotional and mental growth had to be denied in order to sustain the clinging relationship with the mother that protected him against a world he finds wholly alien. The "feelings of fusion" that Krystal and Ruskin speak of are sought for protection but they also constitute a danger zone: it is in the union with the mother that the realisation of lost chances, of a lost manhood, is at its most profound. In session 19 (see appendix 2), while talking about the need to diminish himself in his interactions with others, the fear that he would be found out to be basically inadequate, he observed that if his mother really believed in him, she would not always try to protect him, send him money and forgive him for everything he does. In this session he expressed a fundamental understanding of the way in which his relationship with his mother, his response to her needs, limits him as a human being. However, it was not possible for him to explore this understanding to its logical conclusion: anger at the person who had cut off his vital supplies, the need to reclaim his life, even if it would mean the destruction of the good object. Because at this stage in his life the expression of the anger that he had denied all his life must by necessity destroy the loving, intimate relationship that exists between him and his mother. The function of drugs here is to blunt the anger, thereby, as Krystal and Raskin observe allowing him to experience "briefly and safely feelings like fusion with love objects" (ibid:470). Charlton (in Schwartz-Salant et al, 1988) observes that aggression is inevitable in the process of separation-individuation, but as separation may cause damage or

annihilation for the child who has not developed a sense of himself as being independently secure in space and time, the expression of aggression must be avoided at all cost. As the expression of anger could mean the separation from the mother, drugs, by blunting the anger, provides the continuing connection to the mother that offers "magical protection from the threat of dissolution of the self" (ibid:60). It is in this context that the regressive function of drugs needs to be understood: it provides a place of safety, it magically protects against the "bursting asunder" of the self by allowing the denial of aggression toward the mother, thereby ensuring that separation would not take place.

7.1.3 Oscillations of Attachment

Although Wurmser's (in Lowinson, 1981) analysis of a phobic structure, with its antithesis, a protective structure that constitutes the psychodynamics of the drug addict, takes place outside the parameters of developmental theory, and although he never manages to specify the origin of the pervasive fear of encroachment and enclosure that haunts the addict, his observations are of importance in this case study. I want to argue that the statement implicit in Wurmser's analysis is that the place of safety is also, in a most profound sense, the place of danger. He observes that the struggle for liberation from the constrictions that the drug addict pathologically fears, leads to the fear of the dissolution of the self. Therefore, relief from anxiety needs to be sought in the form of protection against it. The paradox is that all such protection against the overwhelming anxiety will inevitably become once more a new claustrum and therefore a renewed source of terror. Charlton, in his discussion of the borderline personality describes the anxiety of the fragmentation of the self along similar lines. He observes that the need for the presence of the other in order to guard against dissolution of the self, leads to the desire or fear of being swallowed up, a fear which, ironically, reinforces the risk of loss of the self (in Schwartz-

Salant et al, 1988). This observation is similar to Masterson's assertion that the borderline person vacillates between clinging to and distancing from the object, and is further supported by Melges and Swartz' (1989) observation that borderline personalities are characterised by intense personal relationships that vacillate between loving and hating. Their central thesis is that the borderline person's intense and destructive interpersonal relationships reflect an underlying problem with distance regulation. The main predisposing factor to the borderline person's problems with regulating interpersonal distance is the conflict between fears of abandonment and fears of domination; these opposing fears give rise to oscillations of attachment in the person's current interpersonal behaviour. They observe:

> Because of the conflict between fears of abandonment and domination, the patient experiences negative feedback whether she attaches to or disengages from others. Because closeness threatens domination, the patient disengages, but as this threatens abandonment and intolerable aloness, she again tries to attach, which again evokes fears of domination and subsequent attempts to disengage. Whether she moves toward or away from others, it feels wrong. Consequently, the patient repeatedly swings between attachment (e.g., love, clinging and idealization) and disengagement (e.g., anger, pouting and devaluation) (ibid:1116).

Or, as Masterson so succinctly puts it: the borderline person clinically behaves as "if all life were one long unresolvable rapprochement crisis" (Masterson 1981:29). This vacillation between clinging to and distancing from the object is a pronounced characteristic of Rafiq's behaviour. He clung to the drug unit, but destroyed time and again the trust and respect of the staff which he had worked so painfully hard to earn (see appendix 2, sessions 6 and 31). He gained the affection and trust of the family he stayed with during the month he spent out of the drug unit but he deliberately, or so it seemed, destroyed that affection by going on

a drugging spree two days before he was re-admitted to hospital (see session 9). In therapy he cut the ties of affection and care that were built up over months by not keeping appointments, by long, sullen silences, by denying that any emotional connection had been built up between us.

Wurmser understands the sudden and seemingly inexplicable inversions which take place in commitments and affection as an ego defect, a "fundamental disparity" (in Lowinson, 1981:72) which functions as a protection against claustrophobia. The limitations inherent in committed relationships are thus conceived as confining encasements which need to be broken open by turning to a protective system which, in its turn will become a new claustrum. What Wurmser does not explain, is the danger that pervades each and every relationship that is sought for protection and the intolerable ambivalence that these necessary but destructive relationships pose: the relationship is needed for protection against the world and the dissolution of the self, but it is in the relationship that the self is lost in other. As Rafiq so movingly said in a therapy session (appendix 2, session 31), his life is a nightmare from which he cannot wake. There is no solution - he can only dream on. Drugs at least take the edge off the fear, and allow the illusion of protection in these relationships that promise, at least initially, a connection that will liberate him and save him. Till they in turn threaten to suffocate the fragile self that is ultimately anchored only by his pills.

And so Rafiq circles in his life: a nightmare that has no end and from which he cannot wake. He cannot leave home because the task he had set himself is still undone (see appendix 2, sessions 10, 12, 16, 26 and 27, as well as appendix 1). His place in the family, his mother's needs and his religion have chosen him as a saviour and it is only in the role of saviour, in the performance of this task, that he will find redemption. He cannot leave home because he has never been given permission to leave: his leaving will destroy the

good object as well as himself. But it is only in leaving that he can claim him manhood, perform his task and save himself. The only solution out of this intolerable dilemma, is the addiction to drugs. By being the dependent 'junkie', he remains the loyal son; frozen in the dimension of childhood he lives in a nether world in which he waits for permission to claim his manhood.

7.2 The Absent Father

> It is as if generations of fathers passing before her imagination give some mute testament of life - some comfort. 'Her father!' she had written .... 'Without her father the world would be without its last resource.
>
> '"But"', she remembered with a sudden sobering shock, "it will be me who is the last resource when my father is dead "' (Milford, 1974).
>
> The father is usually remembered by the borderline adult in extreme terms, either as frightening intrusive and abusive, or as weak, spineless, and lacking an usable, digestible masculinity. His sexuality is perceived as a weapon, or as impotently limp, and his nurturing side is spoiled by a combination of weakness, ambition, aggression, and narcissism (in Schwartz-Salant et al, 1988:60).

Rafiq Jaffer's father died when he was 24 years old. Not a boy anymore, nor yet a man, he felt sadness because someone he had known for a long time, had gone (see appendix 2, session 28). But he did not grieve for a father: he had never had a father. The lurching drunk, the pathetic depressive, the man who hid in his room during religious festivals and family gatherings, this man was not a father. He was an embarrassment, a shame that pervaded his son's life. Rafiq talks of him with hatred: he was a "fucking shit"

(see session 28) who could not be trusted, who did not understand his son's capabilities, who had no ambitions for and no faith in his son. But he also remembers him with sadness and a harrowing pity: memories of the man who escaped from a mental hospital, running crying to his parents' house where he's chased away; his father dressed in an old dressing gown, sitting on the bed and staring at the wall, lost in a sorrow his wife and young sons could not share and could not lighten (see appendix 2, session 9).

Although his father joined Alcoholics Anonymous when Rafiq was sixteen, and remained sober for the rest of his life, it is his impotence and weakness that live on in Rafiq's memories and dreams; it is his patterns of failure that Rafiq compulsively repeats in his own life. When he, after months of trying to remain drug-free, returned to drugging, he dreamed that his father had gone back to his drinking. "But why?" Rafiq cried in his dream, "Why did you start again? Tell me, Daddy, tell me why!" (see appendix 2, session 9).

The testament that Rafiq's father left his son was a testament of failure and sorrow. Rafiq never believed that his father's death would leave him without a "last resource"; since the age of fourteen the "last resource" for him had been drugs. But in fact, his father's death did leave him without a last resource. While his father was alive, his presence cast a shadow on the world Rafiq and his mother inhabited, and the mere shadow provided a degree of safety, a fragile boundary that allowed some freedom, a vestige of inner space. Rafiq's mother was also a wife, and a wife committed and loyal to her husband. Although he failed dismally in his attempts to provide for the family, the onus to provide was still on the father: he was the failure and Rafiq lived in the shadow of his failure. When he died, Rafiq was required to take his rightful place as heir and provider; the mother now was not a wife anymore, but only a mother, dependent on and obedient to the son who had become the head of the household and the earthly representative of

God in their nuclear family. When his father died, Rafiq seemingly collapsed under the burden of his family's expectations, and went back to drugging after having been drug free for at least five months.

I do not, however, believe that Rafiq's return to his addiction indicated a fatal flaw or an inner weakness, nor that it showed him up as unable to carry his responsibilities. Even if it did, this kind of explanation is largely irrelevant. I want to argue that Glover's observation that drugs symbolise a substance onto which conflicts are projected as a defence against regression towards a more psychotic state, should be taken seriously and is of importance here (Glover, 1956). Lacan maintains that it is the father's presence and the father's name (which also stands for the father's 'no') which mediates between the unconscious one-to-one fusion between mother and child. Without that vital mediation, the child remains in the imaginary order where the ego does not signify back to itself, but in a fusional relationship to others. Entrance into the symbolic order, into the structured world of language and the law, is thereby denied to the child, and (s)he remains in a world where the laws of language do not apply. This is the world of the schizophrenic. Lacan maintains that the schizophrenic has "refused to Oedipize" (Lacan, 1977:48) and by virtue of this refusal (s)he remains trapped in the complexity and fluidity of the unconscious. I want to argue that the death of his father potentially removed the only fragile boundary (if substances are excluded) which still existed between Rafiq and his mother, and that without that boundary, the maternal embrace could only lead to psychosis.

In the "Autobiography of a Schizophrenic Girl", Renee describes her madness. She writes:

> For me madness was definitely not a condition of illness: I did not believe that I was ill. It was rather a country, opposed to Reality where reigned an implacable

> light, blinding, leaving no place for shadow; an immense space without boundaries, limitless, flat; a mineral, lunar country, cold as the wastes of the North Pole. In this stretching emptiness, all is unchangeable; immobile, congealed, crystallized. Objects are strange trappings placed here and there, geometric cubes without meaning. People turn weirdly about, they make gestures, movements without sense; they are phantoms whirling on an infinite plain, crushed by the pitiless electric light. And I - I am lost in it, isolated, cold, stripped purposeless under the light (1970).

I believe that it was the "stretching emptiness", the "immense space without boundaries", "the blinding light" that left no place for shadow, that Rafiq sought to avoid in the return to his addiction. He had many times been on the edge of the country that Renee describes; during and after the completion of his programme in the drug unit he frequently hovered there: he went through times of feeling dead and empty, he felt disconnected, lifeless, unable to feel or communicate, unable to make an emotional connection (see Appendix 2, sessions, 23 and 26-31). He complained about losing himself in others around him, experiencing their embarrassment and humiliation and sadness (see appendix 2, sessions 19, 21 and 25). He struggled with language, weaving ideas and memories into fragments of sentences that no- one understood; language failed in its purpose as a vehicle of reason, and his words became trapped in the symbolic meaning they held for him personally, thereby only conveying confusion to others. He has never exhibited the formal thought and perceptual disorders that characterise the psychotic, but in the cut-off, dead world he so often inhabits, he comes perilously close to the condition Renee describes. Khantzian and Wurmser's suggestion that the psychopharmacological effects of drugs can serve as a substitution for defective or nonexistent ego mechanisms of defense, is of importance here. I want to argue that the psychopharmacological effects of drugs serve as a defence

against regression to a more psychotic state, that Rafiq's addiction is a necessary and inevitable condition that protects him against "the immense space without boundaries". It is in this context that the progressive function of drugs has to be understood. I believe that in Rafiq's case the compulsive use of drugs is an attempt to negotiate the separation from the mother, an attempt thus to negotiate the developmental tasks that were arrested. I am suggesting that it is possible to hypothesise that if the father is unable to play the role of mediator of the transition from the womb to the world, drugs may substitute for the father and provide a wedge in the "mutually collusive embrace with the mother" (Seligman, 1982:10). It may provide distance and oblivion, a vestige of inner space that is focused on the nurturing of the self. In the drugged state there is surcease from the mother's demand for a union that would answer her needs. The drugged state is a state of self-absorption, a greed to feed the self. It is only with the help of drugs that Rafiq can temporarily loosen the ties of his mother's needs and feed himself, thereby preventing himself from being swallowed up by those needs. It is through drugs that the fragile and dependent self is prevented from being lost in other. Rafiq's addiction ensures continual dependency within the frozen boundaries of the maternal embrace, but by the same token his addiction provides a hiding place, a sanctuary against engulfment. The unconscious, instrumental use of drugs in Rafiq's case, is about finding a place of safety against the maternal engulfment, an engulfment which can only lead to the final loss of the self.

The instrumental, progressive function of drugs does not, however only lie in its defense against regression to a more psychotic state. I want to argue that the addiction to drugs takes over the function of the father in more than one respect. Moreover, that it serves as a protection against the castrating power of the men who represent the world of business and law, (the symbolic order) in Rafiq's family. By the same token his addiction provides a vestige

of support which makes possible an attempt at negotiation for a legitimate place in that world.

Freud argues that it is the recognition of the phallic power of the father which makes it possible for the boy to move into manhood and take over the omnipotent penis of the father. By submitting to the symbolic role of castration, the boy resolves the fear of castration and enters into his phallic heritage (Jones, 1956). As Masterson (1981) however points out, the child only becomes intrapsychically available to the full impact of the father once he had individuated from the mother. If the father is emotionally unavailable, or physically, verbally and/or sexually abusive (Seligman, 1982) and the mother unable to inspire trust and confidence through the necessary metamorphosis of her love which needs to accompany the different developmental tasks (Jager, in Kruger, 1984), the child is unable to achieve emancipation from the mother. Freud failed to understand that it was not the terror of castration, the submission to symbolic castration, that makes it possible for the boy to enter into his phallic heritage. It is the promise of the father that he will be welcomed, that he will be held and supported in all his vulnerability which makes it truly possible for the boy to enter the world. By the same token, Lacan misunderstands the father's 'yes' for the father's 'no'. The father says 'no' to the collusive embrace with the mother, but it is in his permission for hope, in his verbal and non-verbal assurance that a legitimate place in the world exists for the child, that the emancipation from the mother and the entrance into the symbolic order, becomes possible. Richard Knowles, in speaking of hope, states:

> The occasion for hope is the sensing of one's vulnerability to death, illness, and so on, but it is also the occasion for despair. The central question in the first stage of development and in later experiences of this first crisis is whether, in being tempted to close off one's life and possibilities, one is able to be open enough to see

possibilities for the future (Knowles, 1986:34).

It is when the father is not able to offer hope for the future that the terror of symbolic castration becomes overwhelming and the child needs to retreat to the protection of the mother-child dyad, thereby postponing the phase of the triad. The lack of support from the father in the transition from the womb to the world is perceived as the closing off of hope, a failure to provide a place of safety, so that all channels of communication and negotiation are sealed off.

For Rafiq a life without drugs does not seem possible. Knowing that he would lose the only safe place he had ever known, he still drank the beer that would result in his discharge. He had to because he was "falling". He said that there was "nothing to hold on to, there was no way to be without it" (see appendix 2, session 31). And indeed he was right. No glimmer of hope penetrated the bleak, deceitful landscape of his childhood, no-one made it possible for him to envisage possibilities for the future. His uncles were loud, confident men who mocked him and his father; they were overwhelmingly successful and it was in the contrast between their success and his father's failure, that his invitation to the symbolic order was formulated. The harshness of their demands, the unwelcoming nature of their invitation, turned the recognition of the phallic power of another as being bigger and better than his own not into a creative challenge, as it should be, but a crushing weight under which he collapsed. Castration, or the threat thereof, remained in his mental life the high point of the psychological fear of loss, and hence of danger. No solution to the fear of castration was possible: the loss of the mother could not precede a gain; it could not even be attempted because the stakes were too high, the choice too limited. There was no promise of protection from the men who represented the symbolic order for him. They stood for a world of ruthless competition in which he was required to take his place without their support; their invitation to enter

this world never held the promise of support, only the threat of annihilation if he should fail. Their legacy had not been a "testament of life", but shame. In the interview with Professor Galanter (see appendix 2, session 21) Rafiq felt his ears turning red and his whole body flushing. He was once again in the presence of his uncle, and he was ashamed. He felt he was being negated, violated and knew he needed to protect himself. But in that exposed state, he was small and helpless and could only cringe away from the power of the other. In the invitation to resolve the fear of castration, Rafiq was overwhelmed by the superior strength of his uncles; as his own aggressive drives had to be denied from infancy in order to preserve the idealised object, he was unable to make use of these drives in order to incorporate the castrating agent into his own personality as an internal authority figure. Nor was it possible to turn to the "impotently limp" (in Schwartz- Salant et al, 1988) sexuality of his father for support and guidance into the future. His father's sexuality held no hope for future possibilities, only failure. His father did not represent danger as his uncles did, but failure to protect against danger, failure to provide a place of safety.

When Rafiq said that he had to take the beer, even though it would mean discharge, he was speaking the truth. He was falling and there was nothing to hold him. He had been denied a father to "hold" him and he had been denied hope for the future: his legacy was despair, the falling into the empty space left by his father's absence and his mother's fears. But he had not given up in his attempts to live in a world he had never been welcomed into: if he had, he would have inhabited Renee's country. It is in this context that the progressive function of drugs needs to be understood. Although Rafiq did not know a father who could provide hope for the future, he still clings to the ideal of fatherhood as it is portrayed in myth and legend: someone to support him, someone who could make him less alone; ultimately someone who could help him to move through the required rites of passage, and make it possible for him to

establish himself in the world of men as a separate, autonomous being. He seeks this father in other men: Chris Robinson, who gave him shelter and acceptance and provided a model he could strive to imitate; Dr G, who gave him medication that lessened the anxiety and made it possible, for a short time, not to fear the prospect of interviews; S., the male nurse who mediated between him and the female nurses, and thus made it possible to joke, to be a wit (see appendix 2, sessions 13, 21, and 22). Ultimately, however, it is in his pills that he finds the support he so desperately searches for; it is in his addiction that he finds the strength to attempt his rites of passage. During a therapy session in which he mourned the loss of S. the male nurse, and the absence of a supportive father in his life, he came to the understanding that he had always felt unsupported. He had always felt a failure, as if there were something wrong with him, as if there was something "lacking" in him. He understood that he had to drink and drug in order to go to family gatherings, job interviews and social occasions. He had to be drugged in order to hold down a job. Drugs "filled" him up, they gave him the support he needed (see appendix 2, session 13). Drugs made him feel "whole" (see appendix 2, session 28), they anchored him in a shifting, changing world in which he had not been given a legitimate place.

Charlton (in Schwartz-Salant et al, 1988) speaks of this struggle to negotiate the rites of passage in his analysis of the borderline personality disorder. He says:

> Analysands themselves do however present the image of the borderline when dealing with aspects of movement and resistance: in dreams of passing over borders, in images of a Berlin Wall which entraps and divides, in thoughts of moving from one place to another, in the desire for initiation, and the wish to become a different person (ibid:44).

I believe that Rafiq's addiction is inextricably tied up with his attempts (which at times amount to a heroic struggle) to find a place and a role in the world. For Rafiq the world is an alien and hostile place (see appendix 2, sessions 3, 4, 15, 19, and 26). He has been alone in his quest for legitimacy, in his desire for initiation, and although he yearns for a father, a brother, someone to support him and guide him, he has had to make this difficult journey on his own. Up to now, drugs had been his only companion. They have almost destroyed him, but they have also almost certainly saved him.

I want to argue that it is in the above context that the works of Hartmann, Wieder and Kaplan, Milkman and Frosch, and Hendin (in Lowinson, 1981) need to be understood. Although these writers differ in emphasis, they share a common stress on the functional and instrumental use of drug addiction. Their view that the use of substances serves as a prosthetic which functions as a correction to impaired or defective ego functions, thereby assisting the individual in coping, allows an understanding of the progressive function of drug addiction. In this section I have tried to illustrate how the need for substances arise out of the arrest of the normal developmental tasks. I have argued that substances assist in the struggle to enter society, the law, the place of the self in the family system of names, language itself; moreover that, without the support of substances a regression to a more psychotic state may be inevitable.

7.3 The Sense of Self

> A man may have a sense of his presence in the world as a real, alive, whole, and, in a temporal sense, a continuous person. As such, he can live out into the world and meet others: a world and others experienced as equally real, alive, whole and continuous.

> Such a basically ontologically secure person will encounter all the hazards of life, social, ethical, spiritual, biological, from a centrally firm sense of his own and other people's reality and identity (Laing, 1971:39).

> He was not unlike a traveller walking into a landscape which may prove mirage (Winnicott, 1988:24).

Lacan believed that the alienated ego is born in the imaginary order where the ego does not signify back to itself, but in a fusional relationship to others. When the child enters the symbolic order, (s)he experiences his/her relationship with others through the mediation of an increasing number of signifiers. The child now lives within an order of symbols which mediates relationships and which removes him/her further and further from the immediately lived first signification. Claudia Black (1981) in her analysis of the coping patterns adopted by the children of alcoholics, provides an understanding of how the failure to enter the symbolic order is entrenched in the interactional structures of the alcoholic family. She observes that what a spouse or child does while living in an alcoholic environment they do because at the time it makes sense to them. As the problems surrounding alcoholism cause more and more inconsistency and unpredictability in the home, the behaviour of the non-alcoholic family members typically becomes an attempt to restabilise the family system. Members of this family system act and react in manners which makes life easier and less painful for them, and as emotions are so intense and frightening in an alcoholic home, they are repressed; if they are expressed, it is frequently done in a judgemental manner, placing blame on one another. When rules are established, they are not based on protection but instead are built on shame, guilt and fear, the primary, silent rule being based on the need to disguise or hide the events that occur in the family.

As the family law is based on the unspoken rule that the frightening and painful events at home must remain hidden, the child who grows up in such a family cannot trust people to take his feelings seriously. Since the incidents which occur at home are minimised, rationalised and/or blatantly denied, the child's emotions remained unvalidated, and the child is propelled into a life of second-guessing: what is really happening and what emotions should be attached to what events.

In her work with young children Black found that the majority of them tend to adopt one, or a combination of the following three roles: the responsible one, the adjuster, and the placater. In adulthood these ways of surviving often lead to unhealthy extremes. The unusual development of coping behaviour often results in emotional and psychological deficits, and these "survivors", end up not surviving at all. The roles that the children adopt are closely linked to the emotional and psychological voids which occur as a result of the unpredictable and inconsistent parenting in alcoholic homes, and are related to issues such as trust, control, dependency, identification and expression of feelings (ibid:63).

Rafiq Jaffer's account of his childhood and ways of coping closely resembles Black's description of the placater. She describes the placater as the child who tries to make others in the home feel better, as if he is responsible for whatever pain the family is experiencing. For the placater the best way to cope in his inconsistent and tension-filled home, is by acting in a way that will lessen his own tension and pain, as well as that of the other family members. He will thus spend his early years trying to fix the sadness, fears, angers and problems of the family members (ibid:9).

This explication of the psychological and emotional voids that originate in the deceitful and emotionally chaotic home of the alcoholic, is best understood within the framework of the

developmental theories discussed in the literature review (see sections 4 and 5). Klein (1948, 1952, 1955, 1963), Freud (1973, 1977) and Lacan (1977) all three describe an early relationship in which the infant does not perceive itself as a separate being, but exists in an enmeshed and fusional relation to the mother, a relationship in which the self cannot be distinguished from other. In order for the infant to acquire an identity, a sense of self, a separation from the mother needs to be negotiated. For this difficult process to be successfully negotiated, the infant needs the father's support or, failing that, a mother who is able to help the child separate from her by supporting him in managing the transitions he needs to negotiate. Of central significance in this process of separating itself off from the environment, is the reflection of the self that is received from the environment. Winnicott (1988) maintains that the environment, personified in the mother, reflects the self back to the baby; however, when the baby does not see himself (i.e. if his emotions are not validated in the interaction with the mother), but sees the mother's mood, needs or the rigidity of her defences, the mother's face ceases to be a mirror, and what could have been a significant exchange with the world turns into a watchful observation of the world.

The coping patterns adopted by children in alcoholic homes described by Claudia Black, seem to tie in with Winnicott's observation that when the mother's face is not a mirror "perception takes the place of apperception" (ibid:132). The child's emotions are not validated, but made subservient to the dominant need in the home, which is to deny the extent of the damage wrought by the alcoholism of the parent. The child needs to study the parent's face, not in order to find himself in the reflection, but in order to respond to the need which is conveyed by the mood of the parent. Masterson's observation that the mother's defective mirroring derives from an emotional withdrawal which is specifically related to a specific mode of self expression by the child, is of importance here. The self expression which causes emotional

withdrawal is related to a type of expression which interrupts or frustrates resonating with the projections the mother has placed on the child in order to shape him for use as an object essential to maintain her own intrapsychic equilibrium (Masterson 1981). In the case of the child in an alcoholic home, any type of self expression is probably prohibited, as it by necessity intensifies the already charged atmosphere, and challenges the denial with which a certain amount of equilibrium is achieved.

I have already discussed in depth the projections Rafiq's mother placed on him in order to maintain her own intrapsychic equilibrium (see section 7.1). In this section I am concerned with the self, or rather, the lack of a sense of self that derives from the mother's failure to meet the infant's gesture, i.e. when she substitutes her own which is to be given sense by the compliance of the infant. I am moreover concerned with the role drugs play in providing a sense of identity, a sense of " presence in the world as a real, alive, whole" (Laing, 1971:39).

Masterson (1981) observes that the complaints related to self expression as articulated by borderline patients, fall in two categories. The first category comprises the various instances in which they are unable to identify their own wishes, thoughts and feelings, The second category has to do with the inability to initiate, implement and activate the individuative thoughts and feelings that can be identified. As has been discussed above, motivation, emotion and behaviour in the alcoholic home are dominated by the need to suppress individuation, so that individuative stimuli can not be allowed to break through. As Masterson points out, the need to cling to the object, in order to avoid the abandonment depression, dominates all other needs, so that the individuative stimuli that manage to break through cause great anxiety (see chapter 5).

Both categories apply to Rafiq Jaffer's inability to experience

himself as a presence in the world. In a therapy session in which he circled in disconnected memories and thoughts, expressing himself in half-finished sentences which failed to convey any meaning, it eventually emerged that a letter from his mother confused him to the point where he had lost all sense of himself, of what he thought and felt about himself (see appendix 2, session 11). He came to the conclusion that he lived in his mother's image of him, and only when that image fitted his own, could he have a sense of his presence in the world. Rafiq found it very difficult to identify any emotion, and a large part of every therapy session was spent on the attempt to identify emotions such as anger and sadness (see especially sessions 20 and 21). The danger in identifying emotions lies in the possibility of rejection: once the emotion is identified, it needs to be expressed, and the expression of anger, sadness or dissatisfaction may not only destroy the relationship (see appendix 2, sessions 2, 4, 11, and 25), but the person against whom the anger is directed, as well (appendix 2, session 17). This fear to experience and express emotions which are perceived as negative of course ties in completely with Masterson's observation that the true self, i.e. the self that constructively engages with the environment, is a function of individuation, and does not exist if individuation has not taken place (Masterson 1981). It is thus not possible for Rafiq to experience and express his emotions, to feel alive, alert and creative while he lives in his mother's image of him. Rafiq is still seeking his reflection in the environment, in the image others hold of him. This lack of a sense of identity, of not knowing who and what he is, of looking in the mirror and not finding himself there, was supremely manifested in two therapy sessions in which he complained of acute discomfort when he is not noticed (see appendix 2, sessions 15 and 20). When people do not notice him, he feels that he does not exist. He is unable to find a sense of who he is, what kind of person he is, without a mirror being held up to him by others. He thus constantly needs feedback from others. "What do you think of me?" he would ask the other patients. "What kind of a person do you think I am?" "Do

you think I am an assertive person?" "Do you think I behave in a natural way?" When he fails to find his reflection in the environment, he himself needs to take over the task of holding up a mirror. He monitors himself. "Do I behave in a natural way now?" he asks himself. And when he watches television: "Is this a natural pose?" "Should I look sad, or should I just look interested? What would people think if I look sad?" For Rafiq the central question in his life is not to be or not to be, but how to be. How to be a person when he lives in another's image of him. And, sadly, how to be a person when that connection is severed. While Rafiq still participated in the therapy groups he, despite feeling trapped by the rules and frequently irritated and undermined by the group members, felt connected; he felt he had a home. When he earned his freedom by successfully completing the programme, he also lost his home, and the depression, the feelings of emptiness and deadness, became overwhelming (see appendix 2, session 26-31). Separation means abandonment. Although it is not possible to find a sense of an own identity, a firm sense of self in the fusional one-to-one relationships in which self signify to others and which characterise Rafiq's interactional modes, it is even less possible at present to establish a sense of an autonomous being in the abandonment depression. In separation lies the threat of homelessness, ultimately of non-existence, non-being.

The search for the self is also connected to the search for the father, and ultimately to the need for drugs. In a therapy session Rafiq himself articulated the links between his drug addiction, his quest for support from a father and his fear of non-being (see appendix 2, session 18). He needed to make appointments for interviews, but found himself unable to do so. His depression was so severe that he could not bring himself to phone for appointments, the very act of speaking proved too much for him. He described himself as "dead" inside, "hollow", as if there was not a person there at all. He was a "non-being". He wished that people could understand that it was not possible to make appointments and

go for interviews because there was no person there to do these things. "I need drugs to be someone, to do these things", he said. After this description of non-being he got lost in memories of Chris Robinson, the unit manager who became a role model and protector for him during his first admission. He once again mourned the loss of Chris. When Chris was there, Rafiq felt protected, he felt the ward was his home. He felt that Chris knew everything about him and that he understood him. He felt connected to Chris, he knew he had a place in the world, a home.

In order to have an identity, a sense of an autonomous being in the world, Rafiq needs to feel connected and supported. When that connection and support are absent, the world is "strange", and he is alone. He is a stranger in the world, a fragmented being who needs to find himself in the image of others. Drugs substitute for the absent father, for the "welcome" that was never extended to him. Without drugs, he is "nothing , empty, just pieces". Drugs make him a whole being (see appendix 2, session 28). It is only when drugged that Rafiq does not need to search his neighbour's face for an image of himself, that he can anchor himself, through the solidity and familiarity of his own being, in a world where he is not a stranger anymore.

CHAPTER 8

CONCLUSION

In this case study I attempted to provide an understanding of drug addiction within the framework of developmental theory. I made use of Object Relations Theory, Lacanian Structuralism and Freud's concept of the Oedipus Complex in order to contextualise theories of drug addiction within the parameters of the tasks and arrests which take place during the developmental process. I argued that there is a very specific connection between the developmental tasks that the compulsive drug user is unable to negotiate and his/her addiction. I furthermore attempted to situate the regressive/progressive debate currently raging in drug addiction literature within the context of the dual functional and instrumental use of drugs. I argued that drug addiction serves both a regressive and progressive function and that the dual function can only be separated at the cost of negating the specific developmental tasks that need to be mastered during normal development. The study is limited by its scope and the specific pathology of the patient whose case material is used. I believe, however that I have shown that drug addiction can not be understood outside the parameters of developmental theory.

I attempted to illustrate the regressive function of drug addiction by analysing Rafiq Jaffer's relationship with his mother. My argument is built on the premise that the unpredictable and chaotic environment of the alcoholic home he grew up in, affected the relationship between him and his mother from early infancy. Rafiq's mother's preoccupation with her alcoholic husband made it difficult for her to be available to Rafiq's emotional and perhaps even physical needs on a consistent and predictable basis. During the paranoid-schizoid position, the lack of predictability and consistency intensified and pathologised the normal developmental fear that persecutors may invade and destroy the good object. This

led to a fundamental distrust in the strength of both the good object and Rafiq's own libidinal impulses to keep the bad object at bay, with the result that the good object had to be turned into an ideal object which would protect and safeguard him against the danger of internal and external destruction. The persecutory anxiety which was pathologised during this stage made it impossible to move on to the depressive position because he was too precariously posed between survival and destruction to allow ambivalence toward the ideal object. Rafiq's mother's fear for her son's safety and her need to preserve the intimate, dependent mother-child relationship, furthermore lead to the withdrawal of maternal libidinal availability during the rapprochement suphase when the task of individuation and separation from the mother needed to be negotiated. I argued that the anxiety of the precariousness of survival and the fear of the abandonment depression are both made tolerable through drugs. The regressive function of drugs needs to be understood within the framework of Rafiq's need to avoid separation from the mother. His drug addiction preserves the intimate, dependent relationship with his mother, and makes it possible to deny the anger which would threaten the loss of the ideal object, thereby putting his very survival at stake.

At the same time, however, drugs make it possible for Rafiq to attempt the developmental tasks he failed to master through his inability to negotiate separation from the mother. I argued that the progressive function of drugs is to be found in providing a distance, which is not achieved through anger, from the mother and that this distance provides a defence against regression to a more psychotic state, thereby making at least the attempt towards mastery of his developmental tasks possible. I furthermore argue that drugs serve a progressive function in Rafiq's interpersonal relationships in that they serve as a mediator between him and the world; they substitute for the absent father and provide the support to attempt the tasks he needs to negotiate in order to

achieve individuation.

As Rafiq has never been validated in his quest for individuation, he has never been able to attain a belief in a legitimate place in the world. He perceives himself as a fragmented being in a hostile world. It is only with the support of drugs that he is able to achieve a feeling of wholeness; it is through the support of drugs that he can make his sporadic attempts to enter the world as a whole, autonomous being.

Ultimately, however, the regressive function of drugs cancels their progressive component. Rafiq's attempts at individuation through the support of drugs need, by definition, to fail. While Rafiq's addiction keeps him locked in the maternal embrace which neither he nor his mother is able to break, his quest for mastery can only take place within the confines of the fear of engulfment by the mother and the corresponding fear of abandonment. Determined to perform his task as saviour, the tools he employs in support of that task can only lead to his own destruction. As such, he remains precariously posed between survival and destruction, unable to tell his own story and unable to write a script for his life. He tells the story of his ambivalence and need across his body through pills and alcohol, saving and destroying both himself and his mother in the only way her conflicting needs and his history make possible.

APPENDIX 1

PSYCHOMETRIC ASSESSMENT

Lentegeur Hospital — Confidential

Name: Rafiq Jaffer — Age: 26

Clinician: Ina Roux — Supervisor: Chris Robinson

Referred By: Ward 4 — Date of Testing: 21.3.90

Reasons for Referral

The patient has been severely depressed for a number of weeks. As he finds it difficult to talk in the therapeutic groups, the therapeutic team has been unable to formulate a psychodynamic explanation for his condition. It was thought that a Thematic Apperception Test may highlight some of the reasons for his depression.

Relevant Background Information

The patient's father was an alcoholic who died in 1988. The patient has since been living with his mother, maternal grandmother and younger brother. He has been addicted to drugs since the age of 16.

Behaviour during Testing

Mr Jaffer seemed anxious and depressed. He complained of headaches and found it difficult to concentrate on the pictures.

Test Administered

Thematic Apperception Test.

THEMATIC APPERCEPTION TEST

Card 1

The boy looks very sad. Hopeless. I would say this is a musical instrument. He loves music. His instrument is broken, or there is some kind of mishap to his plans for the future. His instrument cannot be fixed. Or if he is let down, it is a hopeless situation. He is thinking 'what next?' If there was some ambition for a musical career, he has been let down and he wonders if he is going to make it. The bottomline is: he is in despair, whatever the reason, and confused.

Card 2

What I see here is ... this woman is the mother. Somehow she is watching her son ploughing. She seems to be quite satisfied with what she is seeing, happy and content. Her son is working very hard with his crop. He is putting a lot of effort into it. That is her daughter. She is probably more into academic improvement, going to school, or maybe going into the world to make it, in an academic sense. Somehow she is leaving behind her old life, the primitive kind of existence.
Q. How does the son feel about working so hard?
A. The son enjoys it, he gets some satisfaction out of it. He is working with his mother looking on. He looks like the hard working type, the rugger type.

Card 3BM

Is it a man or a woman? It looks like a woman. It seems she has come to the end. (Laughs) (20" silence). For her ... to me it seems she has come to the end of her life. There is ... seems like a bunch of keys. It looks like a cell. Someone has forced her to stay in this place. I mean ... forced her to ... I do not think she has

any other choice. Like a desperate kind of situation. Emotionally I would say she is ... (15" silence). Emotionally she is right down, no hope, she is totally at a loss. What I see is a sad, pitiful creature, human.

Card 4

What I see here is, this woman is pleading for this man not to leave her. From her expression she is quite desperate that he should stay. She is really clinging on to him. And it seems like ... seems like, from the expression on his face that he has already made his mind up. He is quite adamant. Nothing will really stop him. The fact that he is looking away, and not bothering to listen what she is telling him. Somehow she looks like a respectable kind of woman; where my doubt comes in is the picture in the back. I mean, the picture signifies something else. She may be a loose type of woman. I do not know if the last bit makes sense but one ought to see.

Card 5

The woman is peeping into the room, looking for someone. Or something. The way she has opened the door, and the way she leans into the room and even the expression on her face ... she looks quite expectant, and by the form of her eyes, she is ... to me she expects something nasty, something that is not really good. In a way she knows what she is going to see. The furniture, the way everything is arranged, gives it an eerie kind of feeling.

Card 6BM

What I see is ... something sad, or something of great importance is being told to this man by the woman. The woman could be his mum, or an elderly person in the family. He definitely has a respect for her ... he has his hat off. Or having his hat off could signify

that he is being told some sad or tragic news. By the shape of his eyebrows and slight frown, he gives a feeling of concentration. Somehow by her not looking at him, looking out of the window ... it could imply that it is some sad information or news that she is giving him. Whatever it is ... by her posture ... it is something of great concern.
Q. How does he feel about what is being told to him?
A. Whatever it is, it is of great importance to him.

Card 7BM

The guy on the left is definitely of a greater age. There is definitely an age difference. One is older. (20" silence). By the shape of his eyes, looking down ... it suggests he, the older one, is sure of himself, or holds himself in some high esteem. He could be ... possibly giving the young guy some kind of advice or cautioning him. Or, it seems like the young one is looking at something, like some kind of activity, and the older one is ... it seems as if he has a better understanding of what is happening, and is pointing it out to the younger one. I would say ... his grey hair and moustache somehow suggests some kind of authority. And if the young guy is looking at something ... he is definitely .... His concentration is there but he is listening to what is being said to him, he is attentive.

Card 8BM

To me it looks like ... it is some kind of operation. This guy is lying on the table. I am seeing a gun. It looks like the front part of a rifle. My first thought was they were trying to kill him. Why I am saying they are trying to operate on him ... the guy looks quite helpless. He is looking away. Perhaps he is not conscious. He has his arms at his side, it shows that he is helpless. Somehow I cannot associate with ... I mean this guy in front looks like a boy to me. To me it seems as if he does not fit in. Ja. Why I say this:

the expression on his face does not associate with what is happening behind him. Somehow he looks more like being content. Somehow that does not coincide with what is going on around him. I am trying to figure out the gun. It could belong to one of the men. Or ... because ... they are using, not an instrument, but a sharp knife to cut him open. Ja. If they are trying to operate on him it looks like a very professional job.

Card 9BM

To me it seems they could be soldiers taking a break. Or they could be workmen taking a break from a job. They definitely feel quite exhausted. Somehow it seems that the guy in front, on the left hand side, is talking to this guy (behind him), finding out something. This guy is relaxing there (points to a figure at the rear, to the right). This somehow shows this guy (points to figure in front, to the left) is a nuisance, or that he is being disturbed. The manner in which he lifts his hat, without getting up ... yes.

Card 10

What comes to mind ... there are two people embracing each other. The woman seems to be seeking some comfort. Somehow there is a close attachment between the two of them. Her eyes are closed. They are trying to ... there is a possibility that they are trying to find solace in each other. Somehow, what I see is ... he is definitely comforting the woman. What is clear is that they care for one another.

Card 13MF

What I can gather ... the woman lying down is definitely naked. She has got something covering her up, a sheet or something (15" silence). The way in which her hand is hanging makes her look lifeless. (20" silence) This guy certainly does not like what he

has just seen. Somehow he has swung around or turn away. And ... I suppose that is why he has covered his eyes also, with his hand. To me it looks more like disgust he is feeling ... the way in which he covers his eyes. It certainly could not be horror. The type of furniture ... just a table, chair, an ordinary bed, even the naked woman, somehow gives it a sordid kind of atmosphere. I think it is possible that she could be dead though. And probably he discovered the body and that is why he turns away in this manner.

Card 14

Shows loneliness. Everything else is dark, he is looking out of the window. He is looking out, possibly out at the future. He could be feeling lonely, helpless, depressed even. He could be wondering what more life had to offer. He could be feeling trapped. He could be looking out, trying to take in him life, all the things life had to offer. He could be trying to be optimistic. I am putting myself in his situation. Yes. I mean, whatever he is feeling in here, in this room, in the darkness, is nothing. He can find something only outside. There is nothing of value he can find in here. He is looking out, trying to find something there. He has got his head tilted back, he is looking up, trying to take in the world. Or ... he feels trapped, looking at the world from where he is seems easier than to be out. The posture in a way signifies some kind of strength or control he has. He has got the window wide open, instead of peeping. It could show ... somehow he wants freedom.

COMMENTS

A certain inhibition and an incomplete narrative characterise these stories. Some start with richness and depth but inevitably dwindle into an inconclusive ending. The storyline is often fragmented with an emphasis on detail which avoids rather than solve the conflict inherent in the stories. Mr Jaffer clearly has access to an active fantasy life but has erected rather rigid defences against its

expression. The themes of despair and ambivalence which dominate the ideational content may well explain his need to protect against allowing his fantasy free reign.

There is clear evidence of depression in the ideational content. Of importance is that despair is consistently experienced in the context of impotence, of being trapped in or by a situation or place which confines and restricts. In Card 3BM, which usually elicits reasons of despair or guilt, Mr Jaffer misconstrues the figure for a woman, which may indicate that fantasy is pushed away from conscious awareness by using someone of a different sex; in this case he clearly defends against the knowledge that a restricted life is not worth living. He recognises despair and identifies with it but can offer no solution, not even suicide. He observes that the woman has comes to the end of her life, but follows this statement immediately by a defence: he sees a bunch of keys and not the gun which would have been the logical next statement if suicide was seen as a way out of this situation.

The same theme is present in card 14. Once again the person Mr Jaffer identifies with is depressed, lonely and trapped. His world has shrunk to a dark room which permits only the present. The future lies outside the room but once again Mr Jaffer is unable to construct a narrative in which he as a subject can find a way of entering the future. His lived world is one of ambivalence, of being hemmed in by a present which offers him nothing.

The inability to move into the future is well explained by card 1 which taps the sense of self. The boy Mr. Jaffer identifies with has plans and hopes for the future but his instrument is broken. His future depends on his ability to mend his instrument, but Mr Jaffer does not know if this will be possible. Once again the narrative breaks down and Mr. Jaffer circles in doubt: he does not know, he cannot say. It will be difficult to find an answer.

The theme of separation, the fear of entering the world, is further expressed in card 2. Here Mr. Jaffer is able to find an answer to his dilemma of needing to stay and wanting to leave. He identifies with both figures and so find a solution: the young man stays with his mother and is happy to do so, the young woman leaves behind her old life and enters the world. By choosing someone of a different sex to carry the fantasy of " leaving the primitive kind of existence" behind, Mr Jaffer avoids the conflict which faces the man in card 14. But although Mr. Jaffer uses splitting and denial to a significant extent to avoid his central conflict, he seems to have come to a decision, albeit on a deeply unconscious level, about his life. In card 4, which reflects male-female conflict, the man is adamant to leave the woman. As the conflict between leaving and staying is central in Mr Jaffer's narrative, the decision of the person Mr Jaffer identifies with, is significant. He once again avoids conflict by looking away, by not arguing, but he has made up his mind to leave. A further indication that Mr. Jaffer may be able to address his dilemma, is the fact that suicide is not mentioned in card 3, and that the posture of the man in card 14 signifies some kind of strength or control.

I would hypothesise that Mr Jaffer's central conflict is in some way tied up with his mother. In card 5, which may tap a response to an overinvolved mother, the narrative breaks down into loosely connected observations. Mr Jaffer clearly felt the need to be concrete when required to discuss this card, to focus on facial expressions and the arrangement of furniture; this emphasis on detail can be seen as a form of defence against the emotions elicited by the card. He further defends against undesirable feelings by not allowing himself to see the woman as a mother. She remains an unspecified female, not related to him and thereby unable to affect his life by her suspicions. Of significance though, is that this woman expects to see something unpleasant, and that there is something uncannily disturbing about the situation. Once again Mr. Jaffer avoids the conflict while making it clear

that he is aware of its existence. The same detachment and emphasis on irrelevant detail are evident in Mr Jaffer's response to card 7BM, a card which usually elicits information about the subject's attitudes towards his father. The young man in Mr Jaffer's story is dutifully attentive, but no emotional attachment links him to the older person. In card 6BM, which elicits attitudes toward the mother figure, the young man listens respectfully but has nothing to offer in return. In both cards the narrative gets lost in observations which not only avoid the resolution of conflict but the conflict itself. There is no interaction with the figures which represent authority and parental intimacy in his life. He is detached and expressionless; by denying the intimacy he also denies the effect these figures may have on his life.

In his depiction of interpersonal relationships it is clear that Mr Jaffer feel comfortable with intimacy as long as it is confined to the expression of solace and comfort, (card 10) but the narrative once again breaks down in card 9BM. This card usually elicits feelings concerning male companionship or the homosexual threat of bodily contact. Mr Jaffer's attempts to make sense of this card by listing irrelevant details, broke down in confusion. It is clear that male intimacy is an emotional realm which has many pitfalls, as has male-female intimacy. The same emphasis on detail which protects against the development of a narrative can be found in card 13MF. It is disturbing that Mr Jaffer's halting observations eventually lead to the conclusion that the woman is dead. It is as if, though constantly trying to avoid conflict by distancing himself from his interpersonal relations, in fantasy he is compelled to imagine the worst possible outcome.

SUMMARY

The themes of ambivalence, helplessness and detachment are dominant in the ideational content of these stories. It is clear that Mr Jaffer experiences problems in his interpersonal relationships: interactional modes are restricted to the expression of consolation

and duty, the undertow carrying the need for detachment and avoidance of conflict. Mr Jaffer depicts a world in which it is not possible to act, in which he circles in indecision; he is caught between the pull of the world and the fear of the world. My hypothesis here would be that Mr Jaffer's attempts to avoid/deny his emotions toward his parents are tied to his feelings of impotence. His refusal to allow a narrative to emerge in his interpersonal relationships ultimately prevents him from writing a script for his future.

APPENDIX 2

PROCESS NOTES

Session 1

A session in which Rafiq circled in indecision and doubt. He wove himself in and out of sentences which originated in some secret memory but failed to convey the content of the memory; disconnected, confusing trails of thought were abandoned abruptly. He felt guilty and worthless. He had to look after his mother but did not feel able to; felt he always had to be calm and rational, that he must take responsibility for the household. If he did not, he would be worthless. As he had never been able to do this, he was worthless. There was no way out of the depression, there was no future, just guilt.

I said it must be very difficult to have all these tasks to do and no-one to support him. He cried - silent tears with his head turned away. After a long silence I said it must be very difficult to be without a father to help with these responsibilities. The tears dried up immediately. "No", he said, "it isn't like that. I'm not crying about that". I nodded and let it pass. I then offered therapy on a weekly basis. I said I would be available for the rest of the year but suggested a review after six sessions.

Comment

I realised at the time that the introduction of the father was too soon. It seemed to me however, that he was saying it was too difficult to be the head of the household, the impossible was expected from him. It was during this first session that I formulated the notion of the importance of the absent father in Rafiq's life; in Lacanian terms, the impossibility of entering the symbolic order, that is, society, law, the place of the self in

the family system of names, when the father is not present to mediate the fusional relationship with the mother. A sense of a separate, autonomous self in the world remains lacking, and the tasks which are required to move through his rites of passage and establish himself in the world of men, are perceived as insurmountable.

Session 2

Rafiq came early; he looked cheerful and talked in an eager, rushed way, often stumbling over sentences. He said he felt very hopeful about individual therapy. He thought I might be able to 'save' him. I said that it seemed to me that he had a great need for someone to listen to him and to see him. He agreed. A long, rambling account followed of life on the ward: the weekend was quiet, he did not mix with anyone. When the patients came back on Sunday, he changed, became cheerful, animated. Why did he always feel he had to talk to people - it was so difficult talking to people, he didn't really want to, but felt he had to. He had been thinking about it and had come to the conclusion that he felt scared they might be critical of him. But people seldom were. I said: "It seems like such an effort to be with people." He agreed. He wanted to be "natural", and people had been telling him that he had been more natural lately. But he used to think he was natural and clearly he was not. So could he believe that he was now? I asked what it meant to him to be natural. He did not know, he could not say. Perhaps it meant to be more spontaneous, to be himself. He always analysed everything, he always thought: "Am I natural now or not?" People in groups had been confronting him because he could not get to the point. They said that he talked a lot but could not say what he needed to say. He could not understand what held him back. I wondered at that point if there might not be things that he needed to say but could not say, and therefore he could not say anything. He did not think so, he could not agree; it definitely was not so.

Session 3

Rafiq came in looking anxious and dishevelled. He felt very anxious about finding a job. He had to find one but did not feel he could. He complained that other people in the same situation were able to phone and make appointments for interviews, whereas he felt too anxious to even make the initial phonecall. I asked what it was that he feared so much. After a long silence he answered that he would have to meet new people. "And will the new people judge you?" I asked. They would, they might think he was not up to scratch. He had to be a go-getter, he had to be competitive, he had to make it in the business world. He thought of just selling some leatherwork which he had been making, but that would be running away from his responsibilities. He had to make it, he had to prove his worth. At this stage he was wringing his hands, barely able to remain sitting on the chair.

I asked him what attracted him to the competitive, go-getter world he had been describing. He looked surprised and a long silence ensued. Eventually he said that it was the money. And what attracted him about the money? He wanted money for his mother. She should not be working anymore, he wanted her to be comfortable. I said: "You want to make your mother's life better." Yes. He had tried so many times in the past but had always failed. A long, sad index of failures, miserly preserved in his memory and the family catalogues of successes and failures followed. As a child he wanted to be rich and successful for his mother, he wanted to dassle her with his success. He once told his uncle that he was going to be very rich one day so that he could take care of his mother. Years later, when he was heavily involved in drugging and had lost countless jobs, his uncle called the family together, and told them about Rafiq's promise so many years ago. "Look at him now", the uncle said. The whole family looked at him and his mother, sitting together on the couch. His mother said nothing, she sat with downcast eyes. He could not blame her because she was such a timid

person, she could not face up to his uncles who were loud, confident, strong men. But she had actually never defended him against the family, not once. However, his mother had always told him he should do what he wanted. She had never forced him to do anything against his will. It was just that ... perhaps he was wrong ... but something: her tone of voice said one thing and the words another. He felt she was disappointed in him. Perhaps he was wrong. A long silence followed.

I said that it seemed to me he was carrying a very heavy burden. After another long silence he said: "yes, sometimes ... you know, things are sometimes difficult, Ina." I then proposed that he consider other job possibilities. I wondered if it would be possible to consider the possibility that he might not be interested in the business world only, that there were other ways of making it in the world. He said he would think about it and make a list of jobs he might be interested in.

Comment

I realised the danger of interfering with a cultural and religious way of life. I however strongly felt that the competitive, ambitious world which Rafiq so desired to enter, was inappropriate at present, and the constant burden to prove himself would send him back to drugging. It was also a tentative attempt to address his unrealistic job expectations. I however felt doubtful about my intervention, and as supervision was unavailable at the time, I continued to feel hesitant about appropriate ways of addressing the job situation.

Session 4

Once again a session of broken sentences which led nowhere, emotions offered and withdrawn, and long silences. He was trying to be confident and happy. He stayed in the ward over the weekend. He

wanted to go out but did not want to. C. called him a clown during group therapy. He understood why she did that but still felt hurt. He felt anxious about a job but believed he should feel confident. He wanted to be confident. Perhaps he was. Perhaps he was too confident. He wondered if C. still liked him. He really had all the reason in the world to be confident. He was now ward monitor. He felt relieved that he was monitor and he felt proud. He had more time now that he was monitor. However, he felt he did not deserve to be monitor. He did not know how to be a monitor. How should he be as monitor? Should he be stern and impartial? He thought he should be but perhaps people will stop liking him.

I eventually said that it was very difficult to know how to be in the world. He nodded and started crying. After a long silence I said that perhaps he felt there were too many demands on him, and that he did not know how to meet them. Another long silence followed in which he cried with his head turned away. He then said he was scared he was boring me, that he had been trying to find something more interesting to say. I said: "You feel you have to entertain me like you have to entertain everyone else?" He nodded and said it was very important for him when someone showed him affection, and that he became very scared of losing it.

Session 5

It was my last day in the ward, and Rafiq and I discussed arrangements for the continuation of therapy. He seemed to be confident and happy at first. He commented on how grateful he felt that the staff members and other patients seemed to like and respect him. In the past he always had to drug in order to feel confident in himself, but now felt confidence without drugs. He then became quite agitated and told me about a period of nine months he had spent with an uncle in the Transkei. This uncle was a harsh, confident person who frequently humiliated him, abused him verbally and sometimes physically and mocked him in front of

customers. He had just been dismissed from a job in his hometown and felt that he had "burned all (his) bridges". He felt he needed to remain in the little village in the Transkei and work for his uncle in order to prove himself and regain the respect of his family. However, it was extremely difficult, and as it was impossible to find pills, and mandrax and dagga were only available when commercial travellers passed through the village, he drank. The smell and taste of brandy made him heave and always brought memories of his father. However, he forced himself to drink it and always kept a bottle in the toilet. He would disappear from the shop every half hour or so and take a few sips. It was the only way he could face his uncle and the bleakness of the village. One night, when he was very drunk as well as high on mandrax and dagga, he attacked his uncle and was thrown out of the house and the village. He hitched back to his hometown, and arrived at his parents' flat drugged and dishevelled, demanding money. His father gave him money, but on his way to the merchant he met up with some missionaries and decided to go with them on a mission. He stayed off drugs for five months but went back on drugs when his father died.

This account was delivered in an agitated rush.He then told me his fantasies of revenge against his uncle, and abruptly fell silent. After a long silence I said that he had been telling me about a time which was very difficult and humiliating for him; he had been saying it was impossible to face life without the support of drugs. I wondered if he now felt he needed drugs in order to go out into the world and find a job. He nodded, and said he had been thinking about it; he had been craving pills for a few days already and thought about it constantly.

As we were already thirty minutes over time, I closed the session after an assurance from him that he would not actually try to get hold of drugs.

Comment

At the time I felt Rafiq needed to tell the story of the humiliation he had endured at the hands of his uncle. The subsequent events made it clear that he was telling another story and that I had misunderstood him: I now think his story was a warning to me that he could not make it without drugs, and an attempt to ask for my help. He could not ask for help directly but perhaps hoped that I would understand. I failed him. He got hold of pills directly after the session, and gave some to other patients as well. Three patients were immediately discharged, but it was suspected that others were drugging as well. The ward and the patients were searched, and drugs were found in various rooms. Rafiq was discharged after it was found that he had initiated the drugging. He left, abusing the staff, promising that he would never come back. The next day he was back, begging to be re-admitted. It was eventually decided that he would be accepted as an outpatient and re-admitted after a month.

Session 6

This session lasted two and a half hours. Rafiq was dishevelled and out of control. He begged me to intervene on his behalf and get him re-admitted, wept and circled in guilt and self-recriminations. Eventually he calmed down and said that he was also proud of himself: he had been without drugs for a week now, and previously it would have taken him a year to recover from his drug spree. However, he felt he was imposing on the people with whom he stayed. He could not make any contributions financially and this made him feel very vulnerable. He then read me a letter he had written to his mother. He told her that he wanted her "to be there for (him)" but he also wanted her to let go. It was a very loving, intimate letter and he felt good about writing it.

I then asked him how he now felt about the staff in Ward 4. (His

group therapist had told him she never wanted to see him again, and others also expressed their disappointment). He said that he thought they should have realised that he was too confident and out of control. But he understood their disappointment and very much wanted to make up for what he had done. I said he had told me during the last session that he was craving drugs. He thus gave me a message which I, like the staff, failed to pick up. After a long silence he said he had felt during the last session that neither therapy, nor I in some way, meant anything; therapy was not helping at all and I did not really understand him. I said he must have felt I had failed him in a very important sense; he must have felt very let down. He agreed that that was how he felt. I then asked whether he did not perhaps feel angry too. He denied this, saying that he did not often feel angry and he did not like feeling angry. He just felt disappointed. I asked him why it was so very difficult to tell me that. He replied that he was scared I would feel he had failed me. I said: "So, instead of telling me how you felt, you drugged, Rafiq?" He said maybe. There might have been other reasons as well. I agreed, but said I thought my failure to understand his message played an important part in it.

He then talked about his mother, how much he wanted to give her a different kind of life, how much he wanted to get back into the world and make a success of it. He thought he could. He thought he had it in him to make a success in the business world. He wanted to get back into the ward; he once again wondered how he could get back, he wondered if I could not help him. I once again reminded him that I was not in the ward anymore, and therefore not part of the decision-making team; also that he had broken the most important rule. I gave him my home telephone number and told him he could phone me if he really needed to.

Comment

I found the session unsatisfactory. I could not quite understand

the reason for his behaviour and felt anxious and distressed. There was something in his behaviour that I felt I ought to understand but could not. I also felt the need to be very cautious but did not know why.The fact that I still did not have any supervision because my supervisor had left the hospital and was not as yet replaced, added to my feelings of frustration and anxiety.

Session 8

It had been a difficult week for Rafiq; he had been feeling depressed and anxious. The family he stayed with wanted him to go to the disco with them over the weekend. He had been telling himself that he should just be natural, that he could make it. He felt, however, that he really did not want to go. On the other hand, perhaps he didn't want to go because he was scared and therefore he should go. I observed that it was difficult for him to know how he felt about things. He agreed and seemed to relax a little. He then proceeded to tell me about a telephone conversation he had with his mother. He felt very good about her response to his letter. She told him to stay where he was and that his family had no right to pressurise him to return to his hometown. (He had numerous phone calls and letters from his uncles, aunts and cousins, urging him to "sort (himself) out" and come home). She did not offer to send him any money either and he felt relieved about that; he thought she understood what he meant when he asked her to let go. His mother told him she only wanted him to be happy and to become a man.

I asked him how the implication that he was not as yet a man, made him feel. After a long silence he replied that actually he felt very hurt about it; however, he agreed with her that he was not as yet a man. I asked what was his family's definition of a man. He answered a man was someone who was able to take financial responsibility for himself and his family, someone with a good job, a house and a car. I then asked what his definition was. He said a

man was someone who liked himself, who felt confident about himself and who was able to be natural. I commented on the difference between his and his family's definition of a man, and wondered if this difference added to the tension between them. He said that was one of the reasons why he did not want to return: he felt he did not fit in and he was constantly judged. On the other hand, his father's family had always loved him deeply, he had always been welcome at their homes and could borrow their cars; that was, till he started drugging and smashed their cars. I said that it seemed there was a warmth, support and closeness in the family which he wanted very badly. But underlying the closeness was a feeling that he was being judged and smothered, that he was unacceptable. A long silence followed. He then told me various incidents, all related to his father. His father was an alcoholic and did not mix with the rest of the family. He never used to go to the religious and family gatherings, but sent his sons and wife. At these occasions his maternal uncles and aunts would always ask him why his father was not there, knowing full well that his father was at home, drunk or with a hangover. It felt to him as if all eyes were on him, and that everyone was snickering and gossiping about him and his father. His mother would stand next to him, not saying a word to help him out, and sometimes he would feel her tremble. He became very distressed at this point and said: "It is terrible, man, a family is a terrible thing". He did not want to return; despite the warmth and support he never wanted to return. But he did want to help his mother; although she had told him she did not need his help financially, he had to get a good job, he had to help her and make things better for her.

I asked him what his mother had said exactly. He replied she had said that more than anything else she wanted him to be happy, she wanted him to get married so that another woman could look after him. Life was very hard for her and it had been hard for many years. She now wanted someone else to look after him. I wondered if his mother was not also asking him to let go. He said perhaps, but

he still wanted to make things more comfortable for her.

I pointed out that we had two minutes left. He then said he had been hoping that he would feel better after this session, that he would feel more confident about himself. He very badly wanted to drug over the weekend but because he had my telephone number he felt I cared, and he came through the weekend reminding himself that he could phone. He then started "living" for when he could see C. at Outpatients. But the session was a disappointment; he did not feel he got anything out of it and he did not feel better. I asked if that was how he felt about this session. He said not really, but that he did not feel better and he really needed to feel better and lighter about himself. I said that therapy was often distressing and painful and might make him feel worse and not better. He might often dislike me and feel that I did not give him anything. I asked him to tell me when he felt this way, that I would still be here next Friday, regardless of what he said. He laughed a bit and said: "Yes, we'll see about that."

Comment

I still felt uncomfortable and as if I had failed him in some way or another. He missed the next two sessions, which reinforced my anxiety and feeling of failure.

Session 9

2 hour session.
Rafiq was back in Ward 4. He drugged heavily the weekend before his return, and seemed to be in a very bad state. His nose was bashed in and his eyes were swollen. His face looked bruised and sore. He was very depressed and talked for more than an hour about his drugging spree. He was mugged, and his father's ring got stolen. He did not know how he was going to tell his mother about the loss of the ring, and knew she would think he had sold it for drugs. In

fact, it was the only thing in his possession which he had not sold over the years. The family with whom he stayed now disliked him and told him how disappointed they were in him. The whole Sunday night he dreamed about his father, terrible dreams which he could not remember except for bits and pieces about which he could not talk.

He then started talking about his father. When he was a youngster his father drank heavily. As he was the eldest son he had to help his mother with his father. The two of them would sit up every night, waiting for his father to come home. They would sit side by side on the couch, not talking and not touching. Sometimes he would fall asleep and dream - terrible dreams - and would wake up and see his mother still sitting there. He would then feel guilty that he had let her down. His father always came home late at night, swaying and vomiting all over the furniture his mother kept polished and so clean one could eat from it. Rafiq would put him to bed and wipe up the vomit. Sometimes his father would be violent. He hesitated. There was a memory, when he was very young, of sitting at the far end of the passage, watching his father and mother - but he could not remember. Sometimes his father would boast and promise them all kinds of things. His father was depressed for years and would sit on his bed, sometimes for months on end, staring at the wall, unshaved, dressed only in his old, dirty dressing gown. Rafiq would sit next to him and try to cheer him up. He would point out all the good things in their life, and assure him that everything would be all right; they just had to have faith and work very hard. He felt so guilty, as if his father's unhappiness were his fault. He often asked him if he had done something wrong, if there was a way he could make it better. When his father eventually joined Alcoholics Anonymous he stayed sober for the remainder of his life.

He hesitated, and then said he now remembered his dream. He had dreamed he was in bed, asleep. His father walked into his room, swaying and reeking of alcohol. He (Rafiq) stumbled out of bed and

ran up to his father. He grabbed him round the legs and shouted: "But why? Why did you start again? Tell me Daddy, tell me why!". At this point he broke down and cried for a long time. He left soon afterwards.

Comment

I felt deeply moved during this session. I was well aware that there was now a need to set limits to the time we spent together, but could not find it in myself to stop him at any stage during the session.

Session 10

Rafiq came in looking distant and slightly hostile. He said that coming to my ward he again had the feeling of being a visitor, of not belonging, the same feeling he had had while he was an outpatient and just coming to the hospital for therapy. I said that it seemed to me he was saying he did not feel he had a home, a place where he could belong. He answered that it had always been difficult for him to leave home, that he felt exposed and vulnerable whenever he left home or Ward 4. He had never been able to succeed in the world, to finish anything. I said that perhaps it was because there was too much unfinished business left at home. After a long silence he said that he had been thinking about his father and talking about him in groups; he had been crying a lot lately. During his father's sober years he really cared for him (Rafiq) and reached out to him. He tried to buy him with dagga and money, and insisted on going on a Dale Carnegie course with him. He could not accept his father's love, but now he felt he had missed out on something important, that he had in fact rejected his father. He then started talking about his childhood again: memories of his father vomiting, abusive, boasting; memories of coming back from Mosque on a Friday afternoon and seeing his father swaying from lamppost to lamppost, escaping from the local psychiatric

hospital and found sobbing and still in his hospital clothes on the pavement outside their block of flats. But then his father changed. He told a number of stories of this time: his father writing to various family members, apologising for the years of drinking, putting flowers on his own father's grave every Friday, putting Rafiq to bed when he came home drugged, wiping up his vomit when he came home drunk. I said that he had memories of a time his father tried very hard to reach him and to repair the damage he had done, a time his father showed him respect, and that it hurt very much to understand that it was now too late to ever have a relationship with his father. He started crying and said that his father had respected him. That hurt him the most. Then a story about his own violence; how he had once kicked his father when his father had stolen his money and came home very drunk. He felt nothing about it then and felt nothing now. But his mother always told him that she was so grateful that he, unlike his cousin who also had an alcoholic father, never abused his father. But she always reminded him of that incident and always cried when she talked about it.

I said that kicking his father was a very angry and contemptuous act. It seemed to me that he had felt contempt for his father. He had the right to feel such contempt at the time. He cried for a long time. Eventually I said that perhaps he was crying because he wanted and needed a father he could respect, but he did not have such a father. He agreed and continued crying. A long silence followed which I broke by saying that it seemed to me that his mother was expecting the impossible from him: she expected him to clean up after his father and witness his drunken behaviour, but at the same time she needed him to respect him. This was something he could not do. He said that he had always wanted to please her, that he very much wanted to look after her. I said that it seemed to me that it was sometimes very difficult to please her, and that he could only do it at the cost of his own feelings. He did not answer and the session ended soon afterwards.

Session 11

A session which resembled the initial ones. Rafiq circled in thoughts and concepts and memories which seemed to lead nowhere. He talked about therapy groups in the ward and a discussion about affection and warmth; he gave a detailed report on what everyone in the group had said; he suddenly understood he had always rejected his feminine side, he now realised that his feminine side was his best side; N., a therapist in the ward had told him that he always tried to please others and that he felt guilty when he asserted himself. He found this a very interesting observation and thought it was true; however, a friend whom he always tried to please, told him that he thought him an independent and assertive person. This pleased Rafiq and he wondered if N. was correct in his observation. He then proceeded to wonder if he had not become too conservative.

I eventually interrupted him and asked how he was feeling at that very moment. After a long silence he said he felt confused. I assured him that I could identify with this feeling because I felt extremely confused myself. He laughed and seemed to relax. The endless flow of words stopped, and he sat quiet for a few moments. We then went back to the beginning and talked about the meaning of affection in his life. He said affection meant being accepted and respected. It meant warmth. I asked him if he had ever experienced this with anyone. Perhaps once, he said, with a girlfriend he had loved very much. Not with anyone else? He thought not. I asked whether he had ever experienced it with his mother. He thought for a long time and eventually told the following story: In December, after his first discharge, he spent three weeks with his mother. They spent a lot of time together and were very close. They sat together at night and talked and she shared many memories and youthful dreams with him. It was a time of closeness but he felt suffocated, it felt like a nightmare, and sometimes he thought he was dying. He could not share anything with her. He felt she might be hurt by the things he wanted to say. But he did not know what he

wanted to say. I said: "Affection means acceptance - it thus also means what you have to give can be received by the other person. It seems to me that you are saying what you feel and want to give and share cannot be received by your mother". A very long silence followed. He then said he had a letter from his mother the previous day. He put it in his pocket by accident and had it with him. He wanted to read me the letter. His mother wrote it was time for him to snap out of his self pity. She had cried so many tears and life had been so hard, she had no tears left to cry. Now she wanted to be left alone. She did not want him to do anything for her; she could look after herself. She simply wanted him to become a man. It was little enough to ask from one's son. She then proceeded to tell him how well his brother was doing at school, about a cousin's marriage and how often she prayed that he would get married too.

I asked Rafiq how he felt about the letter.He hesitated. He thought that ... perhaps he felt ... he was taken aback by the letter. Perhaps he also felt a bit misunderstood. I said he had been feeling reasonably good about himself the last couple of weeks and had worked well in groups. He now seemed confused and hesitant, as if he did not know what to think or how to feel. He agreed and said it was exactly how he felt. I then said: "I think you live in your mother's image of you, Rafiq. When that image does not match your own, you become confused. And that is why you now again talk in riddles. You don't know what you feel or who you are." He seemed startled, then said he felt I was right. He did live in his mother's image of him and he did not always like that image. I agreed and said it was difficult to find a sense of self in another's image.

Comment

I felt angry with Rafiq's mother and believed there was also a lot of anger in him. However, it did not seem appropriate yet to tap that anger. I was also left with a growing sense of distress, a

feeling that Rafiq was much more fragile than we thought at first. I felt increasingly convinced of a more serious disturbance, a damage that was not fully understood yet.

Session 12

A session about not having a home, of not belonging. He could not leave the ward over the weekend, though he felt he ought to. It reminded him of all the previous times in his life he had been unable to go out because he was too scared to. He gave various examples, and talked once again of the family gatherings and how difficult it was to go to these occasions. Ward 4 was a dear place to him, a home. It was scary to go out. He felt he was a coward, and could not meet his obligations. I said it was difficult to go out into the world if one feared one would not be received. He agreed.

Comment

It was a session of long silences and little talk. However, he seemed to find it restful and seemed less anxious than usual. I felt it was one of our better sessions.

Session 13

S., a male psychiatric nurse, who had been Rafiq's ward therapist for the last five months, had left the ward the previous week. Rafiq missed him keenly and although S. continued to see him whenever Rafiq felt the need for him, he found it difficult to get used to his new therapist and felt lonely in the ward without S. Life had suddenly become more difficult in a number of ways. There was a nurse, M. in the ward whom Rafiq liked very much and Rafiq, her and S. used to spend a lot of time talking, swopping jokes, and drinking tea together. The conversations were nice, lighthearted and witty; he could be witty and "natural" with S. next to him. But

now it had become a strain talking to M., and suddenly he could not be witty and natural anymore. All their conversations inevitably now turned serious because he could not sustain the wit and lightness. She never left him with a smile now anymore. He would so much like that, he said wistfully, to be left with a smile, knowing he had been fun to be with.

I asked in what way S. made it possible for him to be the witty "natural" person he wanted to be. He replied that S. gave him courage. "Courage for what?" I asked. Courage to be the person he wanted to be, courage to feel comfortable. I said that it seemed to me that S. supported him and mediated between him and the world. He agreed. I then said: " It must be very difficult to go out into the world without a father, to be so very unsupported". He cried for a long time and then said he had always felt unsupported. He had always felt a failure, as if there was something wrong with him, something lacking. He had never been able to make it. He now for the first time understood that he had always felt unsupported. He had to drink and drug in order to go to family gatherings, to job interviews, to discos'. He had to be drugged in order to hold down a job. The drugs filled up something, it gave him the support he needed.

He then asked if he could come for therapy twice a week. I agreed.

Comment

In this session Rafiq accepted the interpretation he rejected in session 1. I seriously started considering borderline personality disorder. However, Chris Robinson's assessment of Rafiq still prevented me from making up my mind. My supervisor was non-committal, feeling this was something I had to make a decision about without his interference.

Session 14

Rafiq brought a letter from his mother with him. The letter said nothing and everything: she did not want to hurt him, she would rather not say anything. She prayed for him night and day but would not like to nag him. She prayed he would find a nice girl who could guide him and look after him. She wanted him to get married. Life was hard and she wanted someone else to look after him now. She then said he always told her she should share things with him, so she was going to do it from now on. She proceeded to give him bits and pieces of information about herself: she had new glasses, she had felt a bit unwell lately, etc. In the last paragraph she apologised for talking so much about herself.

I asked Rafiq how he felt about the letter. He did not know; perhaps he felt a bit confused but he did not know why. A long silence followed. There was something about the end which puzzled him ... but he was not sure, he did not know. She seemed to give something, or share something, but then she took it back again. He did not understand why she had done this. And how did it make him feel? He did not know. Perhaps a bit confused. I asked if he did not perhaps feel a bit resentful about it. Silence. I then said if I was in his place I would have felt a little angry. He said that she had always done it; she was so unassuming, hesitant. She always thought her problems were not important. And then he felt ... he felt .... Silence. He felt guilty. I said: "yes, you feel guilty". I then asked about the first part of the letter. He did not know. He felt like doing something when he read the letter. Silence. He did not know what he felt like doing. Silence. He felt kind of restless. Silence. Eventually he shrugged his shoulders and said he had actually stopped thinking now, he was just sitting there. I said: "All right. Perhaps you felt like doing this?": I took the letter, folded it and tossed it on the table. "Perhaps you felt like saying 'oh, let me be!'". Rafiq turned pale . He said he could never ever do that, he could never say that to his mother. I asked

if he could not even do it when alone in his room. He said no. She was his mother and she had suffered so much and she loved him so much. I asked what then happened to the feeling of resentment he hinted at. He said he had always managed to dump that on his father. After a long silence I said it was easier to be angry with his father - it was a straightforward, uncomplicated anger. He agreed and left soon afterwards.

Comment

A lot of complicated, mixed feelings in myself during this session: anger with Rafiq's mother for her mixed messages and subtle hostility; a desire to get him "unstuck", pity for him, a need to protect him against his mother. At the time I knew he had no access to his feelings of anger and that I was imposing my own feelings on the session. At the same time I felt we were hopelessly stuck, that he was on his way to his circles and riddles again, and I wanted to shock him out of it, I wanted to give him permission to be angry. However, I agreed with my supervisor that my response was uncalled for and did not help him at all.

Session 15

Rafiq had gone to a disco at Ward 2 the previous night. He felt very anxious about it beforehand and very tense during the first hour. Initially he just sat there but then forced himself to dance. He danced with the two fattest women there, and "really went wild"; clowned on the dance floor and everyone noticed him. Afterwards he was teased by the other Ward 4 patients but felt good about it. M (his ward therapist) said he could give himself a pat on the back because he managed to be himself and to enjoy himself without drugs. Rafiq however did not feel that good about it. (He in fact looked sad and troubled).I asked him why he felt good when he was teased. He said that at least he was noticed. He was not noticed during the first half of the evening and that made him feel

uncomfortable. He needed to be noticed and he often felt he was not, that he had no presence. I asked him to describe the feeling when he walked into, say, a disco. He said he felt small and helpless, as if he did not exist. He then talked about his childhood. There was a gang of wild boys his own age in the block of flats in which his family lived. He frequently got hurt, and this upset his mother and grandmother greatly. He described a number of incidents in which he got injured in some way or another. He would be rushed to hospital, with his mother crying and blaming herself and his grandmother scolding the other boys, telling him he was different from them, that he was sensitive and much more frail. Both women would bewail their poverty, their hard life, the environment in which he had to grow up.

I said perhaps the message he got from his mother was that he was not strong, that he was small and vulnerable. He agreed and said he always felt very humiliated because such a fuss was made over him. The other boys got hurt as well, and no-one even noticed.

Rafiq then told me about one of his aunts who had five sons. He once spent a summer holiday with this family. The boys were wild and very mischievous and the six of them terrorised the neighbourhood, went on hiking trips and got into various scrapes with neighbours, the police and the townspeople in general. The aunt would spent a considerable time on the phone every day, yelling at people that "boys will be boys", standing at the gate with arms akimbo, shouting at the neighbours to leave her sons alone and "mind (their) own bloody business". She made them huge meals, saw to their injuries and left them alone. Rafiq was crying by now. I said: "So, she trusted you to look after yourself, Rafiq? And it was a very good feeling and made you feel strong and present." Yes, he said. And now her sons were very successful business men. When he was with them he felt confident, as if everything was possible. But it was only with them that he felt confident. He once went to Johannesburg to look for a job but felt

completely overwhelmed by the city. He went back home and told the people he did not like the fast life. But he did like it, he very much wanted to be part of it. But he was too weak, sometimes it felt as if he simply did not exist. How could he go out there if he did not exist?

I said that it had to be very difficult to live in the world if one felt one was not trusted to be strong enough. He said with a rare bitterness: "But I really do live in my mother's image of me, man. I keep on thinking about that. I'm not a person at all, I live inside her head." Immediately afterwards he withdrew, and sat in a heavy, uncomfortable silence for the rest of the session.

Comment

My conviction that a diagnosis of borderline personality disorder could be made, was reinforced during this session. I also had a growing sense of how difficult it was for Rafiq to live in the world; he was not equipped, he was not ready. I felt anxious about him because his time in the ward was coming to an end again; I struggled with feelings of imminent disaster. I had started dreaming about Rafiq: short snatches of him looking sad and seedy, red-eyed, bruised or bleeding. These images remained with me and intruded during the sessions, so that the dream-image sometimes became more real than the flesh-and-blood person.

Session 16

Rafiq said he was very depressed but did not know why. Eventually it emerged that he felt unsure about his stay in the ward. There was pressure on him to start looking for a job. He felt threatened and that no-one in the ward really cared about him. Once again he felt unsupported. I linked this feeling to the feeling of being unsupported and alone that he had had all his life. I said perhaps he now once again felt he was being pushed out before he was ready,

that he felt he was forced to take responsibility while he actually needed to be supported. He agreed and talked about his youth and how unsupported he used to feel.

He then showed me a letter from his mother. She wrote that she did not want to say anything to hurt him so she would rather not say anything at all. She was very proud of him and she now realised she had made many mistakes and God was punishing her for her sins. But sometimes she asked God why should her punishment be so very harsh.

I asked him how he felt about the letter. He said he did not know. Usually he read her letters over and over but this time he only read it once. After fifteen minutes of silence he said he felt guilty. He did not elaborate and left soon afterwards.

Session 17

A continuation on the theme of the previous session: he wanted to be independent but felt resentful at being pushed out. There was resentment against a male psychiatric nurse in the ward who had called him in to discuss his plans regarding a job and accommodation. This was the same nurse he dealt with when he drugged in the ward and was discharged. On that particular night Rafiq came back to the ward swaying and slurring his speech. J. confronted him about drugging. Rafiq denied it initially, but when J. insisted, Rafiq started abusing him, and tried to attack him physically. Rafiq was then asked to go to the seclusion ward, which he refused to do; consequently J. discharged him on the spot. Their relationship had been strained ever since. I said it sounded to me as if he was very angry with J. He agreed after first wondering whether he was not just resentful, whether it was not simply a matter of disliking J. because of his "cleverness and superior ways". He then said he would never be able to trust J. again. I wondered if perhaps it was only possible for him to be angry when he was drugged. After a long silence he agreed and proceeded to

tell a number of stories centred on being drugged and angry in an ugly, uncontrolled way, lashing out at people in an indiscriminate fashion. I asked him what made it so difficult to be angry when he was straight, why he needed to be drugged in order to feel and express anger.

A long silence followed. He was clearly thinking very hard and when he started speaking he struggled to articulate himself. Sentences were left unfinished and thoughts were so jumbled up they made little sense. What emerged was a need for people to like him and a fear that they would not if he expressed his anger. This was followed by a number of stories centred on feeling angry but being unable to express the anger for fear of hurting people. I said it sounded to me as if he also wanted to protect people against his anger. He was not sure about this. A silence, lasting till the end of the session, followed.

Session 18

A session of long silences and half-finished sentences. Rafiq said he felt depressed, he could not speak, he could not think. He was supposed to phone for job interviews but could not bring himself to phone. He could not even lift the phone. I asked him to describe his depression to me. He felt as if he was "dead" inside, as if there was not a person there at all; it was as if he was all "hollow inside", "a non-being". He could not make appointments and go for interviews: "there isn't someone to go -I wish people could understand that ... there just isn't ... -I need drugs to be someone, to do these things". He then related various examples of interviews in which he was either drunk or high on Obex, stoned on Prohypnol and Mandrax. He would be unable to enter the building where the interview was to take place, he would circle the pubs in the area and eventually succumb to the need for a drink or some kind of drug, even if it was only Thinns. He could not function in the jobs he got without drugging. He would promise himself only to

drug for the first two weeks, till he knew what was going on and did not feel so strange and alone anymore. Because he was drugged however, he would be unable to follow or understand orders and would eventually be dismissed.

He felt the staff in the ward did not understand how difficult it was for him to arrange interviews. He felt they did not understand him anyway and they did not care much about him either. The ward was different this time. Since Chris Robinson * had left, things had changed for Rafiq. It did not really feel like a home anymore. When Chris was there Rafiq felt protected, he felt the ward was his home. Chris knew everything about him, and understood him. Although he did not have much personal contact with Chris, he told the staff things about himself and talked about himself in the groups because he knew it would get back to Chris. In this way he was connected to Chris, he felt connected, he had a home. He lapsed into a brooding silence.

Eventually I said: "It is very difficult to do the tasks required from you when you feel unconnected, isn't it? It is difficult to be a person when you are unconnected and unsupported." He started crying but did not say anything more and left abruptly, without attempting as he usually did, to get me to walk to the front door with him.

* The previous unit manager. Chris Robinson started the drug unit and ran it for four years. He left the hospital at the end of March 1990.

Comment

It was during this session that I eventually made the diagnosis of borderline personality disorder. I had been reluctant to make the diagnosis, possibly because I felt, on an inarticulate, unacknowledged level, that it would affect my attitude towards

therapy with Rafiq. I had worked with borderline patients in Ward 4, and the staff was in agreement that the prognosis concerning the borderline drug addict was inevitably extremely poor. My own experience in ward 4 firmly supported this prognosis. After Rafiq had left, I sat for a long time in my room, struggling with a feeling of hopelessness and exhaustion. Perhaps I had become too involved with him, perhaps I did want to "save" him, as my supervisor, much to my annoyance kept pointing out to me. Whatever the case may be, I now realised that my therapy with Rafiq would be a holding job, an attempt to make the glue stick from one day to the next. Perhaps some other therapist would one day be able to help Rafiq negotiate his rites of passage, but it would not be me. I understood then that Rafiq still had many years of drugging before him, that he had set himself an impossible task and that the route into the world was fraught with potholes and pitfalls which I would not be able to help him with. This made me sad because I cared for him very deeply.

Session 19

Rafiq was still very depressed. The occupational therapist had told him he was too dependent on the ward, and this caused him embarrassment and discomfort. I asked him why he felt he did not have the right to be dependent. He said he had thought about it. During his first admission Chris told him he could come back any time, that he could stay in the ward for a year or longer. He knew he had the right to feel dependent but he could not believe it. There were lots of things he knew but could not feel. For example, there was a very timid patient in ward 4 whom he had been encouraging to be more assertive. This boy changed so much that he was able to participate in a play which the patients produced for the staff. Rafiq would never be able to do this. He however forced himself to sit back and watch the play without criticism and embarrassment. He got it halfway right: he managed to sit back and enjoy it, but he still watched the staff the whole time.He did feel

*embarrassed. He did not know why. He thought, although he did not like saying it, that the play was not very good. He felt embarrassed on behalf of the patients. All his life he had felt sad when others felt sad, embarrassed when others were foolish. I said it seemed as if it was difficult for him to keep a distance between himself and others. He agreed. He always felt responsible for other people's feelings, he was so aware of other people's emotions that he could never just be himself. I said: "It seems to me you often have to be less of a person in order to make others feel comfortable, that you often diminish yourself in order to make others more confident." He suddenly came alive, jumped up and banged his fist on the table. "Exactly", he said, "that is it exactly - I have to diminish myself". He then gave various examples of incidents in the ward with fellow-patients in which he felt the need to make them feel good about themselves, in the process presenting himself as unassuming, ignorant, impressed by their knowledge, deeply grateful for their attention.

I asked how he would be if he did not have to diminish himself. He said he would be too harsh, "too much". He would hurt people, push them away. He always felt he had to hide himself. I asked what he had to hide. Something. Even when he got on with people, he felt they would find out. People sometimes respected him and liked him but that made him even more anxious because he knew they would eventually find out. I again wondered what they would find out. After a long silence he said they would find out that he was basically inadequate. I said: " Is this the way you feel about yourself, Rafiq? That you are inadequate?" He said he had always felt he could not make it. No-one had ever believed in him ... even at home ... his mother said she believed in him and she knew he would be a success one day but he knew ... if she really believed in him she would not always try to protect him, she would not always send money and forgive him for everything. She had always treated him as if he was frail and helpless. He fell into a reverie and left without saying anything more.

Session 20

A session of broken sentences and rapid mood shifts. Rafiq started off by saying he felt he was doing much better: he did not feel compelled to participate in conversations any more, he thought he was much more "natural" now. He constantly checked himself, asked himself: "Am I natural now?" These days he felt his behaviour was natural. However: although he really liked sitting with the others in the lounge because there was always such a lot of laughing and talking going on, he often got up and went to his room to read because he sometimes found it difficult to contribute. He would rather be on his own than not contribute. He was not noticed when he just sat there, and he found that unbearable.

What emerged was this: he constantly needed to assess himself. Even while watching television, he would ask himself whether he looked natural or not, whether he felt natural, whether he should look sad, what others would think if he looked sad. He needed constant feedback from others. "What do you think of me?" he would ask the other patients. "What kind of a person do you think I am?" "Do you think I am an assertive person?" "Do you think I behave in a natural way?"

Comment

Rafiq's need to assess himself is linked to his need to be seen, the lack of which is further linked to the inability to feel himself as a presence in the world. At the time I felt my role could perhaps be that of mirroring only. This was corroborated in supervision. The theoretical understanding and the agreement in supervision did not however make it any clearer as to how this could be achieved in therapy.

During this week all Lentegeur staff was notified that a professor Marc Galanter would deliver a lecture on the unique abuse of

Cannabis-Methaqualone (Mandrax) in the auditorium. The professor was introduced as the director of the division for alcohol and drug abuse at New York University Medical Centre, and everyone was urged to attend his lecture. Ward 4 staff was instructed to present a special case during a ward round (not for public attendance) to enable the professor to demonstrate his years of expertise in this field. The therapeutic team decided to present Rafiq. I decided against attending the ward round but made copious notes on the central conflicts in Rafiq's life, with special stress on his inability to sever his dependent ties with his family, his anxiety about employment, and his feelings of being unsupported. I also gave a comprehensive history of family relations and conflicts and provided a psychodynamic formulation which stressed the absence of a strong, supportive father in his life.

Rafiq came to me after the ward round. He was pale and shaken and said he was humiliated and taken aback by professor Galanter's attitude. Apparently the professor asked a few questions and then told him he should "return to (his) roots". He advised Rafiq that he and his father should both join AA and support one another "during (their) time of crisis", that it was time for Rafiq to "take on (his) responsibilities like a man"; that it was time to grow up. Rafiq was then dismissed with a friendly nod and a pat on the knee.

I lost my temper, forgetting all about therapeutic decorum, and told Rafiq what I thought of professor Galanter. After nervously protesting that the man "was after all a professor", he seemed to relax and even started giggling a little. He then went back to ward 4, where he was assured by everyone that professor Galanter was, to say the least, gravely mistaken in his views.

Session 21 (This session was taped)

Rafiq came in smiling, looking jaunty. He wanted to talk about

professor Galanter. He felt fine because everyone in the ward told him the professor was clearly in the wrong. What he could not understand, was his reaction to the man. I asked how he felt in that situation. He said he went in with high hopes, expecting the professor to say something very important. He felt grateful to him for taking time to listen to him (Rafiq) and believed the professor would be able "to sort things out" for him. When he however realised where the discussion was leading, his ears turned red, his whole body flushed. He felt ... he did not know how he felt. I said it sounded to me as if he became very ashamed. He said yes, he was ashamed. He felt diminished. After a long silence he repeated himself. He felt diminished. He felt he needed to protect himself.

I asked: "You felt you needed to protect yourself?"
"Yes"
"But you did not."
"No".
I said: "Your instinct was right. The professor's attitude was a violation of you, and you needed to protect yourself".
"Yes", he said, "I felt negated. I felt negated as a person there."

I said: "But you did not trust your instinct"
"No".
I wondered what the instinct was about, how he had to protect himself. He said he felt like hitting out, it was that kind of feeling. "An angry feeling?" I asked.
"Perhaps", he said. "It might have been a feeling of anger".

I pointed it out to him that he felt negated and angry during the interview but that he meekly accepted the professor's advice and even thanked him for it. I wondered why it was not even possible for him to at least remind the professor that his father was dead, and it would therefore not be possible to join the AA with his father's support. After a long silence he said both C. and N. (the two psychologists in the ward) had told him this man was an

authority, that he was very important in his field. Both looked nervous; it was almost as if they were preparing him beforehand for the interview.

I said: "You are saying you could not trust your instinct, you could not trust yourself, and you could not trust your knowledge that this man was breaking every therapeutic rule in the book."
"Yes", he said. "My instinct was to hit out but instead I cringed."
I asked him what prevented him from hitting out. At first he said he did not know. Then he said it was like being with his uncle. He felt the same way when with his uncle: ashamed and angry but unable to say anything, pretending to go along with whatever his uncle said. His uncle was an elder in the family, everyone respected him; he could not go against family tradition. I said I could understand the problem with speaking out against his uncle, but this man was not an elder in his family. He had authority, but he was not an elder. Rafiq nodded. "Yes", he said. "But you see, C. and N. were nervous of him."
I said: "So, because C. and N. were nervous you could not trust your instinct that you needed to protect yourself against this man?"
"Yes".
I said: " I wonder if you were not protecting C. and N."
He looked away and walked off to the window. When he turned to me again, he had tears in his eyes.
"But why do I do it?" he asked.
"Is that what happened, Rafiq? I asked. "Were you protecting them?"

It all came out in a rush. Yes, he needed to protect them. He felt he was presented because he was the star patient, he was special, he would not challenge or be rude like some of the others in the ward. He would make a good impression. He could not embarrass them by disagreeing with this man. He was an important man.

I then wondered if he was not also responding to the professor's

need to be important. Rafiq repeated that the professor was an important man and he came to the ward round in order to provide a solution; it would have been humiliating for him to be contradicted by a patient, even if it was just pointing out that Rafiq's father died two years ago and the professor was told about it.

I said: "Yes, it would have been humiliating for him, Rafiq. So you would rather carry the humiliation". He started to cry.
"I always do it", he said. " I have always done it. I carried my father's humiliation. He was the alcoholic, it wasn't me. And my mother .... I always feel what other people feel. It hurts me when they are hurt. I feel humiliated when other people are."

I said: It must hurt very badly when people close to you are hurting and you cannot help them".
"Yes", he said. He then suddenly changed. There was a new doctor in the ward, Dr. G. and this doctor really understood him extremely well. He talked to him about his anxiety and put him on a new kind of medication which he said would help for the anxiety. This man understood him so well and he now felt with the help of the medication he might be able to arrange interviews. He had many plans, he was very confident, he couldn't wait for the following week. He was going to get a good job, and make money and he was going to be just like Chris. By this time he could hardly sit in his chair. He thought he might well be like Chris someday: confident, smart, caring. He used to watch Chris all the time, he knew exactly how Chris dressed, how he was with people. He could be the same, one day he was going to be just like Chris.

I said: " You feel very confident at the moment".
"Yes", he said. "I know I can be the kind of person I want to be, I know I can present myself the way Chris presents himself".
"But sometimes you feel very low", I said. "These times of feeling low may come back".
"Yes. Perhaps. But I can cope with them now".

I said: "So, you feel very confident now but you also know the low times may come back".
"Yes, yes I know". He was now impatient and said he wanted to go back because he thought he might be able to quickly see Dr. G. There was something he wanted to ask him about the medication. He winked at me. I had the distinct feeling he was going to say something like: "men's business, you know". But he did not and strutted out, for the first time ever before time was up.

Comment

I found the sudden shift in mood interesting. At one point during the session we were very close but he suddenly changed the mood as well as the topic. I thought perhaps the intimacy provoked some anxiety and he needed to create distance between us. I found it interesting that the distance was created by talking about two men whom he admired, one of whom he loved. It seemed to me as if a necessary phase of normal development, one which was lacking in Rafiq's life, was introduced in this session and that a step toward separation/individuation was attempted, albeit in an immature and tentative form which might not be repeated for months. My supervisor disagreed. He believed that Rafiq was very far from attempting that step, and the sudden withdrawal was simply part of the characteristic oscillations of attachment the borderline person exhibits.

Session 22

Rafiq was still very confident and happy. He brought various pamphlets about jobs and we spent some fifteen minutes discussing the possibilities open to him. He said he was very excited and could not wait to go out and find a job.

I asked him what a job meant to him. He replied it meant security, stability, acceptance. It always felt good and safe to have a job,

that is, in the beginning; it was a feeling of belonging somewhere. However, it always turned sour,and then the job became bad, an unsafe place to be. We agreed that things were always either good or bad for him, and discussed the possibility of a middleground. He said he was trying the middleground at present, but it was an uncomfortable place to be, and he did not want to be there. He wanted to be completely confident because then he felt safe.

He then told a variety of stories about jobs which started well but went wrong. He realised during the discussion which followed that the things which went wrong were not big things in themselves but they stood for rejection and he himself was frequently responsible for the escalation of trouble and the subsequent dismissal from the job.

Session 23 (This session was taped)

Rafiq came in looking dreadful. His face was pale, without expression, his eyes seemed like glass, lifeless. He said he was very depressed and felt dead inside, empty. He thought it must be the new medication. Initially he felt good on the medication, now he felt terrible. I asked him if anything happened during the last few days which could have upset him. He said suddenly he just started feeling nothing was worthwhile. He tried mixing with the other patients but found them boring. It felt as if he could not understand what they were saying, their words were empty. Because he felt so restless and unhappy, it was difficult to stay in his room, but when he joined the others he felt even worse. There were all those empty words, just "floating" around. A fellow patient was on the same medication but she did not seem to feel the way he did. I said it seemed as if he felt that he was not connected to others, as if he was completely on his own. He agreed and then said it was too late anyway, they gave him this new medication when he had almost completed his programme; it seemed to him they were just experimenting with him.

I wondered if he was not referring to Dr. G when he talked about "them".
"Yes", he said. "Dr G. I am just used as a guinea-pig". I asked him how he felt about being used as a guinea-pig. After a very long silence he said he supposed it made him feel a bit angry. He then sat in silence for another few minutes.

I said: "This Dr. G. ... he showed great understanding and sympathy when he first interviewed you, did he not?"
"Yes"
"And he gave you medication which you thought would take the anxiety away and make it possible for you to go for interviews and get a job?"
"Yes. The anxiety is gone now but this feeling ... of just being dead inside, of not being alive at all ... it is worse than the anxiety, man, much worse". Silence followed.

I then asked: "And how much contact have you had with Dr G. since that interview?" Apparently not much. He tried several times to no avail to talk to Dr G. Once he felt quite desperate and told Dr G. he had to see him. They were in the entrance hall, Dr. G. was in a hurry and told Rafiq to quickly ask him what he wanted to know. There were too many people around and Rafiq could not talk to him. Another time when he tried, Dr. G. looked very impatient and said he did not have time. Silence. He then said he understood of course that Dr. G. was a very busy man. I recalled Rafiq's conviction , during his first interview with Dr G. that Dr G. was a caring and dependable man who would help him to go into the world without anxiety. Rafiq interrupted me in a hurried, almost furtive way: he did not want to talk about it. He felt very uncomfortable talking about it. I said: "Because it hurts too much talking about it?"

A long silence followed in which he looked tearful. He then said: "I feel you care, Ina. I feel I can talk here. I feel like crying".

I said: "Yes, it hurts very badly when you feel let down, and once again without support".

After a long time of crying he admitted that it hurt. After a long silence I asked if he perhaps felt a little bit angry also that something which was offered was taken away again. He replied he might feel a little bit angry but he understood of course that Dr G. was a very busy man and that he, Rafiq, was just one patient amongst many.

I reminded him that we had talked about anger before and agreed he could only express anger when he was stoned. I asked him if he was going to get stoned over the weekend. He looked sullen and uncomfortable and said he felt pushed. I admitted I had pushed him throughout the session. I then asked him if he would feel imposed on if I asked him to phone me should he want to drug. I assured him I would not try to dissuade him but I would like to know where he was and how many pills he had with him. He agreed to phone.

Comment

I was fully aware of being very active in this session and pushing Rafiq to talk when he at times did not want to. I however felt Rafiq had reached a very important phase in the programme, one which had proved too threatening the previous time, and that he was on the point of going back to drugging. I could not agree with my supervisor that no attempt should be made to prevent him from drugging, that it might be something which he needed to do in order to work through his conflicts. As far as I was concerned, an important part of my task was to prevent him going back to drugging for as long as I could. Rafiq was in a drug rehabilitation programme and he needed to stop drugging. My supervisor further observed that Dr. G had now become the bad mother and that I was still the good mother. I could not agree. I understood Dr. G to be the bad father, the absent father who could not help his son to

enter the world. It seemed to me that the medication and care provided by this man held out a promise of support, like the kind of support given by a father who helped his son to negotiate the difficult entrance into the world. The promise which was not kept left Rafiq "dead" and empty, once again alone and disconnected, with no resources. Once again he had to face the difficulties of individuation on his own. I thought, not for the first time, that Rafiq should be in therapy with a man; being the "good mother" did not open the pathway to the world for Rafiq.

Session 24

Rafiq came in looking almost euphoric. He had a very good weekend. He had been to town and met a girl with whom he had a "fun-time". He felt very proud of himself because he went up to this girl, introduced himself and asked her to join him for a cup of tea.

The rest of the session was spent discussing jobs. We talked about the various possibilities open to him and the kind of job best suited to his current situation. He seemed to have given up the idea of instant success and wealth and focused on a clerical job, in banking or insurance.

Session 25 (The rest of the sessions were all taped)

Rafiq read a letter he had written to his brother to me. He was worried about his brother's ambitions and values and told him he also used to see success in terms of money and power but he now thought differently. He asked his brother to allow himself to be playful and innocent and told him to believe in himself and enjoy his adolescence. He was worried that his brother would not be able to understand what he was trying to tell him. I said his brother would understand what he was ready to understand, the rest would keep. He laughed and said that was what he had learned in therapy

with me. He learned what he knew already. He never felt pushed and was never told anything he was not ready to hear.
He then started talking about his termination group. He always thought his last group would be traumatic and shameful, that people would say things about him which would make him feel ashamed. Instead it was the best session he ever had. Many people told him he was an inspiration to them, he taught them a lot, they admired him, etc. He really felt good about it, and very moved, but not sad. It made him feel he had a lot to offer, even more than he was giving now; he could give more. However, he was pleased he was in phase 4 now. He had been feeling quite bored lately. He had been feeling he was on a different level than other people, that few people really understood him. Perhaps he was quite a complicated person? Most of the time he had to simplify things to enable other people to understand him. And in simplifying things he lost himself. He did not really mix with the others all that much and the other patients saw him as a loner. He did mix but he never felt part of the group. He always somehow felt he was different. I asked him if he wanted to be part of the group. He said he did not know, perhaps not. It was difficult to be alone in his room, he quickly got restless and needed to be with the others. But when he was with the others he did not feel he was part of the group. Perhaps if he gave more, he would be more comfortable. He knew now that people saw him as a strong, warm person, perhaps it would be better from now on.

I asked him what other people could give him, what it was he wanted from people. After a long silence he said he could not think, he did not know, that he was struggling to understand this; perhaps he did not understand the question. I re-phrased it. After another silence he said he wanted acceptance. However, he did not want it as desperately anymore as he used to. He gave the following example: the ward 4 patients have access to the kitchen and usually cook meals for themselves at night. When Rafiq cooked, he normally offered food to a specific fellow patient whom he admired. When

this man cooked he never offered Rafiq any food. The previous night Rafiq decided to "test" this man's friendship and went to him while he was cooking for himself and his friends and asked for some chips. The man refused, saying he did not have enough. Rafiq said ordinarily he would feel very bad in this kind of situation and either start crying or fighting. This time, though, he simply turned away. I asked him if he would again cook for this man. He said he did not know but thought he would. I said: "You are paying a high price for acceptance, Rafiq". After a long silence he agreed, and then told the following story: a few days ago, while they were having a braai, C., the ward psychologist, came to him and gave him some pamphlets as well as Manpower's address. She told him she had made an appointment for him with Manpower. This was done in a friendly but detached way. He thanked her and she nodded and walked away. Afterwards he felt bad about it. Usually he would smile a lot and thank her repeatedly; he now felt he had not sufficiently expressed his gratitude; she might feel he was not grateful enough. But he also felt very good about it in a funny kind of way. He did not know why but there was something good about his response. I said: "Perhaps you feel good because you did not diminish yourself. He laughed and nodded.
"So, Ina, I am getting there", he said.
"Yes Rafiq," I said, "you are getting there".

Session 26

Rafiq said he felt totally empty inside. He felt irritable, lifeless and restless. He had been trying to do his leatherwork during Occupational Therapy but just watched the clock. He did not know whether he was lazy but could not concentrate. He just felt empty.

He then gave me his C.V. and we talked about jobs and whether or not he should tell prospective employers that he had spent the last year in a drug rehabilitation centre.

I then asked: "Rafiq, what is happening to you?" He did not know; there was just this feeling of emptiness, he could not think past it. A long silence followed. Eventually I said: "You are out of groups now. I wonder how that is for you."
"It feels strange", he said. "I am bored in the ward, restless; there is nothing to do. I don't feel I belong there anymore."
I said: "So, for a time you felt you belonged somewhere, that you had a place. But now you have lost it?"
"Yes", he said.
"And not having a place makes you feel empty and dead inside?"
"Yes."
"Have you ever had a place before?" I asked.
"No", he said. "I have always searched for a place. I have never been able to find one."

His face was expressionless, his eyes looked almost glassy. He moved restlessly in the chair and kept glancing at his watch. The rest of the session was spent in silence.

Session 27

Rafiq came in looking unkempt, shifty. He had not shaven for days and his eyes were bloodshot and tired. They looked sore. He said he had nothing to say. He had gone to Manpower for some tests, but it was a waste of time. He had not been looking at the classified sections in the newspapers, he had not been trying to find a job. He did not have the energy for anything. He had not been mixing with his fellow patients. He felt they did not care anymore, so why should he go out of his way to be pleasant to them.He had been avoiding the staff. He did not think they cared about him, so why should he care about them. This was all delivered in a sullen monologue and he now fell silent, slouching in his chair, glancing at his watch.

I said:" I wonder if you feel now that you are out of groups no-one

cares about you any more?"
"One could say that", he answered. He did not look at me and his tone of voice was sullen.
"And how does that make you feel, Rafiq?" I asked.
"I told you. Dead. Empty."
"Yes. And is this a feeling you have had before, Rafiq?"
"Yes", he said. He lapsed into silence, staring out of the window. After about ten minutes he said he had the same feeling when at home and looking for a job. Sometimes he would feel like this for weeks, just flat and empty. Then he would start drugging again, just to get himself so far as to arrange for interviews. A silence followed which lasted till the end of the session.

Session 28

Rafiq was still very depressed. He had phoned for various jobs but was unable to account for his unstable job record. We once again discussed the advantages and disadvantages of being honest about his drug history. He then talked about the ward and how lonely he felt there. He had not as yet made friends with the new people. He felt they were all shallow and pre-occupied with their own problems. He wished he could have someone who cared about him. He felt he had to do everything on his own; he felt lonely, disconnected.

I asked what it had been like in the past looking for jobs. He said he felt anxious, lonely. He would sit at home, feeling very anxious but hiding it and telling other people he would find something and they should not worry. "Why was it necessary to hide the anxiety, Rafiq", I asked.
"Well, so that other people would not worry", he said.
"And who were these other people?"
"My mum", he said. "And to some extent my grandmother and my younger brother."
"So, these were times of great loneliness", I said. "How would you

have wanted these times, when you were looking for jobs, to be?"
"I wanted to share my worries with someone", he said. "I wanted someone to take me to the interviews, I wanted someone I could talk to about the interviews, I wanted someone to give me advice, someone to support me".
"And who would you want that someone to be, Rafiq?", I asked.
"I don't know", he said and then lapsed into a sullen silence. "Perhaps my father. Perhaps an older brother."
"And was your father ever able to support you in this way, Rafiq?" I asked.
"No", he said. "He sometimes tried to find jobs for me, like sales-assistant, something like that. And I would think, 'the stupid shit, he does not even know what my capabilities are, he does not even know that I can do much better'. Those were menial jobs, man. I could do much better. He was never any help to me, that man. What a useless father he was." He stared at the wall, sullen, empty. Absent.

After about ten minutes I asked where he was, what he was feeling at that moment. He did not answer. I suddenly felt convinced that he was planning to get drugs. "You are thinking of drugs, Rafiq, are you not?" I asked.
"Yes", he said. "It is on my mind all the time".
I said: "You know of course that should you take drugs now you will end up being dependent on your mother again, and that will be the end of you."
"Yes I know that", he said. Silence.

He suddenly looked up angrily: "I want to be myself, again, man", he said.
"No," I said. "You want to be someone else, not yourself. You are anxious and lonely and you feel you are without any support. You want to be confident and happy, you want to make the bad feelings bearable".
"Yes",he said, "I want to make it bearable. That is not too much to

ask. I want to feel whole again. Drugs make me feel whole. This feeling ... I'm just nothing ... pieces; I'm empty. I want to be a whole person." Silence.

He then started talking about his father's death. His father had come home from an A.A. meeting and collapsed on the backsteps. He died from a heart attack. He and his mother waited up for him the whole night. They thought he had gone back to drinking and sat side by side just like in the old days, waiting for him to come home. Early the next morning a neighbour called them. He had stumbled over Rafiq's father on his way to Mosque and also thought he was drunk. He showed them his father, sprawled on the steps. Rafiq thought: 'You fucking shit, you have gone and done it again then'. His mother ran down the steps and he followed her. He immediately realised his father was dead. He felt sad; he felt he had lost someone he had known for a long time but he did not feel grief. He did not grief about the loss of a father, he just had a feeling of sadness. That week his rich family from all over the country came to the funeral, and he started drugging heavily and disgraced his mother. As eldest son he knew he had to take his father's place but he did not feel he could do it. He could not support his mother. Instead he disgraced her in front of the whole family.

I said at the time he felt unconnected and without support and drugs had given him the support he needed so badly; that he now once again felt unconnected and there was no-one to support him. He felt he could only turn to drugs for the support he needed. He agreed.

Session 29

When he arrived for the session Rafiq looked much better than the previous week. He said he received a good testimonial from his uncle and felt surprised and pleased about it.Another long discussion whether or not he should be honest about his history of

drug dependency followed. He eventually decided to tell prospective employers he had spent a year in a drug rehabilitation centre.

He then shifted in his chair and laughed. He said: "Oh, yes, there is something I want to tell you. I got drunk over the weekend, you know." He laughed some more, clearly expecting me to laugh with him. I asked him to tell me about it. He had gone to Town Centre for the express purpose of drinking. He drank two whiskeys and returned to the ward. He felt much better, much lighter and almost like a "whole person" again. One of his fellow patients then asked him to accompany him to Town Centre to buy some food. When they got there they decided to have a few drinks, and he had five whiskeys. By the time he returned to the ward he was drunk and this was immediately noticed by the staff. He however denied it and went to sleep. The next morning the nurse on duty told him she was disappointed in him. He felt bad because he once again had let people down. At the same time, though, he felt it was a big fuss about nothing; it was nothing really. He also felt like going out the following weekend to get drunk; he was in fact looking forward to it.

I said: "So, Rafiq, you have been feeling very depressed for two weeks now and you needed to feel good again?"
"Yes," he said. "That was all it was about. Everyone does it. It is nothing."
"Yes", I said. "But everyone is not unable to stop once they feel a bit better". Silence. He looked confused.
I said: "Alcohol is a drug and you have a drug problem. Are you going to substitute alcohol for prohypnol now?" After a long silence he said he could not accept that, he would never abuse alcohol. I said perhaps not, but he would start using prohypnol again when under the influence of alcohol. And once he had started using prohypnol again, he would not be able to stop.

He sat in a sullen silence for about ten minutes, then said: "Do

you know what this feels like? It feels as if I am back home and my uncles are going for me, talking on and on about my drug abuse and I'm telling them it is not a problem. The same situation, man. You could just as well have been one of my uncles now."
I said: "I think you are saying you feel on the defensive, judged and trapped".
"Yes", he said.
"But the situation is slightly different," I said. "I am not telling you to stop. I am simply spelling out the consequences if you do not stop."
"I can control this", he said.
"I think you may have said the very same thing when you started popping pills", I replied.

After a long silence he said: "But this is frightening, man."
"Yes", I said, "you are addicted to drugs and that is your reality ...."
"That is not easy", he interrupted.
"No-one said it was easy", I replied. "I have certainly never said it was easy, but it is your reality and you have to live with it."
After another long silence he got up and said he wanted to think about it - somewhere else - and left.

Comment

As Rafiq now received a second blackmark in phase four for his drinking over the weekend, the possibility of discharge was very real. I advised against it and it was eventually decided to give him another chance. Afterwards my supervisor told me I was hostile in this session and had not given Rafiq any support. He felt my countertransference, my desire to "save" Rafiq determined my response as well as my subsequent advice to the ward; that I was angry because Rafiq consistently thwarted my efforts to "save" him. He believed drugging was something Rafiq needed to do and that, in trying to prevent it, I was repeating the old, pathological mother-

son patterns which so dominated Rafiq's life. Although I accept that my response may have been too harsh, I cannot agree with his views. I would not allow a five year old child to play with a gun because he is angry with himself. I would suggest another way of coping with his conflicts. In the same way I have at least to try to show Rafiq my disapproval of his self-destructive ways of coping with his conflicts. I was not angry with Rafiq, I felt sorry for him. I had a very clear understanding of how impossible it was for Rafiq to make his way in the world. I did not still believe it was possible for me to "save" Rafiq. Nor, however, was I prepared yet to give up on Rafiq. I did not know where therapy was going - I had an awful feeling that it was going nowhere - but we were in it together and I was determined we would remain in it together until such time as Rafiq choose to go his own way.

Session 30

Rafiq spent the first fifteen minutes complaining about fellow patients who had come back drugged from the weekend. He felt unhappy and bitter about it. He had called a community meeting and told them he found their behaviour inappropriate and unacceptable. The bitterness was about a feeling of injustice: when he had returned drugged to the ward he was discharged. He also felt restricted: he was in phase four and out of the programme but still expected to keep to the rules and regulations. He had received two blackmarks already, he could easily be discharged again. Moreover, no-one cared about him. An ex-patient had returned to the ward, looking totally pathetic, looking just like a zombie. However, his parents were there with him; if only he, Rafiq, had someone out there to care for him. But he was all alone, no-one cared about him. All this was delivered in a hard, angry, sullen tone; there was no eye contact between us.

I said: "You are feeling very alone now, Rafiq, you feel no-one cares about you".

"Yes", he said.
"And you also feel people are unfair to you, that too much is expected of you."
"Yes", he said. "Things are unfair."
"And yet, Rafiq, when you returned drugged to the ward, you had drugs on you, and you gave drugs to other patients. You know that is the one rule for which no allowances are made."
"Yes, I know", he said
"So, perhaps you went one step further than the people who came back drugged this weekend?" Silence. After a few minutes I pointed out that even phase 4 patients could not be allowed to come back drunk because of the effect it would have on the other patients. He did not respond. I felt worried and anxious. He clearly felt trapped and angry and I was convinced he would get himself another blackmark and be discharged, blaming the staff for being uncaring and unfair. He had closed himself off against me and I did not know how or where to find him again. Eventually I said he seemed to feel very trapped and I was worried he would get himself discharged. He agreed and said he was worried about it as well. He sat turned away from me, staring out of the window. The silence went on and on. Eventually I said: "Rafiq, I have confronted you on a number of issues lately. I wonder how you feel about it, if it may not make you feel I do not understand how difficult things are at the moment for you."
"I am not thinking about that now", he said. "I am thinking about other things". I waited. Eventually he said he had so few options. If he did not obey the rules he would be discharged. He had no money - he would have to return to his mother's house. He knew he had to stay on, but he did not know anyone on the ward anymore, he felt no one cared about him anymore.

I said: "You are in a very lonely place at the moment, Rafiq". He looked moved and swallowed hard a few times. "Yes", he said "I am all alone. No one cares about me anymore".

After a long silence I said: "Yet there are people who care". He agreed. The staff members in the ward had each, in his or her own way told him they were worried about him and they cared about him. He knew they had bent the rules in order to keep him in the ward after the weekend he drank. But it did not feel as if they cared. I asked him if he felt I did not care either. He said he knew, intellectually that I cared about him but he could not feel any emotional connection. His mother and brother pitied him but did not love him. He felt everyone pitied him.

I said: "It seems to me you feel everyone has failed you, Rafiq, that you have been abandoned."
"Yes", he said. "That is how it feels. I am alone."
"It must be a very frightening feeling", I said. Silence.

After a few minutes I said I needed to tell him I felt a bit helpless at the moment, I felt he had made himself inaccessible to me and I could not reach him. Perhaps he did not want to be reached? He looked interested and asked if I meant he was causing his own loneliness. I said I did not know but it was a possibility.

Comment

I felt helpless and anxious during these sessions. Rafiq clearly did not trust me and did not like me anymore. We needed time to survive his anger and I knew time was running out for us.

Session 31

Ward 4 informed me early on Monday morning that Rafiq got drunk over the weekend and would be discharged from the ward. They would try to find him a place in Ward 1, which functions as a halfway house. Failing that he would have to leave the hospital. They asked me not to inform him about their decision until they had received an answer from Ward I.

When Rafiq came for his afternoon appointment, he had not yet been told about the pending discharge. He felt extremely anxious and depressed, expecting discharge, simultaneously feeling unable to consider the possibility. He said he could not tell his mother, he could not imagine what life would be like if he should be discharged; there could not be any kind of life possible.

I said: " But you risk yourself, your life, so lightly, Rafiq."
"Yes", he said, "I know, Ina. I knew when I took that beer I would not be able to stop. But I could not not take it, I had to, everything was so unbearable. It was a party, you know, and everyone was happy and dancing and laughing and I felt ... it felt ... as if I was falling, you know. There was nothing to hold on to. There was no way to be without it. I had to take it"

He held out his hand and I took it. I could not find anything to say and we sat in silence for a very long time. He started crying.
"Why did I have to spoil everything again, Ina?", he asked. "How am I going to tell my mother? This is like death, man, this is what death must be like".
"Losing something safe is like dying, Rafiq?" I asked.
"Yes", he replied, "it is like dying". We sat in silence again.

He suddenly cried: "When is this nightmare going to stop!"
"What nightmare, Rafiq?" I asked.
"This. My life. The last eight years have been a nightmare, it has just been a nightmare!"
"Yes, Rafiq, I know", I said. There was nothing more I could do now for him except hold his hand. I was struggling not to cry. We sat in silence till the end of the session. We made an appointment for the next day and I asked him to phone me at home if he needed to.

Session 32

Rafiq just heard he had to leave the ward. He talked about changes,

adjustments. He was relieved that he did not have to leave the hospital; he also thought it might be a good thing to leave Ward 4, that it would teach him some independence. He talked in a hurried, flat tone, his face looked angry and swollen. He had to protect himself now, he must find out what this halfway house was like, he must get his life together, he had to protect himself. "Against whom must you protect yourself, Rafiq?" I asked.
"The staff on the ward, I don't trust them, you know, I cannot trust them anymore, the patients, I don't know these new patients."

"You feel very alone now, Rafiq, don't you?" I asked.
"Yes", he said, "exactly, that is how I feel, there is no-one to help me now".
"It must be very painful to be so alone, Rafiq", I said.
"Yes", he said.
"And even now, here with me, is it still alone?"
"Yes". He looked angry; his head was turned away. I wondered whether it did not perhaps make him feel a little bit angry to be so alone. He looked surprised: "Angry? No, I don't feel angry, there is no anger. I am hurt. I am alone, man. That hurts." I nodded but there was nothing to say which would not in some sense negate his loneliness. I could not get to the anger, I felt he had closed himself off against me. I felt I had to respect his need to protect himself. We sat in silence till the end of the session.

Session 33

Rafiq came to tell me he had found a job, and would start that very afternoon. The job was not what we both wished for. In desperation he had contacted a cousin who offered him a job in his shop. Hours would be long and the salary negligible. He was, however, determined to take it. As he would work till 6pm every afternoon, we arranged to meet on Sundays.

Notes

During the next four weeks Rafiq and I struggled to hold on to some kind of relationship. I went to the drug unit every Sunday morning at half-past eight but Rafiq never turned up for the appointments. Afterwards he would phone or write a letter, complaining bitterly because I did not phone him at Ward 1 to tell him I was waiting at Ward 4. I always told him I was available for therapy and would be at Ward 4 at the appointed time. However I was not prepared to phone him beforehand; he had to take responsibility for his own therapy.

Early in November we started meeting on a more regular basis. Rafiq is doing well at present. He is still not drugging although he occasionally drinks heavily over weekends. He has been able to overcome a few difficult problems at work without returning to drugging and has been promised a raise in salary. He is determined not to return to his hometown and has found accommodation with a cousin. At present our relationship is friendly and comfortable.

LENTEGEUR HOSPITAL

WARD 4

R U L E S

A. RULES WHICH, IF BROKEN, WILL RESULT IN DISCHARGE:

1. Drinking any type of alcoholic beverage, sniffing of any substance or use of drugs in the Unit.

2. (a) Two black marks in one phase.

   (b) Three black marks in the programme.

3. Physical violence i.e. fighting with fellow patients, members, or damaging hospital property, which included defacing walls, notice-boards, cupboards.

4. Lying to staff members about factual matters.

5. Stealing of other people's property.

6. Sexual Contact between patients in Ward 4, or with patients in the hospital, or on weekends out.

B. RULES WHICH, IF BROKEN, WILL RESULT IN A BLACK MARK:

1. Not attending any activity on the ward programme or one arranged by Staff or patients.

2. Smoking in prohibited areas.

3. Leaving the ward without permission.

4. Drugging and drinking over weekends.

5. Verbally threatening or swearing at fellow patients or staff members.

6. Using the kitchen after 10 o'clock at night.

7. Entering of rooms of opposite sex.

C. CONSEQUENCES OF A BLACK MARK:

1. Two in any phase: discharge.
   Three in the programme: discharge.

2. Phase I Loss of first weekend out due to you.

3. Phase II and III- From the day black mark is confirmed by staff, you will be confined to the ward for seven days. During the seven days you will forfeit your Phase II and III privileges.

D. GENERAL WARD RULES:

1. All patients must participate in all ward activities (See B1).

   1.1 All patients must be on time for all activities.

2. Patients may only use medication prescribed by the ward doctor. Medication brought in by the patient must be handed in to staff.

3. Smoking is only allowed in the TV lounge and on the stoep outside at all times. Visitors lounge during visiting hours only (See B2). No bedding or easy chairs to be used in the lounge.

4. Patients may not leave the ward without permission from the staff. Register must be signed. Ward may only be left via the front entrance (See B3).

5. All patients must be in bed by half-past eleven.

6. Patients will be required to submit to urine or blood drug-screening tests at any time.

7. While patients are undergoing treatment, social mixing over weekends out is discouraged.

   7.1 Association with non-rehabilitated drug users and alcoholics is discouraged.

8. Intimate relationships and sexual contact between patients is not permitted (See A8).

-3/

8.1 Relationships and sexual contact with patients in other units is not permitted.

9. Deodorant spray and aftershave lotions will be available to patients at certain times:

* In the morning: 7:00 am to 8:00 am.
* In the afternoon: four to half-past five.
* They must be used in the presence of staff members in the diningroom, not in rooms or elsewhere.
* None may be kept on the patient's person or in their rooms.

10. Noise level must be at an acceptable level in all areas. i.e. level should not cause problems for others in your environment.

11. Music - volume must be at an acceptable level in all areas.

Tape and radio may be played at following times:-

(a) The TV-lounge in the afternoons between one and two o'clock.

(b) Rooms from four o'clock till sleeping time.

12. Television - may not be used as a radio.

TV time: GMSA (six o'clock to finish of programme).

In the afternoons from four to bedtime (See D5).

13. Video's - will be allowed over weekends during the afternoon, with staff's permission.

14. Telephone: All calls will be restricted to three minutes.

PHASE I patients: Will not receive phone calls personally. Staff will relay messages.

May make no phone calls from the ward or outside public telephones.

Up-country Phase I patients will be allowed to receive one personal phone call per week, between 4:00 pm and 10:00 pm.

PHASE I and II May receive two phone calls per day between four and nine o'clock.
All up-country calls until 10:00 pm.

May make phone calls from public telephone between half-past twelve and two o'clock and from four to five o'clock (See D4).

15 **NB.** If patient assaults anyone on the ward - a case may be brought against him/her.

E. KITCHEN:

1. Kitchen may only be used between six and ten o'clock at night for preparation of own food (See B6).

2. People using the kitchen are responsible for cleaning all items used (utensils, stove, counters, sink).

F. DININGROOM:

1. All patients to be present in diningroom at all mealtimes.

2. No patients to leave table without permission from the diningroom monitor.

3. Acceptable noise level (See D.10).

G. ROOMS:

1. No smoking.

2. Patients are responsible for making up their own beds and keeping their rooms tidy. Must be done before breakfast (8 pm). Bedding to be changed every tuesday.

3. Pictures only allowed on notice boards.

4. No writing on walls, notice boards or cupboards.

5. No female patient may enter a male room/dormitory and vice-versa.

H. LAUNDRY ROOM:

1. Washing and ironing of personal laundry only to be done in laundry room.

2. Wet washing only to be hanged on clothes-line or clothes-horse, not rooms.

3. Patients using the laundry room responsible for keeping it clean.

4. Iron to be kept in office. Register to be signed when requesting to use the iron.

I. VISITING:

1. See under phases for visiting times.

2. Visiting over weekends, Saturday and Sunday between one and four o'clock.

3. Visitors restricted to reception area and visitors lounge.

4. Visitors who appear intoxicated will not be permitted to visit.

5. All parcels and bags brought in by visitors and/or patients will be searched by staff.

PHASE ONE (3 WEEKS)	PHASE TWO (4 WEEKS)	PHASE THREE
1. FIRST THREE WEEKS OF HOSPITALISATION.	1. WEEKEND LEAVE FROM SATUDAY 08H30 TO SUNDAYS 16H30.	1. WEEKENDS OUT FROM FRIDAY 12H30. BACK SUNDAY 16H30.
2. TO STAY IN WARD FOR FIRST THREE WEEKS AND WEEKENDS.	2. NO VISITORS DURING THE WEEK.	2. MAY RECEIVE VISITORS DURING THE WEEK: 18H00 TO 20H00 TUESDAYS AND THURSDAYS.
3. NO VISITORS ALLOWED DURING WEEKDAYS, ONLY OVER WEEK-ENDS FROM ONE TO FOUR O'CLOCK.	3. MAY RECEIVE PHONE CALLS AS PER GENERAL WARD RULES.	3. MAY RECEIVE PHONE CALLS AS PER GENERAL WARD RULES.
4. NO INCOMING PHONE CALLS, STAFF, OR OTHER PATIENTS.	4. MAY MAKE PHONE CALLS DURING LUNCHTIME: 12H30 - 14H00	4. MAY MAKE PHONE CALLS DURING LUNCHTIMES 12H30 - 14H00.
5. MAY NOT MAKE PHONE CALLS.	5. MAY VISIT HOSPITAL CAFETERIA DURING TEATIMES - 10H00 - 11H00 AND LUNCHTIMES 12H30 - 13H30 ONLY.	5. MAY VISIT HOSPITAL CAFETERIA BETWEEN 10H00 - 11H00; 12H30 - 13H30.
6. PATIENTS MUST COMPLY WITH ALL GENERAL WARD RULES.	6. MAY NOT LEAVE THE WARD AT OTHER TIMES.	6. MUST COMPLY TO ALL GENERAL WARD RULES.
	7. MUST SIGN THE BOOK BEFORE LEAVING THE WARD.	
	8. MUST COMPLY TO ALL GENERAL WARD RULES.	
TWO BLACK MARKS IN ONE PHASE - DISCHARGE THREE BLACK MARKS IN THE PROGRAMME - DISCHARGE.	**NOTE:** PATIENTS RETURNING LATE FROM WEEKEND WILL LOOSE TIME FROM NEXT WEEKEND. ½ DAY FOR EVERY HOUR LATE, OR PART THEREOF.	

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