A STUDY OF THE MANIFESTATIONS OF THE DEATH INSTINCT AS EVIDENCED IN THE CASE OF A PATHOLOGICAL ORGANIZATION

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A mini-thesis submitted in partial fulfillment of the requirements for the degree of M.A. CLINICAL PSYCHOLOGY at Rhodes University

Grahamstown June 1990

ACKNOWLEDGEMENTS

I wish to express my gratitude and appreciation to the following people, whose unique contributions made this study possible:

To Toni, my patient, and to Shirley de Villiers, Marc Feitelberg, Tony Hamburger, Su Knight, Michael Parker, Joan Schön and the Human Sciences Research Council.

The opinions expressed in this study are those of the author and do not necessarily reflect those of the H.S.R.C.

ABSTRACT

The case study method was used to investigate the manifestations of the death instinct as evidenced in a pathological organization. Work of Kleinian analysts in this area was employed as a basis for interrogating the material that emerged in a five month psychotherapy with a borderline disordered patient. It was demonstrated how the pathological organization was employed as a means of evading paranoid-schizoid fears and depressive position anxieties. Two ways in which defences were assembled into the pathological organization could be traced, both leading to resistance in the therapy. The one set of defences would entail a complete withdrawal from contact, where the patient would hold herself aloof from experience through a solitary invulnerability. The other set of defences involved an active attack on the vulnerable, libidinal self. Identified with the bad, anti-libidinal self, the patient would attempt to annihilate the libidinal self in various ways. Fragmentation of her thoughts and memories, self-destructive behaviour and phantasized and actual attacks on the objects in her world which called forth her neediness were all evidenced.

In conclusion, the issue of whether a more active interpretation of the manifestations of the death instinct or a less interpretative, more holding therapeutic stance should be adopted in the therapy with patients exhibiting a pathological organization was raised.

CONTENTS

Chapter 1

THE CASE STUDY METHOD

Research in the scientific community is generally equated with those forms of research adhering to the methods developed in the positivist tradition. A greater part of my own training in the field of psychology entailed a study of research design and statistics, where we were taught to set up experiments using large samples of individuals from a defined population. The observer was to remain independant of the subject under investigation in order to guard against the "Rosenthal-effect" or "experimenter bias", and validity of the quantified results was ascertained through statistical analysis.

The case study method rests on a set of principles very different from those outlined above. Bromley (1986) shows how an understanding of case studies in psychology is fostered if we compare them to the emergence of case-law in jurisprudence, which "emerges through a process of conceptual refinement as successive cases are considered in relation to each other" (p.3). It is an idiographic as opposed to a nomethetic approach: rather than averaging out the individual variations of a large sample of subjects in order to reveal basic factors common to major classes of people, it undertakes a detailed description and analysis of an individual in the expectation that this will "gradually lead to deeper understanding and to practical applications in more and more areas of interest" (Bromley, 1986, p.6). External validity is established not by

statistical inference, but by analytic generalization. As Edwards (1989, p.7) put it:

> "It is not assumed that a case being studied is typical or representative, but that the key aspects of theory implicit or explicit in the presentation of the case material will be of value in conceptualizing other cases."

Clinical case law is repeatedly tested against new cases to ascertain external validity. Internal validity is attained through logical inference: a conclusion is arrived at "on the basis of a rational argument about the relevant evidence" (Bromley, 1986, p. 3).

The evidence in the psychological case study is intimately bound up with the relationship between the therapist-researcher and the patient-subject. Rather than attempting to maintain a distance between the two, it is the nature of the trusting relationship evolving between them that gives the therapist access to deeper layers of material that would otherwise have been difficult to obtain. The therapist's awareness of counter-transference issues is essential to this method of research, as it is this knowledge which is used in counteracting what in the positivist tradition is referred to as "experimenter bias". We see here the concept of practitioner-as-scientist, in which the practitioner-scientist has to have a high level of awareness of his own issues as well as of interpersonal sensitivity. It is a concept as old as psychoanalysis itself: Freud stated that it was "one of

the distinctions of psychoanalysis that research and treatment proceed hand in hand" (Freud, 1963, p.120).

This method, which involves an in-depth study of an individual in which interpretation of the detailed material gathered plays an essential part, has been favoured by clinicians in developing theories of personality. Kvale (1986, p.155) goes so far as to say that the intensive case study method as embodied in psychoanalysis is "the qualitative research method which has yielded substantial contributions to psychological knowledge." This section does not aim to enter into the argument of qualitative versus quantitative research methodologies, as I am of the opinion that both have their place, the applicability depending on the purpose of the research. As Laskov (1987, p.18) points out:

> "If one's purpose is to describe the experience of a single person, to develop interpretations or explanations of that experience, or to develop courses of action and to make decisions appropriate for this particular individual, then the case study method is an extremely useful one."

Within the case study method, one can categorize a number of different types depending on the purpose of the study. I shall give a brief resume of the categories as presented by Edwards (1989).

Exploratory-descriptive studies are those in which the phenomena are approached in an open way, with as few preconceptions as possible. The aim is to disclose a rich

understanding and description of something which has previously not been studied in any depth.

Descriptive-dialogic studies are located within the earlier phases of theory construction, where careful description of phenomena, though expected to embody general principles already articulated, can also be used as an informal test of existing concepts. These studies may thus contribute to a tightening of the theory, albeit in an informal way.

Theoretical-heuristic studies are concerned with developing or testing the adequacy of existing theory in a more rigorous manner than in descriptive-dialogic studies. This requires the selection of a case considered likely to reveal answers to the questions the researcher has about the theory.

A crucial or test study can only be done once a theory is well developed, and particular theoretical propositions within the existing framework are the focus of enquiry. The study is set up in such a way that the theoretical proposition is either verified or falsified by that which is evidenced in the case.

While the four categories of case studies described above lie on a continuum, ranging from descriptive studies, to those concerned with developing theory, to those in which aspects of already-developed theory are rigorously tested, two more categories exist which do not lie on this continuum. They are illustrative-didactic and working case studies.

Illustrative/didactic studies are employed to illustrate theoretical princples through the use of case material. They go beyond simple illustration, however, as they can also be employed to provide "evidence for the generality and validity of case law" (Edwards, 1989, p.7). As has been mentioned, it is essential to the development of case law that it be tested against new cases.

Finally, working case studies use existing theory to solve practical problems without hoping to change the theory in any way.

The case study being presented here is an example of an illustrative/didactic study, the aim being to illustrate and provide further evidence for the concept of the death instinct as evidenced in a pathological organization. Employing a knowledge of the case law already developed in this area, an attempt was made to flesh out the ideas with reference to the material emerging in the psychotherapy, and to explore the unique ways in which the death instinct showed itself in this patient.

In order to protect the patient, the identifying data in this study have been disguised.

The thirty-five therapy sessions were taped, and were only examined on completion of the therapy, so that the patient's experience in the therapy itself would be allowed to unfold freely. Sessions were taped so that the study would not be

subject to failings in the researcher's memory. At the time of the therapy itself, notes were made of the therapist's reactions, dreams and counter-transference feelings, as these were felt to be essential to a deeper understanding of the material. In the interpretation of the material, care was taken not to jeopardize the accuracy of findings by selecting only the data that fitted the case. While any case study entails selection of material, a conscious attempt was made to respect the integrity of the data.

Chapter 2

LITERATURE REVIEW

In the following section I shall track the concept of the death instinct, first as introduced by Freud in 1920, then as an essential part of Melanie Klein's theorizing and finally, to how it has been employed in the notion of a pathological organization. The latter is a defensive structure, rooted between Klein's paranoid-schizoid and depressive positions, and is particularly resistant to change.

2.1 FREUD: THE INTRODUCTION OF THE DEATH INSTINCT

Freud's introduction of the death instinct heralded the beginning of a deeper awareness of aggressive and destructive phenomena. Prior to 1920, he held that the two instincts present in humans were the ego or self-preservative drives and the sexual drives, the two working in opposition to each other. The governing principle of the mental apparatus was that of the pleasure principle which aimed to avoid unpleasure by lowering tension to achieve a state of quiescence. In his clinical work, however, he came across phenomena which could not be accounted for in these terms. Repetition compulsion phenomena, for example, seemed to be in opposition to the pleasure principle, as unpleasant experiences were repeated in spite of there being no possibility of the wishes represented in them obtaining satisfaction. The negative therapeutic

reaction, too, seemed to require an alternative explanation. Here any progress and understanding arising in the course of analysis was attacked and spoiled by the patient. The analyst seemed to be confronted by "a force which is defending itself by every possible means against recovery and which is absolutely resolved to hold on to illness and suffering" (Freud, 1937, p. 242). In certain forms of depression, self-punishment could reach the point of suicide, and masochism represented a perverse relationship to pain.

Freud therefore proposed that there was a force at work which was in opposition to Eros, the life instinct:

> Besides the instinct to preserve living substance and to join it into even larger units, there must exist another, contrary instinct seeking to dissolve those units and to bring them back to their primaeval, inorganic state. That is to say, as well as Eros there was an instinct of death (Freud, 1930, p. 118-119).

The self-preservative and sexual drives now became subsumed under Eros, which was in conflict with the aims of the death instinct. These two opposing instincts, however, were usually encountered in a state of fusion:

> An instinct of the one sort can scarcely ever operate in isolation; it is always accompanied - or, as we say, alloyed - with a certain quota from the other side, which modifies its aim or is, in some cases, what enables it to achieve that aim (Freud, 1933, p. 209).

The life instinct, in normal fusion with the death instinct, tended to neutralize the destructive energy of the latter. It was also through the activity of Eros that the death

instincts, initially directed inwards and driving the individual towards self-destruction, were diverted outwards and became manifest as aggression and the motive for mastery. Freud did also conceive of the possibility of defusion of the two instincts, in which case each would pursue its own aim independently. If we keep in mind that the aim of the death instinct is to fragment those unities which the life instinct seeks to bring about and maintain, it is evident that defusion is a triumph for the destructive instinct. Defusion of the instincts could be observed clinically when regression to earlier phases of development occurred, whereas an advance in libidinal phases of development contributed to an increase in the capacity for fusion. Freud placed greater emphasis on investigating the manifestations of Eros, however, saying that, "the death instincts are by their nature mute and that the clamour of life proceeds for the most part from Eros" (Freud, 1923, p.46). It was left to succeeding theorists to develop this concept.

2.2 THE WORK OF MELANIE KLEIN

2.2.1 The Death Instinct

Melanie Klein accepted Freud's dual-instinct theory, and placed particular emphasis on innate aggression as a manifestation of the death instinct. Segal (1979) points out certain differences in Klein's conceptualization. Firstly,

whereas a portion of the death instinct for Freud is deflected outwards by the organism, for Klein it is projected by the primitive ego into an object. In other words, while the ego for Freud is not present as a psychological entity from the very beginning, for Klein there is enough ego at birth to experience anxiety and to use a defence mechanism. This projection results in the phantasy of a bad object, the object now being imbued with all the destructive qualities of the death instinct. The rest of the child's destructiveness is now directed towards this newly created object. The infant's first object-relation has thus come about due to this process.[1]

Secondly, for Klein the death instinct evokes in the primitive ego a fear of annihilation and disintegration, and is therefore linked directly to anxiety. Freud did not make this link: for him the fear of death or annihilation is a derivative of castration anxiety.

In discussing Melanie Klein's work it will become evident how essential a part of her theorizing the death instinct is. Freud did not incorporate this concept into his hypotheses to the same degree. In his final model of the mind - the tripartate structure of id, ego and superego - he stated that "(t)here can be no question of restricting one or other of the basic instincts to one of the provinces of the mind. They

1 Developmentally, this occurs earlier for Klein than for Freud, who postulated a phase of autoerotism and then of narcissism preceding relationships to external objects.

must necessarily be met with everywhere" (Freud, 1940, p. 149).

The conflict between the life and death instincts was superceded by the conflict between the id - which represents all instinctual demands - and the ego, which is ruled by the reality principle. The notion of the death instinct was also not an essential part of Freud's discussion of defences or of the phases of development (oral, anal, etc.), and remained, essentially, something introduced to explain certain clinical phenomena, but not taken much further.

2.2.2 The Paranoid-Schizoid Position

Let us return to Melanie Klein and the events surrounding the projection of the death instinct into part-objects.[2] Danger generated by the death instinct is managed by splitting this instinct from the life instinct: in Freud's terms, by keeping the instincts in a state of defusion. This is the primary defence mechanism used in the first three to four months of life, a phase known as the paranoid-schizoid position. This split sets up, intially, a split in the ego between the all-

2 Objects are referred to as "part-objects" for two reasons. Firstly, the infant initially experiences the mother as a collection of parts: her breasts, her eyes, her hands, etc. It is only in later development that she is related to as a whole. Secondly, because the content of the objects is derived from the infant's instincts, they are imbued either with libido or with aggression and are split into all good or all bad respectively.

good, loving parts of the self which are under the influence of the life instinct and the all-bad, hateful parts of the self under that of the death instinct. When the infant feels threatened by the inner workings of the death instinct, it projects these feelings into part-objects which are then experienced as all-bad and persecutory. At the same time pleasurable, contented states, reflecting the life instinct, are projected outwards and give rise to feelings of trust in an idealized and all-good part-object. It is the breast which is the recipient of these early projections, and Klein refers to the all-bad, denigrated breast and the all-good, idealized breast. The latter is introjected as the good inner object and is the core around which the ego eventually becomes integrated.

Object relations during the paranoid-schizoid position are also isolated into two separate ways of relating: the good, loving self relates only to the good, loving part-object, and the bad. hateful self relates only to the bad, hateful part-object. The primitively organized infant cannot tolerate ambivalence. It is too dangerous, therefore, to allow loving of the hated object or hatred of the loving object. It is evident, then that the cleavage wrought by the mechanism of splitting runs right through the infant's ego, its objects and its object relations, in each case separating the endangered from the endangering. Klein stresses the importance of being able to achieve this clean split - it is a precondition for the eventual integration into whole objects, a continuous

sense of self and an ability to tolerate ambivalence. As Ogden (1986, p. 59) points out:

> It is only when one has achieved relative freedom from the anxiety that loving experience is, or is about to be, contaminated by hating experience, and vice versa, that one may dare to bring these different facets of experience into closer relation to each other.

Before concluding the discussion on the paranoid-schizoid position, I should like to look briefly at some of the defence mechanisms employed in this phase. The primary mechanism - that of splitting - has been dealt with. The other defences are all employed to maintain the split.

Mention has been made of the defence of projection of both hostile, angry feelings and contented, loving feelings. Freud's concept of projection, where discrete unwanted impulses are split off and projected outwards, was taken further by Klein in her concept of projective identification, which is the mode used by the infant in the first few months of relating to the people in its world. Here entire parts of the ego are split off from the rest and invade the recipient. The perception of the object onto whom the projection has occurred becomes distorted, and there is often a corresponding need to control the recipient of the projection, as she now holds essential parts of the self. The recipient in turn may find herself feeling that which has been projected into her. Projective identification, then, becomes more than a defence to expel parts of the self: it is also a form of

communication, albeit one where the recipient is treated as an impersonal object with no needs or qualities of its own.

Idealization as a defence entails an exaggeration of the nurturing, gratifying, all-good aspects of internal and external objects, with all evidence to the contrary being denied. Originally necessary to protect the ego from the annihilatory attacks of the all-bad part-objects, in normal development the idealization of objects becomes tempered with reality so that acknowledgement can be made of their non-gratifying aspects as well.

Denial is a mechanism whereby attention to reality is selective of that which the individual wants to believe. Anything contradictory is treated as if it did not exist. It can therefore substantially interfere with reality testing.

In normal maturation, the primitive defences of the paranoid-schizoid position are largely subsumed by more mature methods of dealing with conflict: methods like repression and displacement. Klein, however, purposefully refers to developmental "positions" rather than stages. As developmental stages, the paranoid-schizoid and depressive phases are over by the end of infancy, but they remain present in the personality as modes available for organizing experience, with certain defence mechanisms and characteristics, throughout life.

2.2.3 The Depressive Position

From the second quarter of the first post-natal year, splitting mechanisms begin to decrease. The divide between good and bad part-objects starts to close, bringing about an awareness that the world is peopled by whole objects, separate from the self, which have both good and bad qualities. Together with the integration of the object is an integration of the ego, which becomes less and less split into good and bad parts. Introjection is the predominant mechanism, and if circumstances are favourable the infant introjects a whole, caring mother, and fusion of the two primary instincts is stimulated. This brings with it its own set of conflicts. Attacks made in phantasy can no longer be seen as resulting only in the annihilation of the bad object: ambivalence means that hatred must now be directed at the whole object, and the infant fears that his destructive impulses have harmed or will harm the loved and needed object. His emotional reaction to this is guilt, as well as mourning and sorrow for the good object felt to be lost because of his attacks. Klein refers to this phase of development as the depressive position because of the depressive anxieties that are aroused. These anxieties lead to attempts to repair or restore destroyed objects. This is termed reparation, and is done through restorative phantasies and behaviours which express love and

gratitude to the object. While operating in the paranoid-schizoid mode, an individual may attempt to restore an object to its former state in an omnipotent way, trying to eradicate all traces of harm done. True reparation, however, is done symbolically. Capacities for abstract thought and linking develop in the depressive position, making this possible. Segal (1964, p. 63) comments on the effects that the normal unfolding of this developmental phase has on the ego:

> As the infant goes through repeated experiences of mourning and reparation, loss and recovery, his ego becomes enriched by the objects which he has had to recreate within himself and which become part of him. His confidence in his capacity to retain or recover good objects increases, as well as his belief in his own love and potentialities.

This is a relatively slow process, and there may be times when the ego needs to be protected from the despair of loss and mourning by mobilizing defences of a manic nature. Any feelings of dependence in relation to an object may be denied. Instead, these feelings and the pain associated with them are replaced by those of triumph over and contempt for the lost object. These emotions reflect the death wishes against the object. Another form of manic defence is idealization, one of the defences also utilized in the paranoid-schizoid position. Here good internal and external objects are idealized to protect them from ambivalent impulses: feelings of destruction towards these objects are denied. In normal working through, the need to employ these defences lessens as

the ego builds up resources. Continuing, excessive dependence on them interferes with development.

2.2.4 Circumstances Impeding Development

When considering the circumstances which impede movement through to a satsifactory negotiation of the depressive position, there are two main areas which bear looking at: constitutional endowment and the relationship between the caregiver and infant.

The relative inborn strength or constitutional endowment of the life and death instincts varies from infant to infant. If there is a predominance of libido over aggression, projection of the former into objects will result in idealized good objects. These will defend the ego against bad, persecutory objects and facilitate movement towards ego integration. If, however, the strength of the death instinct is greater, the course of development will not be as smooth. Splitting and idealization will be resorted to to an excessive degree in an attempt to protect good objects and counteract persecutory fears. Bad objects may undergo secondary splitting into fragments which are projected outwards and give rise to multiple persecutors. Confusional states and depersonalization result from re-introjection of these fragmented objects, because it is a splintered and disintegrated reality that is being introjected.

With a predominance of the death instinct, the child will invariably become a victim of the workings of envy. For Klein, envy is the most intractable form of the death instinct, and in Freud's terms seems to be as close to a defused form of this instinct as one can observe. The malignancy of this form of hatred is that it is not directed at bad objects, but is specifically aimed at the destruction of good objects. In the infant's phantasy, the frustrating object - originally the breast - is wilfully withholding nurturance in order to satisfy itself. The infant feels resentful and cannot tolerate not being in control of its own well-being. It becomes a case of, "If I can't have it, no-one will", and the good object is spoiled. This breaks down the tidy split that initially needs to be maintained between good and bad objects and results in the qualities of the two being confused. Good objects, having been attacked, cannot be introjected to form the core around which the ego will become integrated. Ego integration is therefore hampered, and the break-down in splitting means that the individual is now open to the terror of persecutory anxiety. Klein's concept of envy is useful in explaining what Freud termed the "negative therapeutic reaction". Resistance in therapy is a way of spoiling the therapist's powers and destroying the source of love and help.

The other area to be considered is the relationship between the infant and the mother. Maternal deprivation which results in feelings of frustration will confirm the infant's

expectation that his objects are dangerous, and lead to an increase in hate and destructiveness. Good experiences, in which the child feels loved and understood, soften these expectations and decrease innate aggressiveness. Greenberg and Mitchell (1983, p.134) point out how the cycle of projection and introjection is influenced by what is encountered or provoked in reality:

> To the extent to which one can perceive discrepancies between internally derived anticipations and reality, to allow something new to happen, the internal world is transformed accordingly, and the cycle of projection and introjection has a positive, progressive direction. To the extent to which one finds confirmation in reality for internally derived anticipations, or is able to induce others to play the anticipated roles, the bad internal objects are reinforced, and the cycle has a negative, regressive direction.

2.3 DEVELOPMENTS FROM THE WORK OF MELANIE KLEIN : THE OPERATION OF THE DEATH INSTINCT AS EVIDENCED IN PATHOLOGICAL ORGANIZATIONS

Melanie Klein's followers have developed her ideas in their work in the clinical field, and one productive area of investigation has concerned the workings of the death instinct in more severely disturbed patients, most notably in pathologies of the self.

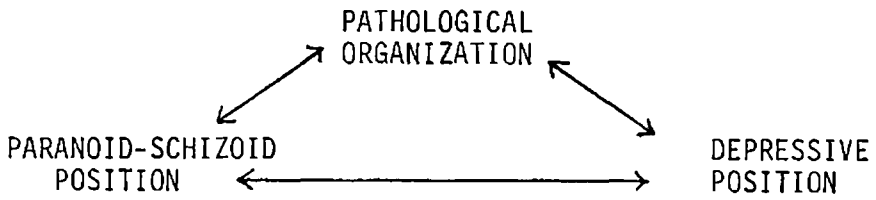
Steiner (1987) coined the phrase "pathological organization"[3] to describe an organized system of defences which roots the

[3] The same concept had previously been referred to as "narcissistic organization" (Rosenfeld, 1971; Sohn, 1985) and as a "defensive organization" (O'Shaughnessy, 1981), but I shall continue to refer to it as a "pathological organization" as this is the term which has generally been adopted.

personality in an uneasy equilibrium between the paranoid-schizoid and depressive positions. The clinical manifestations vary from patient to patient, but one thing they all have in common is that they are pathological: an impediment to development and extremely resistant to change. According to Steiner, the purpose they serve for the patient is as a retreat from the fragmentation, confusion and persecutory anxieties of the paranoid-schizoid position on the one hand, and against the feelings of loss, guilt and pain of the depressive position on the other. These feelings cannot be tolerated because of the presence of an excessive and unneutralized quantity of the death instinct. When discussing circumstances impeding development in the section on Melanie Klein, I outlined the consequences of such an imbalance in the instincts: secondary splitting of bad objects results in multiple persecutors and a fragmented internal reality, and a predominance of envy confuses the distinction between good and bad by attacking and spoiling the good self and objects. Spillius (1983) writes about Bion's conceptualization of how hatred and envy, projected into the breast, can remain unneutralized if the impulses are excessive or if the mother fails to transform the child's feelings into a tolerable experience. When this is the case the reintrojected breast becomes a destructive, envious internal object with which the ego becomes identified. It is the chaos and confusion

resulting from the processes described above which lead to the pathological organizations as described by Klein's followers, as these are offered as a way of organizing the chaos. These organizations, then, are compromise formations - both an expression of the death instinct and an effort to control it.

Steiner (1987) represents the relationship between the pathological organization and Klein's positions in the following diagram:



The pathological organization "acts as a borderline area between the other two positons, where the patient believes he can retreat if either paranoid or depressive anxieties become unbearable" (Steiner, 1987, p. 328). Steiner proposes his concept as being particularly helpful as a clinical tool. If we keep the above triangular equilibrium diagram in mind, he says "it helps us to identify the leading anxiety of the session which is often connected with a transition or a threatened transition between two of the three states" (pp. 338-339). He stresses the importance of recognizing and interpreting any movement towards the depressive position,

even while this movement is almost invariably followed by a sharp retreat back to a pathological organization. The more the personality is dominated by such a pathological organization, the more stuck the therapy becomes, as there is great rigidity in the way the defences are organized in that state. The individual defences employed in the pathological organization are often those which we have come to regard as paranoid-schizoid defence mechanisms - that is, projective identification, omnipotent phantasy and splitting. Yet in the pathological organization these defences are organized in such a way that the paranoid-schizoid feelings of confusion, fragmentation and persecution are kept out. A pseudo-integration occurs which achieves stability and freedom from anxiety at the cost of being severely resistant to change.

Having referred to the role of these organizations as a pathological way of dealing with overwhelming anxieties, we need to look more closely at how this retreat to the pathological organization is effected. Most of the authors in this field have explored the way in which what has variously been called the bad, narcissistic, destructive or anti-libidinal self dominates the rest of the personality. Rosenfeld (1971) refers to this type of organization as one of destructive narcissism[4] in which the omnipotent destructive

[4] This is referred to as narcissism because, in Klein's terms, narcissism is a withdrawal from relationships with external objects to an identification with an idealized object. In this case it is the bad internal object which is idealized and identified with.

parts of the self are idealized. "They are directed both against any positive libidinal object relationship and any libidinal part of the self which experiences need for an object and the desire to depend on it" (p. 246). Or as Steiner (1979) expresses it, "idealized bad parts of the self or the object may be labelled as good and denigrated good aspects labelled as bad" (p. 387).

In relating this to Freud's theory of the defusion and fusion of the life and death instincts, Rosenfeld concludes that these states are more accurately described as pathological fusions rather than defusions, with the libidinal parts of the self - derived from the life instinct - imprisoned or deadened by the destructive aspects of the death instinct. In Klein's terms, the bad self and objects triumph over and attack the good self and objects, and the link here to her concept of envy is evident.

Sohn (1985) uses the term "identificate" to describe the destructive part of the ego that becomes split from the rest of the ego and then assumes control, believing itself to be the whole ego. The dependent, libidinal aspects of the ego are denied existence - either by being overruled, or by being projected into an object. In therapy, the latter may result in the therapist carrying feelings of concern or vulnerability while the patient remains immoveable and uncaring - an attitude which, in the patient's terms, is proof of his "strength".

The pathological organization, by crushing neediness and the desire to depend, and substituting a rejective, hard pseudo-self-sufficiency, provides a solution to what Rey (1979) has referred to as the claustro-agoraphobic syndrome. Here the individual, "to prevent pain, anxiety, depression etc., splits off parts of himself, projects them and denies them existence. Immediately he experiences the opposite feelings: fear of loss, of fragmentation, attempts to make contact, etc., and the vicious circle goes on" (p. 225). This is similar to Steiner's (1987) conceptualization which was discussed initially. The emotional contact required of the depressive position is too frightening and painful and evokes what Rey refers to as claustrophobic anxieties. An attempt to escape these by moving away from objects results in the feelings of fragmentation and confusion of the paranoid-schizoid position, which can alternatively be described as agoraphobic anxieties. A pathological organization in which vulnerability is despised, binds objects in a way structured to control the emotional distance from them.

Joseph (1982) adds to what has been discussed so far by stressing the perverse nature of the relationship between the dependent and destructive parts of the self. She refers to this as an addiction to near-death. These patients have become invested in maintaining a position of hopelessness. There is a masochistic desire to see themselves being destroyed. They become involved in activities which seem calculated to harm them both physically and mentally. In

therapy they attempt to draw the therapist into their despair, thereby destroying his work. They also provoke critical interpretations with which they then torment themselves. Joseph hypothesises that, faced with the pain of potentially depressive experiences in infancy and being unable to deal with these, they have identified with and have taken over the role of tormentor. Rather than feel persecuted, they become the persecutor, a position in which they feel less powerless.

Pathological organizations discussed in this section are those sterile, firmly entrenched states in which the needy parts of the self are imprisoned by the destructive, anti-libidinal self, or have entered into an unhealthy, masochistic liason with these. They may operate silently and initially only be recognized in the therapeutic relationship through the patient's profound resistance to change. Alternatively, they may be more evident and some authors have looked at how they may be present in the phantasies of the patients. Rosenfeld (1971) describes how the organization may be represented as a gang or Mafia ruled by a powerful leader:

> "The main aim seems to be to prevent the weakening of the organization and to control the members of the gang so that they will not desert the destructive organization and join the positive parts of the self or betray the secrets of the gang to the ... helpful analyst, who might be able to save the patient" (p. 249).

Steiner (1987) discusses how an organization may sometimes be represented spatially, "in the form of an idealized place such as a desert island, or a cave or building within which the

patient can take refuge" (p. 336). He gives an example of a patient who would withdraw in phantasy to a desert island. The feeling of isolation, with her neediness crushed out of existence, would shield her from the anxieties she otherwise encountered.

While the particular defences employed and the phantasies arising may differ from patient to patient or even from moment to moment in the therapy, the distinguishing characteristics of a pathological organization are the resistance to change and the protection it offers the patient from either paranoid-schizoid positon fears or depressive position anxieties.

Chapter 3

PRESENTATION OF A THERAPY CASE

I shall now present material from a patient to illustrate the value of the understanding generated by the literature review presented in Chapter 2.

3.1 BACKGROUND INFORMATION

The patient in question, whom I shall refer to as Toni, was seen by me over a five month period. Our initial contact was once weekly, with Toni coming in as an out-patient. Changes in her mood and functioning demanded that we change this to two consultations per week and, after a time, that she be hospitalized and continue therapy as an in-patient. At the outset she was aware of the termination date, which corresponded to my departure at the end of my training. Asessment indicated that she should be seen by someone who was able to carry her as a long-term therapy case, and her having been assigned to me points to the unavoidable discrepency in mental health services between what should be implemented and what is available.

Toni was an attractive, boyish-looking woman of 24. She was self-referred and gave a long history of difficulties. She started drinking at the age of 10 and began to abuse headache tablets a few years later, which led to her initial contact with a drug rehabilitation centre. She did well at school and excelled in sport, but went into a depression on completing

matric and was given electro-convulsive shock therapy. From there she began but did not fully complete a training in nursing, followed this with a typing course, and then started to study a degree in Physical Education at university. She dropped that after a couple of months because she felt lonely and isolated. Her work history was as patchy, and she said of herself, "I just give up whatever I'm doing." Throughout this period she was abusing painkillers and tranquilizers.

During the year before starting therapy with me she had moved cities, and in each city had been in therapy with someone from a drug rehabilitation centre and had then been locked up as she had been considered to be a danger to herself. Once it was in a reformatory prison and once in the ward of a psychiatric hospital. Her behaviour at the time included numerous suicide attempts, motor vehicle accidents and the continued abuse of drugs.

On entering therapy, she said that she had been "living a lie", and that she was prepared to be honest about herself for the first time. She needed to discover who or what she was, because until then she had simply acted out what others had perceived her to be. She felt determined, and part of this determination, she said, was that she had not drugged for a number of months, and did not want to resort to drugging again.

To give something of her personal history, Toni was the youngest of three children. The first, a son, was born out of

wedlock and her parents decided to have him adopted. Toni felt that her mother had never been able to reconcile herself to having had her firstborn adopted, and she attributed her mother's alcoholism, which started in the year preceding her birth, to the loss of her son. She had wanted another son to make up for the one lost, and Toni took on the role of the boy in the family. In contrast, her older sister was "totally feminine", and my patient described her as "the perfect one", with whom she had nothing in common.

The mother's alcoholism and suicide attempts were part of the fabric of their household, and Toni took to looking after her when she was inebriated. During those times she experienced her as warm and communicative. When she was sober, however, she became cold and distant. In the course of therapy, my patient described how her mother would lock her up in a cupboard if she cried, a practice which frightened her but which, she felt, had made her strong. The emotional tone of their relationship was referred to as "very bad", and there was a lack of trust.

The father was an emotional, introverted professional man, whose business frequently took him away from home. Toni's belief as a child was that he left to get away from the family, and that she was partly to blame for having been naughty. Her earliest memory was of having learned to count to ten so that she could impress her father when he came back home. On his return, she jumped into his arms and displayed

her newly acquired skill. He responded by asking what came next. She felt crushed by the realization that she was not good enough for him, a feeling which remained with her. As therapy progressed, she confessed to his having seduced her as a child. The marriage was bad, and quarrels between the parents would lead to his seeking refuge in her bed. Initially he aroused her sexually and then left the room. Subsequent to this they had intercourse, and when she fell pregnant at the age of 15, she was not sure if it was he or her boyfriend who had fathered the child that she subsequently had aborted. Toni carried with her the feeling that she had destroyed her parent's marriage, that her mother despised her for it, and that she in turn hated both mother and father.

The boyfriend, who left for another country after hearing about her pregnancy, was the only man with whom she had had a serious relationship. Her subsequent relationships were with women. The first was with Jean, a teacher in secondary school who became like a mother to her, and eventually became her lover for a while. This was one of the most significant relationships in her life, and the contact with this woman remained a source of conflict for Toni, even though it had reverted to friendship status.

On entering therapy, she was involved with Donna, a liason fraught with difficulties. One of the greatest problems was that my patient "hated physical contact", and preferred to be by herself "as all relationships lead to sex". When she had

been in therapy for some time, she spoke of how her desire to make love to her father remained and interfered with her ability to become sexually involved with anyone else. While generally repulsed by him in his presence, he would appear as the object of her desire in sexual fantasies.

The immediate family and the two women mentioned in the preceding paragraphs were the only people with whom Toni had contact. She isolated herself from relationships, and claimed that her only source of understanding and love was her dog.

Evidence of what was presented in the Chapter 2 already begins to be clear in the history that has been presented, but I have reserved discussion of this for the following section, where I shall deal with things as they emerged in psychotherapy.

3.2 COURSE OF PSYCHOTHERAPY

Initial difficulties brought into therapy by this patient revolved around the claustro-agoraphobic dilemma. After a few sessions she had mobilized the defences needed to keep the people in her life at a distance from her: simultaneously, she began to withdraw from her mother, her ex-lover and her present lover. She said of the latter, "she tends to be a bit like a kid and I don't like that at all - it's very irritating." Traces of infantile neediness were being fended off, and as therapy progressed it became evident that anyone confronting her with vulnerability would arouse fantasies or

actions of cruelty. As an adolescent she had abused a baby boy, and at the time of her therapy with me, she could not trust herself with her sister's baby because of the desire to harm him. These were all linked to the denigration of the dependant and needy parts of herself, but it took some time before the more active manifestations of this system of defence became evident in the sessions. At first the defences within the pathological organization employed were those of cutting off and withdrawing. She wondered at times if she was making "too much space", but seemed to be protected from agoraphobic anxieties by keeping a careful control of the distance to which her objects were allowed to go. Her job as a nurse on night-duty suited her particularly well at the time, because, she claimed, "My patients don't expect anything from me. They expect nursing care, they expect just what a normal person expects, whereas other people expect more. Right now I'm only capable of giving what I've been taught to do." The success of her compromise was reflected in questions about the necessity of being in therapy at all: "I'm feeling basically strong, should I be here or shouldn't I be here?" She phantasized about being on a desert island, and longed to get on with her life "without anyone." I began to work more actively in the transference in exploring the claustro-agoraphobic conflict, linking the movements towards and then away from the people in her life, which she spoke of, to the desire to connect with me which was then invariably followed by a hasty retreat. The feeling of a sense of contact which

she had started to allow manifested itself in the resultant fear. She said, "I feel frightened when I come here. It's almost like having to face up to reality, whereas out there you've got to put up a facade."

Her vunerability heralded a movement towards the depressive position and an unbearable longing for connectedness, and the sessions leading up to her hospitalization witnessed marked fluctuations between anxieties of the paranoid-schizoid and depressive types and flights into a withdrawn type of pathological organization. With the emergence of paranoid anxieties, she would glance fiercely at me and ask why I was angry. She began to move her chair at the start of each session - from an angle which opened towards me, she shifted it so that she faced straight ahead, putting me out of view. She would ask me at times to stop looking at her.

In one of the sessions she spoke about how she had become actively involved in an organization campaigning against vivisection, and I reflected that this campaign seemed to embody her feeling that therapy was becoming a living torment. When I reflected the painful feelings, she retreated into silence. The silences started to dominate sessions, and when I was able to arouse her from this withdrawn state, she spoke in a monotone, saying that she had cut off and felt empty. The phantasy of a desert island remained a theme. She also referred to lists of senseless words, jumbled sentences and numbers that would play through her mind like a microfilm.

She would "read them off without understanding them". A transcript she made of one series of these thoughts showed that her thoughts were being fragmented, split up into little bits and stripped of significance. In Bion's terms, this is -K communication, where "understanding (is) denuded until only misunderstanding remains" (O'Shaughnessy, 1981, p. 184). It is evidence of a destructive internal object which attacks links - the links between internal objects themselves, as well as the links between internal and external objects, such as that between client and therapist. Any link entails dependance on the object to which the link is being made. This may stimulate the pain of longing for or envy of the dependable object, and is avoided by annihilation of any link which is forged. Interspersed with the nonsensical jumble of words was the phrase, "Have to die tonight, therapy tomorrow", which seemed to reflect this need to kill off part of herself so that she was not alive to the contact with me. When she began to express this need literally in active suicidal ideation, she was hospitalized.

At this point she evacuated all caring and all desire. From her campaign against vivisection, she now spoke about the wish to rip out her vital organs and give them to someone who wanted to live. This was an apt description of the way in which she was projecting her desire to live into objects, leaving her "feeling dead, going down and down". My counter-transference feeling was that I was carrying her will to live. I would be suffused with the desire to do something to halt

her decline into this death-like state, but was aware that whatever I did was unsatisfactory. Her withdrawal culminated in a silent session in which she drew her legs up onto the chair so that she was sitting in a foetal position with her head turned away from me. In the session following this, she spoke about the initial sexual encounter with her father in which he got up and left at the point at which she felt aroused. The care and availablility provided by myself and by the staff of the ward she was on had similarly aroused her neediness, and she found this intolerable.

It became more tortuous when she was informed of a discharge date which had been set for a fortnight later, and the safety she had sought in the pathological organization gave way to the fears of the paranoid-schizoid position. She telephoned me from home a few hours after she had left for weekend leave, sounding frightened and giving a garbled account of events. She believed that a saleswoman had been suspicious of her and that she had been followed to her house by two different vehicles. Once there, she feared she had killed her drunk and ailing mother by giving her sleeping tablets. Projective mechanisms of defence were being used to rid her of her bad, hateful feelings, and resulted in them being deposited into people who were then experienced as persecutory. Similarly, she projected her weakness into her mother, whom she then wanted to eradicate.

When re-admitted to the ward, she spent most of the weekend crouched in a corner, shrinking away in fear if anyone tried to approach her. In our subsequent therapy session, her thoughts were fragmented. At times it was difficult to understand her, and she seemed to lose track of anything I said. She described her state of mind as, "Just thoughts, and I don't feel them. It feels like I'm going to just splinter." There was panic in her voice as she described how she was being poisoned, how the girls on the ward looked at her as though she had stolen their things, and how her thoughts were written on anything she read. She said repeatedly that she felt that she should leave hospital, because it was making her worse. Her fear was tangible, and I had a vivid sense of what a terrible, poisonous threat I had become to her. I entertained the thought that she should perhaps not be seeing me, as every session seemed to hasten the pace of her deterioration. Supervision and the support of a colleague were necessary in helping me to contain the projections of this patient.

This episode of verging on psychosis did not last for long, and the next session saw some movement towards the depressive position. She confessed to having taken pain killers again, and I explored the meaning of this with her. The drugs, she said, were her friends: they were permanent, always there, and she was in control of them. It should be noted that the type of drugs she took were not stimulants, but would deaden her and aid her withdrawal from things. They helped her to

feel safe by killng off her desires and responsiveness. She contrasted their availability with the fact that I was leaving at the end of the year. I was prevented from opening this up - the dependance on me was destroyed immediately by a fragmentation of her thoughts. She began to speak disjointedly and said that her mind kept slipping. Emerging from the confusion, however, was a statement that she had begun to remember the strangest things: telephone numbers and her secret bank code, neither of which she could usually recall. She had started to access things which would link her to people and make available to her the means of addressing the poverty of her internal world, but these were not allowed freedom. Speaking of her lover's attempts to discuss their relationship, she said, "I can't know what she's asking me." The conflict between knowing her desire to depend, love and be vulnerable and not being able to allow the knowledge was also demonstrated in her response to her tears. She began to cry, and, as she always did when this happened, she started to get up, saying that she had to go. I responded by saying that perhaps the place to express what she was feeling was in the therapy session. She sat down and wept in a restricted, choked-up way for a while. This was followed by her request that she be given permission to leave the ward to go and visit her mother, who was in a clinic because of an overdose. My patient's rationale was that she was feeling that she could be strong and could help her mother. Her vulnerability was again being projected into her mother so that she could take up the

stance of the strong one, hence evacuating the desperate neediness which she had felt in the session. This was supplemented by missing the following consultation, an unusual occurrence for her and when I saw her again, she had effected the shift back to a systemised set of defences in a pathological organization.

At first it was simply a retreat, a withdrawal from all contact. Silence dominated our time together, and if I said anything she seemed often not to hear or would ask me to repeat myself. She spoke lightly, slowly and at times laughingly when she interacted, and the mood was one of a sleepy satisfaction. She described her state in these words, "It's safe. I feel like I've got a skin and nothing inside. Inside my head as well. I can't think. I don't feel pain. I don't feel anything." This she contrasted to the feeling of the week before, when "everything was louder and brighter, and if someone touched me it was like shocks. But I think it was too painful." Then the feeling of being open to connection was alarming; now she was "tuned out, not part of anything", and the change was welcome. Even in this shut-off state, however, were flickerings of what became clearer in subsequent sessions, when she identified actively with the bad, destructive self and in this way more vigilantly attempted to crush out the vulnerable, libidinal self. She spoke of the fear of being violent - of hurting her dog or of injuring her sister's baby. This fear had turned into a desire by the time

I next saw her: she had then decided that she wanted to put her dog to sleep.

The part of her which cared was under attack. She repeated again and again that she was bad, and hit her head against the wall behind her to punctuate these statements. Her nursing experience was now seen in a new light - she said that while nursing had made her feel good, she realized that it was bad to make people rely on one. I interpreted the fear she felt when she began to feel for and rely on people and she turned on me, emphatic that she did not have any feelings. She spoke derisively about the effort that her parents, Jean and Donna were making, saying that she didn't want to see any of them. At the end of the sessions she remembered the reformatory prison to which she had been admitted the previous year, saying, "Maybe I should go back and stay there, because maybe - well, I'm there anyway. I'm there." The libidinal self was already firmly behind bars. In the subsequent session, after projecting hopelessness into me and torturing me through a scenario in which she half-hinted at things, only to retract what she had said, she stated, "I feel like at this stage I've got my barriers back, and I don't want to lose them again. I was a nothing with them down. But the bad things just keep coming into my head. When I look back and try and find one good thing I've done, I can't." Good and bad had become very confused. She related an incident in the ward in which she initially felt she was doing the right thing, but afterwards wondered whether she perhaps "wasn't doing good but was doing

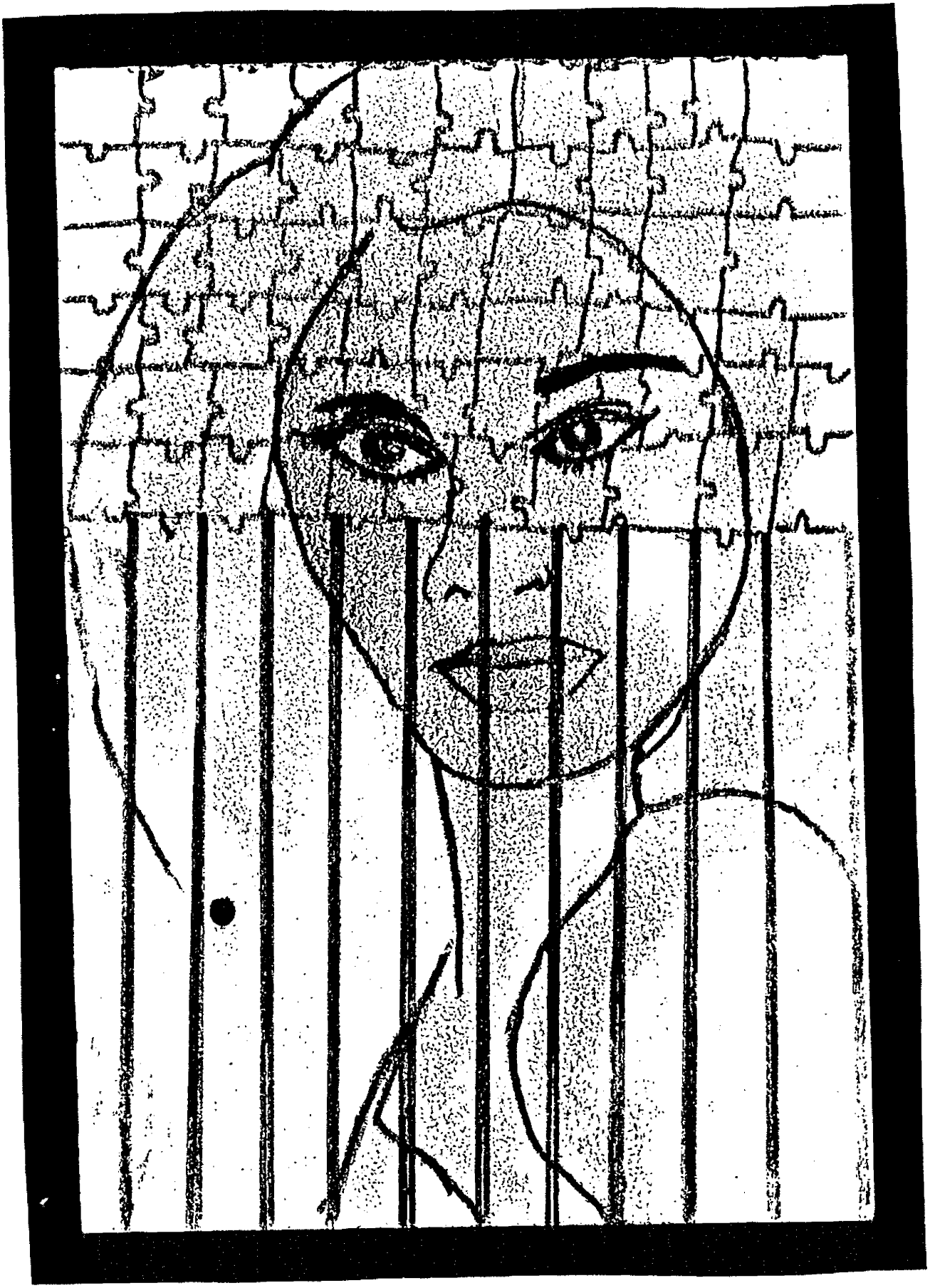
bad". What had previously been regarded as good was being spoiled in an attempt to maintain an imperviousness to relationships.

The tendency to destroy the therapy, which had surfaced at times throughout, was becoming stronger. It seemed that, having felt her yearning to be close to and cared for by me, she sought to spoil the possibility of taking from me. Fragmentation and imprisonment in her inner world were insufficient: she wanted, too, to wreak destruction on external objects which allowed themselves to do what she disallowed herself. She lost patience with the length of time it was taking to "cure" her. Even when she spoke of the trust she had in me, the possibility of anything growing out of this was ruined by her insistence that therapy with me, limited as it was by my planned departure, was her "last chance", and that she therefore had a great sense of urgency for things to change. This also reflects the inability to wait that Joseph (1982) writes of. Waiting with and living through depressive position pain is such torture for this kind of patient that they can only conceive of a magical cure which will preclude the necessity of living through the pain. As therapist, I became disempowered by the omnipotence she would ascribe to me from time to time, saying things like, "I know you will cure me."

Another way in which the therapy was attacked at this stage was through an habitual blocking out of anything that happened

during sessions. This would occur, selectively, from moment to moment, where she blocked out what had just been said, as well as from session to session, where the previous sessions were a blank to her. She would sometimes vaguely ask something like, "Have I been talking in the last few sessions? I don't know." The need for me to sustain links when she was active in destroying them sometimes weighed heavily upon me, and it felt at times as if I was going mad with the transformation of the sense and understanding that I could come to, into nonsense and misunderstanding. This feeling gave me some idea of the madness of what she must be experiencing. She described one form of the destruction of links in the following words, "My thoughts are really weird. Other people can be talking - long sentences - and I lose the content of what they're saying. I listen to each word, but it's not in a sentence, it's just each word, the word before and then - everything before just goes away." This was a world of no connections and thus of no expectations.

The picture she brought to therapy at this stage depicted the pathological organization in a way that was only partially clear to me at the time. I shall present a copy of it, and thereafter her description of what she was hoping to depict, with the associations that emerged:



"She's aloof and I'm aloof. Looks like she's possessed. Frightened but in control. The puzzle is together but fragile. The bars are strong, but also together. She is behind bars. That's how it feels here. Or anywhere. I'm always behind bars. I don't like it: I've got to get out. I feel shut in. It feels very frightening to be locked up, as it does to be out anywhere. I wanted to put a palm tree in the middle, because it's peaceful, like an island where one is alone. She looks alone. The dot on the left is an atom. It's tiny and insignificant, but also very significant. It's insignificant because it doesn't matter who or what you are to anyone. The problem starts when you try not to be an atom. People who try not to be atoms get rejection, get locked up, get told they're little shits. You can't want to be more than just an atom unless you can handle it. But it gets pretty boring being an atom. Towing the line, one after the other, like words. All atoms get locked up sometimes during their life - in cupboards. But some atoms don't. Doesn't mean to say they're luckier, because they get other things wrong with them. They've learned not to cry, so they don't get locked up, but have other things that go wrong."

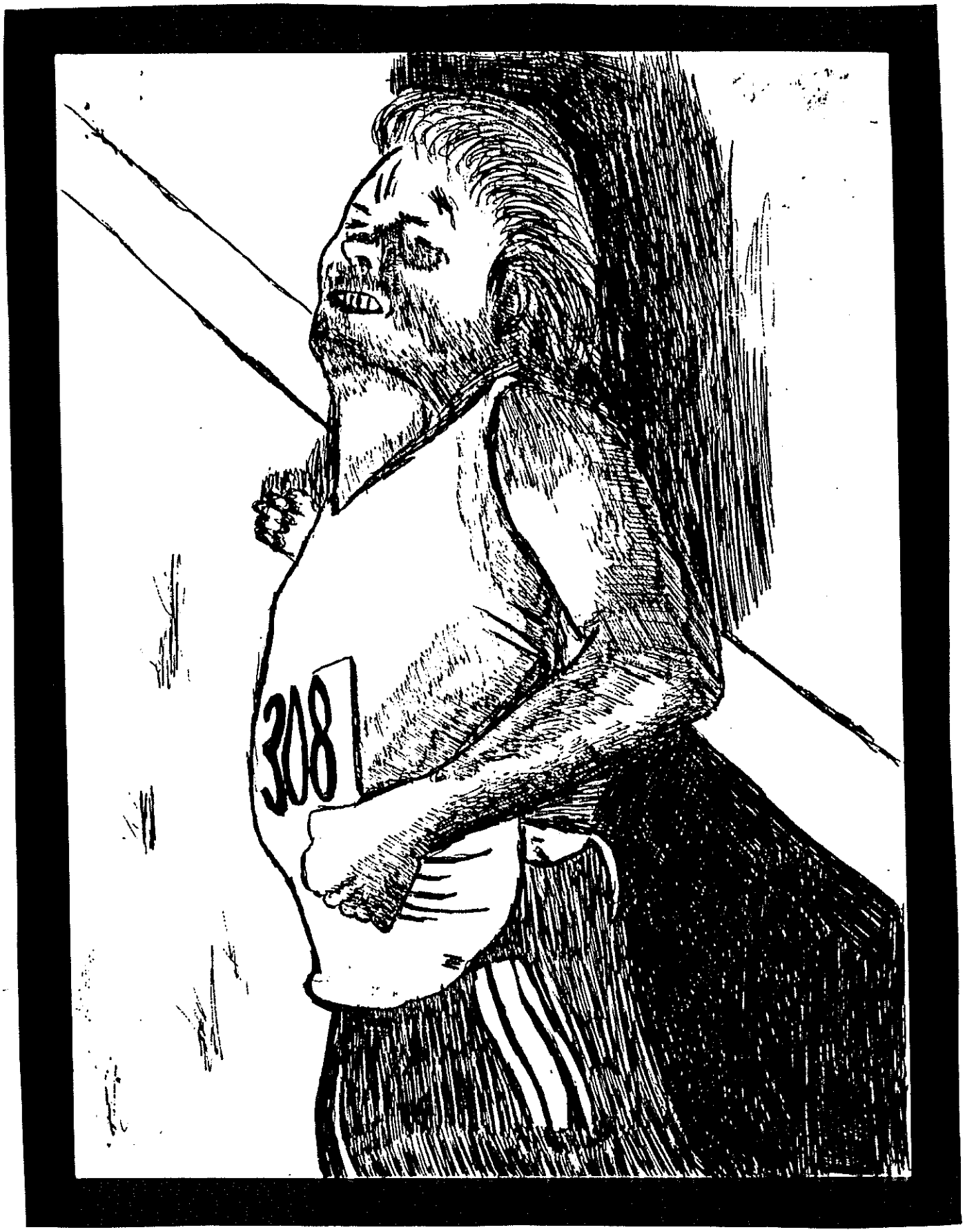
The aloof eyes seem to represent the anti-libidinal self, powerful enough to keep together the bits that otherwise threaten to split into a host of tiny fragments. The intention to add the palm-tree to depict isolation reflects the feeling that she is more secure when she withdraws to her fantasy island. The lower half of the picture seems to

represent the libidinal self, the atom being the essence of this self. Stripped of significance and a rightful place in the world, the libidinal self must be compressed into something minute and put behind bars. This is as a protection against being rejected by others: rather than be at the receiving end of cruelty, she imposes it upon herself. The parts of the self which escape this treatment are those which have "learned not to cry", the invulnerable parts. Later in the session, she spoke for the first time about having been locked in a cupboard by her mother when she cried as a child. She showed a conscious awareness of how she identified with the anti-libidinal self, saying, "So I stopped crying. If you're feeling down, you must do something negative about it: that's how you get rid of it." She claimed that the times she spent in the cupboard were good for her, making her "strong".

A well of feeling must have arisen from the memory of being locked up by her mother, because the next session was spent doing "something negative about it". As well as the usual tactics of attack, discussed previously, she became actively angry, hurling accusations and insults at me, and then reacting to my words as if they were an abuse and an attempt to incriminate her. She shouted at me that she was not angry, and moved her chair to the opposite side of the room. Each outburst was followed by some attempt to restore me - moving away and staring derisively at me from a distance was followed by switching on the light and closing the window so that we were enclosed in a more containing space. Verbal apologies

peppered the abuse. And throughout this absurd and terrifying see-saw was the desire to hurt herself physically. She did in fact knock her head up against the wall repeatedly, a literal accompaniment to the anxieties of merger with and separation from an object, as well as an attempt to knock out her emotional pain by inflicting physical pain on herself. Most of the content of her anger had to do with outrage at the restrictions being placed on her by the hospital - our decision to defer her discharge and to have her report to the ward staff hourly. Her dilemma with the imprisonment that had been effected internally could be avoided by projecting her frustrations onto the restrictions of the hospital. This was safer than threatening the authority of the anti-libidinal self. My interpretation of this, with a link to her past experience of having been imprisoned by her mother, evoked a rush of feeling, which she tried to control by fleeing from the room. She returned in a while, saying that she was frightened by the intensity of her desire to hurt herself. She asked to be locked up. I reflected that she had grown to expect being locked up when she felt upset, and that I wanted her instead to sit with me until she felt safer. She looked wild-eyed and frightened and said a number of times that she would like to go back to the ward and shut herself up in her locker. Then, before the infantile self once again became imprisoned in the internal cupboard, she allowed herself to express some of the terror she had felt as a child, and in doing so, allowed herself to open up to me.

This, inevitably, was followed by a number of sessions in which she withdrew into deadened silences or actively attacked anything threatening her retreat to the pathological organization. The very existence of therapy sessions became a threat. She would say things like, "I'm cured. Aren't you pleased I'm cured? So I can leave now." She made wild plans to leave the city, go to "Durban, America, whatever", in which case, she said, therapy would end, "that's all there is to it. It would mean you don't go away, I go away." She threatened to hurt me in some way before we terminated. At the same time, it seemed that her neediness was allowed a voice between sessions, and she started slipping notes under my door: apologies for having walked out, or longer letters expressing anguish. One in particular, a drawing with a description of what it represented, showed her teetering on the brink of the depressive position: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The associations were lengthy, but in essence came down to the following: "He can't make it over the line because of the pain he feels. No-one is allowed to help him. He feels all locked up inside."

When I initiated talking about these communications, she would say that she did not want to, and would then proceed in some or other way to spoil the therapy. The sessions started to resemble a farce, with me carrying all the concern for her welfare, working patiently and empathically while she poured derision on it all. By allowing myself to be the receptacle of all her evacuated care, as well as carrying my own, and trying to awaken some concern in her, I was playing into her pathology. Once I became aware of this, I started to reflect the process. This evoked, initially, an intensification of her destructiveness. She became irritated and angry, starting sentences without finishing them, contradicting herself and asking me to repeat myself. Veiled suicide threats alternated with sarcastic comments. It seemed, however, that at another level what I was saying was being received, and she started to want to leave the room. She then began a sentence, but interrupted it, pointing to the microphone and saying, "But this 'oke' listening here, he's going to think..." Although she stopped mid-sentence, it seemed that the microphone represented the bad self, the side which had in a previous session also been described as the "devils" that possessed her. The material brought to and emotions expressed in therapy were undergoing censorship. Rigorous interpretation

of all this allowed the door of the internal cupboard to swing ajar and at the end of the session - the timing itself of significance, because she could "escape" afterwards - she strangled out with great difficulty, the conflict between the libidinal and the anti-libidinal self. "I trust you - a little bit - and that's bad. If I trust someone then it's too much. I miss that person and I don't like missing them ... I'm not allowed to feel things for them, I don't want to. I prefer not to."

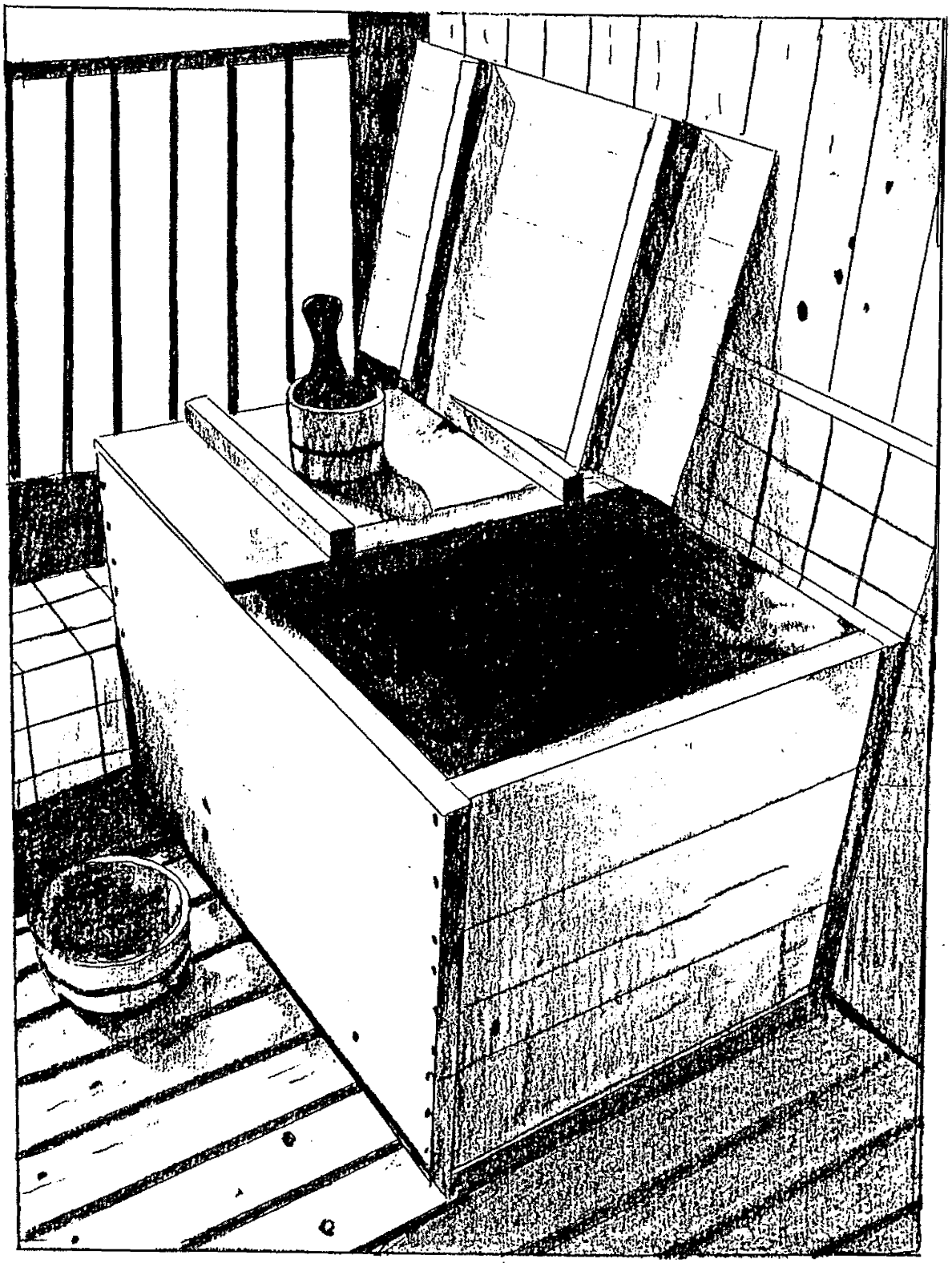
In another note, she expressed the pain of the memory of her imprisonment in the reformatory the previous year. She wrote, "I keep going back there in my mind. I go blank and can't think of anything else but the cell I was in. I hate the view from your window - the wall - because that is exactly how it was in prison... My mind returns there and I feel at times as if I am still there." Therapy was confronting her with the way in which she was "locked up inside", and the libidinal self had found a voice to cry out against this. The anguish felt was still only allowed expression in written notes, however. Even so, the emergence of her neediness was invading me, and I began to get the feeling of how overwhelming it could be. Kept at bay and hence having been unable to grow in relationships with others, it was a primitive and desperate side.

In the subsequent session, she came in stating that she felt "very well, almost high", and proceeded to talk energetically

about ideas and plans she had for the coming weekend as well as for when she left hospital. She had made a reservation at a weekend resort called "Utopia", and appeared to have reached a kind of utopia already. This had "just happened" - in the same way that she had previously attributed frustration and irritation to being in a "bad mood", the present feeling was put down to having woken up in a "good mood". This inability to link circumstances or inner processes to her feelings was another way in which she destroyed connections. Since her hospitalization, she seldom brought anything of what was happening in the ward or on weekends into therapy. I would hear via ward meetings of various incidents involving her, but she would withhold all this from me. My ability to make links was thus also hampered, and at times it felt as though she had led us into a less than real world, where she was being moved by inexplicable forces beyond her control. The psychiatrists on the team for a time got caught up in this, trying to find the causes of her "mysterious" mood swings in her biochemical make-up. Anti-psychotic medication and that for temporal lobe epilepsy were administered. Her vital signs were monitored each hour for a week when they suspected hypo-glycaemia. When I spoke of the manic feel she conveyed for the part of the session under discussion, the psychiatrist in charge expressed that if this proved to be the onset of a manic episode we would at least have a clearer idea of what we were dealing with. We all began to wonder if and to what extent Toni was abusing drugs, and how this may be playing a part in what was

unfolding. At times when I was drawn into my patient's web of hopelessness, having had whatever understanding I came to torn to pieces, I too hoped that we may find answers in her biochemistry. As her dynamic became clearer to me, however, the seemingly arbitary nature of her responses became more understandable. The extent of self-medication never did become clear, but when she spoke of having taken pills it seemed that pain killers or tranquilizers were being used to quell feelings of neediness and vulnerability when the bad self was losing ground.

My patient described her manic defence quite accurately, saying "I have to keep busy the whole time. As soon as I'm not busy I fall apart." New methods were being employed to try to keep her within the safety of the pathological organization, but as I continued to interpret this process, it became evident that the door of the internal cupboard, having swung ajar, had remained open. The tone of the session changed completely as she engaged with me. She referred to a drawing which she had given to me previously but had refused to discuss. A copy of the drawing and an excerpt from the session follow:



Patient: Recently it hasn't been as - as safe, because ... I don't know why, it just hasn't been, in here.

Therapist: Almost as though recently the needy, spontaneous side has a little more power than it used to have.

Patient: Mmm. And it's sort of released - sort of opened the door of that thing (pointing to the box with the raised lid). It's like - I've been let out, and the lid's off, and it's sort of free within myself, it's open, I can get out. But if I get out, there are still barriers to cross. That's why I put in bars again (pointing to the barred opening depicted). It's still locked up to other people, but I feel it within myself. And I hate it, and I - it's just, just been freed because - I don't know. It's not safe anymore, whereas my whole life it's been safe.

Therapist: The policeman side[5] is now not feeling that powerful,is starting to feel a little threatened.

Patient: Is very threatened. It's almost - maybe for the first time in my life I want to be well, and I know the only way to get well is by opening that door. It's totally opened up in myself: I can analyze things now. I can think again, I

[5] This is a term we had come to use for the anti-libidinal self.

> even dream now about things. But it's still closed to the outside world. I'm going to try and sort it out myself. If that doesn't work, I'm going to have to open it out, bash down those bars and get out.

The painful feelings that had started to emerge had to do with the access the libidinal self was now being allowed. This movement towards the depressive position also gave rise to depressive position functions - the ability to analyze and to think. The interpersonal realm remained too threatening, though, and the barriers between herself and others - me, in particular - remained. The connection she had made in the part of the session transcribed above could not be sustained, and she slid into the old pattern of blocking me out, as if she were indeed " going to try and sort it out (herself)". The distance created seemed to give permission for further deepening, and memories of being locked up in the cupboard flooded back. Her words demonstrated the development of an identification with the bad self, "But my mother was an adult and she did what she thought was right. So I thought it was right too. I'd be a spoilt little brat if she hadn't done that. At one stage I was sad in the cupboard. I didn't understand it, but I thought she was right. I was sad, and I thought, "Why am I sad if she's being right?" Now I'm just doing it to myself." This was followed by a subtle change, which I only registered a few minutes later, when the session had ended. She said, "So what do I do to get out of that

then? I know, I've got to ... it's all self-inflicted! Everything I've done is self-inflicted!" Her understanding had twisted so that it could be used in a self-destructive way, a means of tormenting herself by inflicting blame. This seemed to be no more a way of taking responsibility than her previous idea of resorting to a violent "bashing down" of the bars that imprisoned her did. The bad self has many ways, and the headway made in the material that I have just presented must also be seen in the context of my fast-approaching departure. With about twelve planned sessions left to us, any connection to me carried in it the seed of its destruction.

Despite an initial resistance to the therapy in the following consultation, she then referred to the fact that the previous session had been the first that she remembered. The link of memory had been sustained, and she described the session as having been "quite worthwhile." This was followed by a retreat, in which she fobbed her silence off to never having been a talker. I shall once again present an excerpt from the therapy:

Therapist: You were saying last week that the part of you which was being kept prisoner could now be a little freer inside yourself, but that it was still closed up in relation to others. I wonder if that's what is happening between us now.

Patient: I must put it back. Not worth it.

Therapist: Because ...

Patient: I wouldn't know. (Her tone becomes taunting and

scathing). Strange. STRANGE, hey?

Therapist: Perhaps the policeman side would really rather not know.

Patient: There's no point. Today is today. I don't want there to be anything to understand.

Therapist: When you get something worthwile from therapy, there's a part of you that wants to kill it off by saying there's no point.

Patient: It doesn't want to, it just DOES (said harshly).

Therapist: It seems, even, to get a certain amount of satisfaction from doing that.

Pateint: Yah. It's safer, you know. I feel better (said sarcastically). There's no-one I'm going to - um - (sighs and hits chair arm). It's just not worth it, it really isn't.

Therapist: There's no-one you're going to ...?

Patient: I don't see the point in talking about anything! (said forcefully.) And I don't care what it does to me, because I realize I'm never going to talk again. I'll talk again,normal conversations, but not about anything. I'm not - I don't want to carry on with therapy, DEFINITELY not, that's one thing. And - I take things too seriously, that's my problem. I've got to start laughing now. Learn to laugh, and then I'll be FINE.

The above extract clearly demonstrates the fight being put up by the bad self, and needs commentary. I linked this fight to

the neediness and longing evoked in the dependant part when she felt that she had received something of value. A flood of despairing sadness slowly broke through, and although the anti-libidinal self asserted itself in phrases such as, "STOP IT, TONI!" when she was crying, it had lost its power to hold back the feelings of loneliness and desolation. She left the session feeling very upset, and I saw her again two hours later when one of the nurses phoned to say that they did not know how to contain her. She now spoke about feeling exposed, saying with horror, "That session was ME!" She said that I had touched on her secret self, and that my reference to her longing feelings had been frighteningly accurate. There was panic about what she should do with these emotions now that they had been exposed, and she struggled with feeling that she now had no boundaries. In extreme agitation, she confronted the fear of having me leave.

That night I dreamed that a colleague had given me a note from this patient to say that she was going to the castle. While dreaming I was not clear as to what exactly "the castle" was, but I had a sense that it was a place where something bad could happen. I felt extremely tired and hid the note away, pretending that I had not received it. I rationalized to myself that she would be all right as there was no castle in the hospital grounds. Later I saw her corpse being carried away by hospital staff, and I felt distraught and guilty. As well as conveying the extent to which I felt sapped by the therapy with this client and highlighting my own personal

tendency to rationalize away that which presents itself as too overwhelming, this dream speaks also of my perceptions of my patient. She relates to the objects in her world as though they, too, carry the qualities of the anti-libidinal self, and in the dream I fulfill this expectation by ignoring her cry for help. In a world filled with the projections of her bad self, the only solution is to go to "the castle", a place from which she can defend herself, the defence leading to her death: be it a literal death by suicide or a psychic death in a pathological organization. The dream also shows the extent to which I felt despairing of the outcome of this therapy: the fear that she was doomed, and would not ever successfully negotiate the depressive position anxieties that had been aroused.

On the following day she handed in a letter giving three days notice to abscond from hospital, with an awareness that this action would also entail that her therapy with me would not be permitted to continue. As a team we decided that I should see her briefly to spell out why we were of the opinion that this was unwise. The desire to leave was an attempt to flee from the feelings that had been uncovered in therapy, and I was quite firm in my intention to change her decision. Once again, I was carrying the concern while she was prepared to throw herself out into an unsupporting environment at a time when she felt vulnerable. She stayed, but took an overdose the following evening. Before her suicide attempt she had tried to make contact with me, but when I finally had

telephonic contact with her at the end of the day, she sounded distant and said that it could wait until our next session. The team decision was to send her to a psychiatric hospital where she would be admitted to a lock-up ward until such time as they saw fit to discharge her. It was not clear if she would be back before I left the city, and it was with a feeling of great hopelessness that I took leave of her, unable even to do this in a satisfactory way because of her semi-conscious, drugged state. She had succeeded in carrying out the destructive determination to hurt me in some way before I left: it seemed that my issues with loss would not be allayed by a worked-through termination, and I was plunged into a pain of my own.

She was discharged after only a week, however, and returned to the ward, the treatment plan being that she use a short stay as an in-patient to find employment and somewhere to live.

In the first session after her return, there was less evidence of withdrawal or of destructive attacks. She looked well, and one of the nurses on the team commented that the short spell of lock-up treatment appeared to have done more for her than anything we had attempted in the months she had been with us. Although she described the experience as "horrific and traumatic", it had stabilized her. She had been removed from the therapy, and the ward, both of which had given her access to unfulfilled and overwhelming needs, and thus provoking attacks against herself, myself and the staff. The distance

she had had from me, and the fact that someone else had for a time taken on the role of imprisoner, meant that in the therapy she could once again draw closer, and our initial contact was productive. I addressed the attempt she had made to contact me before taking an overdose: a move towards allowing the dependency rather than crushing it out. At the same time, I wondered with her about her inability to sustain that until she next saw me. She responded by describing the experience of not being able to sustain links, saying, "I see it as broken up. I don't see it as something - it's all broken up, not something that carries on. The connection's there for 45 minutes and then it's gone. Like hiding a toy and the kid thinks it's gone."

The last seven sessions saw fluctuations between depressive position longings and the same patterns of withdrawal, denial and destructive attacks as have previously been described. I became aware that a strong dependency had formed with regard to the therapeutic relationship, but that this would be confused and spoiled. The most powerful way in which this attachment was communicated to me was through the mechanism of projective identification - I found myself thinking about this patient constantly, and one evening I reacted to the sight of a woman who looked like her with the startled excitement that one would have for a lover. This experience made clear to me the extent to which I was carrying the feelings that she would not tolerate. When these split-off feelings re-invaded her, she seemed able to entertain them briefly as she moved towards

expressing trust in me, but they would always be fragmented and evacuated once again. These about-swings made the work of termination extremely difficult. My patient alternated between denying that my departure would affect her in any way whatsoever, and being sent into a state of panic at the thought of it. I worked rigorously at linking occurrences in the sessions with the termination issue, and this provoked her anger. The concept of being able to work with this on an internal level was nonsense to her. She said, "You don't have to keep reminding me, I know you're leaving! I don't understand why we're sitting here talking about it, because you're going, and you're going, and that's it!" The panic seemed to be linked to the fear that I would take with me the parts of herself that had been split off and projected into me: she feared "starting all over again" with a new therapist, and hoped that I would give my notes to whoever took over from me.

Another of my tasks in this final stage of therapy was to address the practicalities of where she would live and work when she left hospital, but every attempt to do this made me feel that these were my problems, not hers. This was a continuation of my previous awareness that it was I, not her, who carried the concern for the therapy. She would condescendingly agree to talk about what arrangements she had made, but they changed from session to session, and the chaos infused me with a sense of hopelessness.

Having fought to leave hospital against our will a few times previously, she was very reluctant to go on the discharge date set, but we were firm, giving her permission to attend the afternoon ward programme until such time as she found employment. An orgy of destructiveness followed. She overstepped limits by walking out of the ward programme to find accommodation and by arriving on the ward in what seemed to be a drugged state. When she was informed that she would no longer be allowed on the ward, she felt persecuted and entered a frenzy of spoiling behaviour. She tried to manipulate the situation by making suicide threats and asking how she was expected to stay with her parents when her father would "rape" her. She convinced her father to book her into an expensive private clinic for a couple of days, and asked for an additional source of help to deal with her desire to drug. These actions gave the message that what we had provided had been spoiled. I understood this acting out as a reaction to termination, and was aware of the importance of finding someone with whom she could continue therapy when I left. This was by no means easily accomplished - I felt unsupported as one person after another declined to take her on. I finally found someone, and arranged that she see my patient once before my final session with her. This information helped to contain her, and I shall present the dream that she brought to our second last therapy session, a couple of days before she met her new therapist, a woman whom I shall refer to as Karen:

"I dreamed that I was supposed to see you, and when I got to you, you told me to see Karen. So I went - I didn't know where to go, but I got there. I had a friend who came with me. When we got to her room, Karen started singing war-cry sort of things. My friend joined her, and it was very frightening. I couldn't join in or anything. So I left and came back to you. You had ten people out here waiting to see you. I sat outside. I knew it would take about ten hours, and it was raining. I thought to myself, "This is supposed to be MY time!" But I waited for ten hours, and then you came out and asked me how it went with Karen. I said that it had been okay, but frightening, and that she had too much tinsel and glitter to get through. That's how it ended. It was so vivid. And the friend in it was incredible."

The dream seems to indicate that she is able, initially, to take something good from the therapy experience with me: she is accompanied by the "incredible friend". The new therapy, however, pitches her back into paranoid-schizoid anxieties: she feels persecuted, and must escape. What she had internalized as good - the friend - is caught up in this, becomes spoiled, and joins in in the attack. This leads to the need to a concrete return to the original source of goodness. As therapist, however, I now become like the depriving mother, who leaves her wet and cold while I attend to the needs of others. Despite this, she is able to stay with this discomfort until I come out to ask how she is. This seems to indicate some ability to tolerate waiting with the

belief that her object will eventually concern itself with her needs.

She said in our final session, "This time I didn't run away because the person went away. I didn't feel like coming to therapy to-day. I felt it'd be easier, but I have to change that pattern." This indicated some ability to stay with difficult feelings rather than do something active to eradicate them.

It will, however, take many more years of intensive therapy to make some lasting impression on the dynamics of this patient.

Chapter 4

CONCULSION

In conclusion, I should like to address the overriding question that arose for me both during the therapy with the patient under discussion and in the writing of this case study. The question is one of how much the manifestations of the death instinct should be interpreted, and how much the patient should be allowed to remain entrenched in the pathological organization while supported by the holding environment provided by the therapy. This is a question which remains unresolved in the literature: there are claims and substantiations from clinical practice for both approaches. My impression is that individual therapists align themselves with the approach that fits most comfortably with their theoretical stance and their own dynamics, and that they then maintain the belief that that is the way to promote change. We cannot deny that our theoretical perspective usually has in it something of a self-fulfilling prophecy.

Among the authors referred to, there seems to be some divergence of opinion as to how one should deal with patients who are entrenched in a pathological organization. Rosenfeld (1971) concluded from his observations that the aim in therapy

with these patients is to foster an awareness of the destructivenss of the bad self so that the libidinal self may be rescued. Steiner (1981) points out that the interventions recommended by Rosenfeld may in themselves not be enough, as the dependent self may not always be an innocent victim. It may be obtaining a perverse, masochistic kind of gratification from its alliance with the bad self. This is exactly what Joseph (1982) points to. If this is the case, the collusion of the libidinal self would also need to be exposed in psychotherapy. Underpinning these approaches to treatment seems to be the view that vigorous interpretation of the manifestations of the death instinct are essential to shifts in therapy, and that if this is not done, the patient will remain entrenched in the "no-man's land" between the paranoid-schizoid and depressive positions. O'Shaughnessy (1981), in her presentation of a twelve-year analysis, holds a somewhat different view. She stresses the importance of allowing the maintenance of a defensive organization for as long as it takes for the patient's ego to strengthen and the area of anxiety to diminish. It may only be after many years of this that forward development and a more interpretative approach may begin.

To clarify my dilemma in this regard, I should like to refer once again to the final stages of the therapy case that has been presented, looking at how it was managed by me and at

other ways in which it could have been managed. In doing this, I am aware of how what unfolded in the therapy was influenced by my inexperience as a psychotherapist, and that this in itself prevents me from using this material to arrive at any definite conclusions. In retrospect, I have something of the feeling that "fools rush in where angels fear to tread" when I review all that happened in this short five-month therapy with a profoundly damaged patient. This limitation need not prevent an exploration of issues, however, and should in fact promote such questioning.

In the sessions preceeding my patient's overdose, the excerpts from the therapy given in Chapter 3.2 and the discussion of what was happening in the therapy at the time, make it evident that my stance was one of more vigorous interpretation. Interpretation was made of the ways in which the anti-libidinal self showed itself and of how great the longing and neediness of the libidinal self in fact was. Links to the past were made, which opened up access to the vulnerability and despair my patient had felt when locked up as a child. This work led to such an overwhelming flood of painful feelings - previously kept at bay by a retreat to a pathological organization - that she made a suicide attempt.

In the light of her history of multiple suicide attempts, two of which were in the months preceeding the therapy, it seems that it would have been unrealistic to expect that pattern not

to repeat itself. Interpretation leading to the exposure of the libidinal self runs the risk of provoking suicidal behaviour: but is it not also through the emergence of the libidinal self into a state of connectedness in a relationship which promotes growth that ultimately brings this behaviour to a halt? Even if this is so, though, can one take the risk of exploring that which leads to life-threatening behaviour? In this particular case, with termination looming ahead, it seems that my efforts should have been concentrated on containing and supporting rather than interpreting in a way which would open up feelings of dependancy.

The other side to this, however, is that perhaps her very ability to allow dependancy on the therapy in the last while and hence to allow the references to her neediness to reach her, was linked to the fact that an end was in sight. The anti-libidinal self could relinquish its powerful hold in the knowledge that any sense of connectedness and of vulnerability would be short-lived. The pain resulting from the loss of therapy would only confirm the stance that strength could be maintained only by an identification with the invulnerable, bad self.

Should my primary task have been to survive the manifestations of the death instinct - the withdrawn silences and fragmenting attacks? That survival, if continued by her next therapist, would perhaps over time allow the development of ego strength,

and only at this stage would one consider taking a more interpretative stance. The question remains as to whether containment of the patient and survival of her destructiveness does in fact promote increased anxiety tolerance and ego strength. If the pathological organization is as sterile and destructive a state as is suggested in most of the literature, one could argue that the therapist does indeed need to be more actively interpretative in a bid to rescue the good self. It seems that it may be essential to develop a rhythm between these two stances, and that a sensitivity to the timing of interpretations is an essential part of dealing with these patients. Ultimately, however, my feeling is that the emergence of the good self needs to be promoted, but that this will invariably lead to a destructive attack by the bad self, and that it is this Catch 22 situation which makes therapy with patients employing a pathological organization a particularly tricky endeavour. The recognition of this is, I believe, essential to the survival of the therapist in his work with these patients.

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