ADDICTIVE STATES OF MIND

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CHAPTER FIVE

The deprivation of female drug addicts: a case for specialist treatment

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Angela Foster's training was in social work and psychoanalytic psychotherapy. Over her professional career she has worked with drug addiction as an individual and group therapist and Assistant Director of a residential treatment service, as a supervisor to other workers in the field, and as a consultant to substance misuse services. In this chapter she describes how each of these roles must be based on a profound understanding of the fundamental psychopathology of the addict, focusing particularly on the female addict. Central to her thinking is the concept of the female addict's perverse relationship to her own body, and pivotal to this understanding is the work of Estela Welldon. The account that Foster provides is of the female addict's use of drugs to simultaneously alleviate psychic pain and to destroy the body (and relationships). Splitting and projection of negative affect are everywhere, with the result that the addict alienates the sources of support that she most needs. The chapter describes how this is based on experiencing a fundamental failure of being mothered, which she attempts to repair in her successive attempts at mothering herself, yet which she is compelled to destroy. This dynamic is enacted with the

maternal functioning of the therapist and with the institution: for either to survive, the thinking space of supervision is essential.

The image below vividly captures something of the plight of female drug addicts; hence "Mia" is the name I have attributed to my main case example. She is an amalgam of clients whom I have known in treatment and those I have heard about in supervision and consultation over 40 years of work in substance misuse services.

Mia's story

In giving her life story to other residents and staff, Mia vividly described a memory she has of standing in her cot watching her father violently and sexually attack her mother. She thinks she first started to get "out of control" aged 7 as she rebelled against her father's drunken beatings. By age 12 she was drinking, and

Figure 5.1 *"Yasmin admires Mia for always being there for her friends." Mia is a drug addict and prostitute. (From the long-term project "Mia: Living Life Trying" by David Hogsholt. Third prize winner, World Press Awards, 2005.)*

later, when introduced to heroin by older male friends, she found that the beatings no longer hurt. She had a violent boyfriend, left home, and drifted into prostitution as a way of supporting herself financially.

Unsurprisingly, as Mia's time is taken up with procuring the money for her drugs and obtaining her drugs, she fails to take care of herself in any other way. She is physically damaged by her injecting and suffers from abscesses. In addition she cuts herself and appears to have an eating disorder, most likely bulimia—bingeing on her food then vomiting it up, ostensibly as a way of keeping slim, but in fact this, like her other activities, is more evidence of her "addiction" to self-punishment and her inability to believe that she is deserving of any good nourishment or care. She feels a bond with other women in her position and takes on a maternal role with them, which may be as close as she can get to looking after the needy and abused child within herself. She has a child who was taken into care at birth.

Introduction

"Mia" is representative of a significant sub-group of female addicts who are the focus of this chapter: women who are multiply deprived and abused and seem to be addicted to re-enactment of these experiences through self-imposed or self-initiated deprivation and abuse of their bodies. They find relief from pain and anxiety through these processes in which they are always the victim and often the perpetrator. The nature and multiplicity of their addiction(s) has received very little attention, and it is possible that the paucity of writing on female addicts is reflective of a collusion between this client group, those treating them, and society in general to turn a blind eye to their needs and their particular pathology. This may also be reflected in the paucity of specialist treatment models for female clients, and tragically, when they access generic drug treatment services, the sadomasochistic relationships that so often characterize their lives are relived in their experience of what feels like punitive treatment from their care workers when they provoke discharge or discharge themselves for non-compliance with treatment models not designed to meet their needs.

We have come to know these women well essentially because we fail them. Consequently they come to our attention over many years, apparently unable to benefit and move on from the care and treatment we provide. What is it about these women that renders them so resistant to help, why haven't we spotted it, what do they need that they are not getting, and how might we work more effectively with them? I will attempt to answer these questions, hypothesizing about why we have been so slow in addressing the problem and making links to relevant psychoanalytic theory. I imagine workers in this field will be familiar with the biographical details provided, recognize the dynamics described, and, I hope, find my analysis helpful. But first some caveats:

- Early deprivation and abuse doesn't necessarily lead to drug addiction, nor are all those who become addicted to drugs suffering from early deprivation, though many of both genders are.
- Many clients of drug treatment services, both men and women, are able to make good relationships with their workers and recover.
- The particular perverse dynamics I will describe are not true of all female drug addicts, nor are they exclusive to women—though they are much more rare in men, and I will not be covering this here.
- I am not proposing all-female services. This is a different and complex discussion. Male and female drug addicts need to experience healthy relationships with both male and female workers. There is a case for some women-only services for those clients who have histories of severe abuse and who initially need the sanctuary that these services can provide, but the same sado-masochistic dynamics will be present and need addressing.
- Finally, I want to add that my purpose is not to criticize workers in the field, who are, in my experience, highly committed to their clients' care; rather, it is an attempt to analyse the particular difficulties we all face in the treatment of a significant group of women and to offer some thoughts about how these might be overcome.

The most persistent and chaotic drug users are traumatized by failed early relationships, and their drug use is secondary to this,

constituting a form of self-medication to ease their pain. Over time the relationship with the drugs becomes primary, as it is felt to be safer and more reliable than human relationships. They are often diagnosed with borderline personality disorders in which recourse to drugs constitutes a form of "psychic retreat" from both depressive and persecutory anxiety, and they have little capacity or desire to take part in a relationship in which their pain would be addressed (Steiner, 1993). As Steiner (though not writing specifically about drug-addicted patients) notes:

> The priority for the patient is to get rid of unwanted mental contents, which he projects into the analyst, and in these states he is able to take very little back into his mind. He does not have the time or the space to think, and he is afraid to examine his own mental processes. [Steiner, 1993, p. 131]

"Psychic retreats" are borderline psychotic positions in which we remain stuck developmentally:

> It is as if the patient has become accustomed even addicted to the state of affairs in the retreat and gains a kind of perverse satisfaction from it. . . . A perverse pseudo-acceptance of reality is one of the factors which makes the retreat so attractive for the patient who can keep sufficient contact with reality to appear "normal" while at the same time evading its most painful aspects. [Steiner, 1993, p. 12]

Another characteristic of the borderline phenomenon is the claustrophobic–agoraphobic dilemma described by Henri Rey (1979), in which any relationship that falls short of a fantasized perfect match between client and worker gives rise to anxieties, described by Britton as those of being trapped by "a deathly container, or, exposure in a shattered world" (1992, p. 111). Britton continues: "faced with these two catastrophic alternatives, incarceration or fragmentation, some people . . . remain paralysed at the frontier, on the threshold" (p. 112).

These dynamics are experienced in client–staff and staff–client interactions through transference and countertransference, and workers are required to form caring relationships with people who are rarely able to reciprocate. We have to manage ourselves and our ambivalent feelings without resorting to projection or retaliation, at the same time managing that which is projected into us by our

clients. Our job is to give back a sense of reality and substance to people who through continuous processes of projection feel unreal and empty. We have to be able to judge what the client is able to tolerate and contain at any given time and formulate our interventions accordingly (Foster, 2002).

We became aware of the challenges that this poses for staff when I began work in this field in the early 1970s as Assistant Director of a mixed-gender residential therapeutic community for the treatment and rehabilitation of addicts newly detoxified. We understood the importance of focusing on the nature of interpersonal interactions as a route to gaining an understanding of how clients' early experiences of parenting (internalized object relationship patterns) impacted on their personalities and their lives, and it was through this approach that I became particularly interested in the needs of our female residents, who appeared to be more disturbed and differently deviant from the men. I will identify these early concerns with reference to a client, "Sue", but it was only many years later, when Estela Welldon began writing on female perversion (1988, 1996[1]), that I was able to gain a better understanding, illustrated here in an account of "Mia's journey through treatment".

My focus is on the particular nature of perverse female pathology. In psychoanalytic terminology referring to someone as perverse is not a moral judgement:

> it means simply a dysfunction of the sexual component of personality development . . . [and] . . . The main difference in a male and female perverse action lies in the aim. Whereas in men the act is aimed at an outside part-object, in women it is usually against themselves, either against their bodies or against objects which they see as their own creations: their babies. In both cases bodies and babies are treated as part-objects. [Welldon, 1988, pp. 6, 8]

It is essential that we recognize the difference and different needs of female clients who fit into this category, the importance of providing appropriate treatment models in mixed-gender services, and, by implication, the need for policies that equip and enable staff to engage in sustained longer-term work, to the point where their clients are able to use and can be referred on for further psychotherapeutic help.

Sue

In a mixed residential treatment setting, Sue's behaviour reminded me of the little girl in the nursery rhyme: "When she was good she was very, very good, and when she was bad she was horrid." When she was good she was capable, responsible, and caring of others—a valuable, effective, and apparently successful member of our community; when she was horrid, she was "mad"—shouting, screaming, unable to listen to reason and likely to harm herself as a way of "cutting out" her pain and disturbance. We understood that Sue was able to split off and deny her feelings of being bad, worthless, and undeserving through offering good therapeutic help to others. When she could no longer maintain her defences, she became depressed, angry, and self-destructive. Her behaviour was typical of our female residents.

Contemporary feminist psychoanalytic writing enabled us to begin to shed some light on these differences between our male and female clients. Nancy Chodorow (1978[2]) identifies the mother, or primary carer, as all-powerful in an infant's life, both a giving and a withholding figure, and she argues that one way of avoiding the painful envious feelings this generates is to devalue the envied object by splitting off the good and projecting the bad into it.[3] The devaluation of women is, "in the final analysis, devaluation of mother as a primary object of dependency" (Kernberg, 1972[4]). The boy's penis and masculinity enable him to assert his difference, and this facilitates separation, whereas girls do not have something different and desirable with which to oppose their mothers and are more likely to retain a pre-oedipal stance whereby they are pre-occupied with issues of symbiosis and primary love without a sense of the other person's separateness. This is compounded by the mother's projection and identification through which she conveys her ambivalence about her femininity, her own unmet needs, and her repression of these. Consequently girls learn early in life to put their own dependency needs secondary to those of others and, through identification, to recognize and respond to the needs of others while disowning their aggression.

Our female addicts presented as passive victims of neglectful, abusive, and cruel parent figures and partners, and when their

aggression surfaced, it was often more dramatic and violent than that of our male residents and was directed against their own bodies. They were then seen as especially disturbed—"mad"—and therefore to be feared and kept at a distance: marginalized. Welldon notes that men are allowed and encouraged to express anger, whereas women are inhibited from doing so. "They are encouraged and trained to cry and to be sensitive and perceptive about others' needs and predicaments. Revealingly enough, if these 'rules' are transgressed, the penalties are contempt and pejorative comments . . ." (Welldon, 1996, pp. 485–486). It therefore follows that female addicts transgress this social code more violently and damage their social identity more fundamentally than male addicts. In addition, as women are expected to be the mainstay of the family, they suffer greater stigmatization and carry more guilt if they fail to fulfil their responsibilities to husbands and children (see Metherall, 1982). The pain of this guilt then leads to further splitting of the "good" and "bad" parts.

Sue left treatment and went on to be a professionally trained and highly respected race relations worker before killing herself. At this point it seemed clear that none of the treatment she had received had enabled her to internalize a "good-enough" integrated maternal object. Her disturbing behaviour was managed but not properly understood. We failed her because we colluded with her splitting by welcoming and appreciating the care she could offer while turning a blind eye to the disturbance that lay beneath it (see Foster, 1984). One of the big challenges facing workers in this field is to resist being over-hopeful about a client's therapeutic progress by holding the aggressor in mind and daring to address that part of the personality in the belief that this will lead to longer-term gain. Such work requires a great deal of trust on both sides. Workers are understandably reluctant to spoil the good feeling in the present client–worker relationship, and clients, like Sue, will do all they can to maintain the status quo, resisting the deeper work because they are reluctant to relinquish their destructive powers, preferring, instead, to retain these as secret weapons should they need to resort to using them in the future—an attractive but dangerous strategy.

Female drug addicts have needed and used their aggression to survive, and they need to be in touch with it in treatment so

that the destructiveness can be faced and the aggression subsequently harnessed in a positive way to enable them to be assertive about their needs in treatment and in pursuing what they want as they work towards their rehabilitation. Without this, their journey through treatment is the journey of a false, compliant self while the needy part is hated, disapproved of, and marginalized—still subject to the murderous part, as both remain hidden and neglected. As Welldon (1996, p. 486) points out: "women at times keep all negative feelings inside, which leads to depression, low self-esteem, self-hatred and consequent withdrawal from all contact with others. It is easy to see how this might end in suicide." Had we persisted in working with Sue's "horrid" side during her "good" periods, things might have turned out differently.

However, the problem is more complex than this analysis would suggest, because we need an understanding of female perversion in order to help our clients integrate this split. Early feminist writing focused on women's oppression; it was many years before we could begin to think about women as perpetrators as well as victims, and if we can't think something, then we can't work with it. Earlier attempts made by female analysts were simply derided. I will now move on to Mia's story to illustrate these dynamics as they emerge in the treatment setting and how we might work more effectively.

Mia's journey through treatment

When Mia spoke her life story (and when it was reported to me second-hand in supervision), the emotional impact of her first memory was considerable. We had all identified with the toddler standing in her cot helplessly witnessing and being invaded by the images of her drunken father's violent sexual assault on her mother. We took in this image with all its horror via a powerful unconscious process of projective identifications, meaning we felt it as an "offer we couldn't refuse". Projective identification takes two forms that need not be mutually exclusive.

> One is to eject violently a state of mind leading to forcibly entering an object, in phantasy, for immediate relief, and often with

> the aim of controlling the object and the other is to introduce into the object a state of mind as a means of communicating with it about this mental state. [Hinshelwood, 1989, p. 184]

We understood, through reflecting on the feelings Mia induced in us, that Mia has internalized both the maternal vulnerable, needy, and abused object and the paternal aggressive and abusing object: the masochistic and the sadistic. Her self-destructiveness is a re-enactment of the murderous intercourse she witnessed. This is in contrast to creative psychic intercourse, which would produce something healthy—such as a new thought or a belief in a way forward.

Deprivation × 1 & 2: inter- and intrapsychic processes

Following the work of Louise Emmanuel (2002) on triple deprivation, I am proposing that the abused and deprived little girl—Mia—suffers firstly from the impact of parental failure which was out of her control, then secondly from the narcissistic, self-defeating defences she develops intrapsychically in an attempt to protect herself from the pain of the early environmental deprivation. Mia's life story vividly illustrates how defensive, self-defeating processes of secondary deprivation led to chronic re-enactments of her early deprivation and abuse.

Deprivation × 3: Repetition in the system of care

The third deprivation identified by Emmanuel arises in our systems of care. The defences clients bring to a helping organization mean that staff are subject to powerful projections and are, through transference and countertransference processes, at risk of falling into the trap of re-enacting the experiences of early deprivation by colluding with their clients' need to make them fail.

Having told her story, Mia engaged the empathy of the community and felt accepted. This is just as it should be. But something else had happened. Through the process of projective identification Mia had effectively transferred her unbearable and unwanted feelings into the staff, and as a result, unburdened and lighter in mood, she

was free to become a cheerful, willing, and able participant in the community tasks of cooking (though staff had suspicions that Mia was vomiting up the good food) and cleaning. Shortly afterwards Mia also became particularly attached to Yasmin, a younger woman who, unlike Mia, was clearly suffering from her life experiences. Mia was empathic, supportive, and caring towards Yasmin. Mia was being "very, very good". But was this healthy?

Mia was hindering Yasmin's chances of recovery because through this relationship Yasmin was firmly placed in the role of the tragic one who couldn't be expected to take on too much—not least because she was additionally burdened with Mia's tragic self via projective identification. In addition, Mia was not helping herself because, through this process, she was disconnected from her own distress and unable to make use of the therapy available to work with this.

Yasmin had been a willing recruit into role as a part-object in Mia's psychic world, acting as a container for Mia's pain and vulnerability. Left in the role of the victim—the tragic one who couldn't be expected to take on the challenge of working towards her own recovery—Yasmin appeared to lack any inner resources and remained dependent and hopeless, not least because she had projected all her competency into Mia. But Yasmin was reluctant to challenge this by asserting her strengths because she was afraid of losing (a) the benefits of being relieved of responsibility for tackling her difficulties, and (b) the protection of a "special friend" if she did. In the persecutor–rescuer–victim triangle, a person in the *victim* position cannot tolerate his or her own hostility and anger and is unable to distinguish between destructive hostility and competent assertiveness, whereas a person in *rescuer* position can bear neither vulnerability nor hostility in him/herself. A *persecutor* is therefore sought who can be blamed for all hostility (Hughes & Pengelly, 1997, pp. 100–101).

Team members, not wishing to be identified in the role of persecutor, chose not to challenge this developing relationship between Mia and Yasmin (but were sufficiently concerned to bring it to supervision). On reflection it seems that Mia, Yasmin, and the staff had a collective vested interest in being seen as sweet, caring, and well-meaning, even if this also meant being rather ineffective—

a stereotypical image of women. No one wants to own the rage, and all are afraid of inciting it, so the destructiveness remains under wraps.

However, the other residents, who know that being good and helpless is not the true picture of a female addict, are in touch with the aggression disowned by Mia and Yasmin and express this in group sessions by being angry at Mia for not owning her problems and at Yasmin for appearing so helpless, not owning her strengths. This confrontation may well feel persecuting to Mia, and if she is not helped to understand and own her rage, it will become her excuse for leaving treatment, claiming that she is mistreated and misunderstood. In fact, Mia and Yasmin may leave treatment together, preferring to maintain their symbiotic co-dependency—a part-object relationship based on mutual projections—rather than face the pain of being separate, which would involve taking back and owning their own split-off parts.

If the staff and community remain afraid to raise these issues, then a temporary stalemate exists until it becomes increasingly difficult for Mia, as her anxiety level rises, to maintain this splitting. It is then that (like Sue) she becomes filled with self-loathing and rage until she finds some relief in the "blood-letting" of cutting herself, and if she succeeds in goading staff into discharging her, this experience reinforces her defensive belief that she cannot be helped and so change is not an option; she abandons treatment, seeking self-medication, in the form of illegal drugs, to numb her pain. Thus Mia becomes the persecutor, but the victim is her body. When she is bad, she is horrid. With reference to the work of Chasseguet-Smirgel (1985), Stern states that "an addict uses perverse mechanisms to obliterate psychic reality and psychic pain" (1996, p. 262).

In returning to drug use, Mia is at risk because she is desperate to take enough drugs to kill off both her long-standing pain and also the fresh pain of seeing herself as failing in life yet again. This can be thought of as Mia's murderous internal object masquerading as self-care, not least because Mia could unintentionally kill herself with an overdose—her tolerance having dropped during the time she has been drug-free. Assuming she overdoses and survives death but suffers a new devastating crisis as a result, Mia, temporarily in touch with a more integrated self—needy, destructive, and remorseful—has the capacity to request that she is taken back into treatment.

How are the staff to respond to such a request?

First, there might be general, often unconscious, relief when Mia and those like her leave treatment, and this adds emotional support to the rational argument that she has broken the rules, so they have no option but to refuse re-admission. They will argue, rightly, that boundaries are important and that staff cannot be seen to reward acting out. They will also assert, again rightly, that Mia was hindering Yasmin's treatment and that they have a duty of care to maintain a non-abusive treatment environment, otherwise it becomes unhealthy for all and therapeutic work becomes impossible. Residential treatment is an expensive resource, to be taken seriously and not abused.

But emphasis on procedures is no guarantee of reflection on the particular presenting problem or thought about the emotional state and needs of individual clients—in fact, "rules" can have the opposite effect.

> Children . . . who have no means of coping with their distress, evacuate them [*sic*] through their provocative behaviour, leaving their carers feeling devalued and abused. We can understand how easy it would be to react to these constant bombardments by, in turn, rejecting the child, threatening to end the placement, retaliating in ways that simply return the child's unwanted feelings back into him. (Emmanuel, 2008, p. 9)

It is not difficult to imagine how rejection would increase Mia's feelings of hopelessness and despair, lead to further self-destructive acting out, and make any future therapeutic work even harder.

However, there are likely to be splits in the staff group representative of the splits in Mia: between the part (represented above and identified with an internalized harsh father figure and masochistic mother) that considers her to be not only undeserving of help but deserving of punishment; the hopeless part (identified with her internalized helpless and ineffective mother figure), which considers her to be a lost cause (i.e. beyond help); and the part that believes she needs, deserves, and wants further help. Consequently

these opposing parts of the team are viewed by each other as either cruel, defeatist, or soft.

There is a real danger that the "cruel" and "defeatist" sub-groups manage to kill off or silence the "soft" sub-group in a re-enactment of the dynamics of Mia's internal world. But a staff team able to use supervision to reflect on the splits in their ranks can take back their projections into each other—the cruel, defeatist, and soft—recognize the ambivalence they all feel about Mia, and begin to understand her as they piece together their experiences. The "soft" group will argue that Mia needs a second chance and that the last thing staff should do is reject her when she is distressed. This argument rests on the belief that if Mia's request is rejected, the danger is that she will experience this as a repetition of her past traumas in relationships in which only her "false self" (Winnicott, 1960) was acceptable, and "being real"—expressing her rage, confusion, and self-hatred—led to rejection. The staff group as a whole can then try to take a true middle road. This is akin to locating the depressive position. When functioning in the depressive position, efforts to maximize the loving aspect of the ambivalent relationship with the damaged "whole object" are mobilized" (Hinshelwood, 1989, p. 138). This involves recognition that these apparently contradictory positions are all real parts of Mia, which need to be held in mind and linked with empathic understanding—that is, contained: "the containment of anxiety by an external object capable of understanding is a beginning of mental stability" (Hinshelwood, 1989, p. 246).

It then becomes possible for a plan to evolve whereby, for example, a member of the team, invested with authority from the others, agrees to keep in contact with Mia, sharing this understanding with her and working out a plan for her return to the treatment setting. This is not a "soft option". The possibility of returning is likely to depend on Mia conforming to boundaries set by the team. She will be expected to become drug-free, stay in touch by attending for testing to ensure that she is drug-free, and make use of counselling sessions provided as a bridge to her return.

I am proposing that this worker should be a woman, because people with histories of substance misuse, functioning in pre-oedipal mode, tend to think concretely—not symbolically (responding to others as part- not whole objects; as gender stereotypes,

not unique individuals, as is clear from Mia's story thus far). For women who have histories of inviting and receiving abuse from men, a dedicated female worker may be the only viable option at this stage. However, this is still teamwork as the assigned female worker needs support in order to be effective in her role of providing Mia with experience of effective maternal containment—a prerequisite for psychological development. If the male staff are seen to be supportive of this work, then Mia would have an experience of effective parental containment.

Through this process the workers provide a psychological presence able to hold in mind Mia's fragmented and previously split-off parts, contain her fear that to link her needy (maternal) and destructive (paternal) parts would be deadly, and survive her attacks on both the work and the worker by managing both the transference and the countertransference dynamics. This includes being sensitive to the likelihood that Mia will engage in further acting out if she feels overly exposed, shamed, and afraid (for guidance on how to manage shame in therapeutic relationships see Mollon, 2002). Of course, Mia's key worker, her staff team, and supervisor will not always get it right. Understanding Mia in all her complexity takes time, but if through this process Mia can learn to trust, believing that those working with her are genuinely committed to struggling with her, learning from her, understanding her, and holding her interests in mind, then she will have embarked on the path to recovery. Through empathic engagement with Mia's predicament, workers offer a new and valuable opportunity—the possibility of introjecting a bearable sense of herself as separate, whole, known, and understood—that is, the possibility of negotiating oedipal dynamics, locating within herself a more integrated ego, and embarking on the path to recovery.

On returning to treatment Mia naturally remains ambivalent. She swings constantly between the two views of herself as deserving or undeserving, fearful and courageous or despairing, and this again impacts on the staff, but through understanding gained by both parties and the increased trust between them Mia is able to successfully reach the end of her treatment programme. While it is widely understood that most addicts will relapse in the course of their treatment, even those who make good use of the therapeutic help available can deeply disappoint their workers by relapsing just

prior to discharge through fear of not succeeding in a drug-free life. If we can remain mindful of our clients' vulnerability at the point of discharge, we can support those clients who relapse and enable others to avoid this through individually designed discharge plans, a gradual transition, and the provision of aftercare.

Let us imagine that Mia fails to return to her treatment setting either because the staff team choose not to offer it as a possibility or because even when they do, Mia rejects the offer, choosing instead drugs and her old ways of mindlessly getting by. She is more needy and hopeless than before. Drugs will ease the pain, but she is also likely to find a man (whether previously known or not) into whom she can project her own violent, self-hating, and abusive parts and who will abuse and punish her, thereby repeating her mother's and her own experience, as if this is the only remaining solution. She may also find a "Yasmin" into whom she can project her vulnerability. She then becomes pregnant for the second time.

Mia believes that this pregnancy will somehow make her better. She finally has something good inside her and has the chance of giving birth to someone whom she thinks of as an extension of herself (a part-object) into whom she can project both her vulnerability and the ability to see her as lovable and good—another "Yasmin" who will love her. She attends the antenatal service, who are rightly concerned about the welfare of her baby, refer her to a drug-treatment service where she is allocated a specialist female who will see her through her pregnancy, and liaise with social services. Here the danger is that Mia repeats her pattern of being "good", and worker and client are hopeful that this time it will work. Mia becomes drug-free, sees that her man is not good for her, leaves him, is provided with her own accommodation, and begins to plan for her new life as a mother.

> Perverse women can also be mis-diagnosed since, unlike their male counterparts, they perpetrate on their own bodies, or on their body products, namely their children. When they act out with others, perhaps as prostitutes or in sadomasochistic relationships, they are often regarded as having made a conscious choice, or are looked on as victims, and the solution is frequently seen as removing the male leaving the perverse woman untreated. [Lloyd-Owen, 2007, p. 105]

On nearing the time when she will give birth, Mia becomes increasingly afraid that she does not have the necessary inner resources be a "good-enough" mother. So just before her baby is due, Mia returns to drug-taking—which, as we know from her life story, eases her self-doubts, her pain and torment. Suddenly, everyone becomes very concerned, and plans are put in place to remove Mia's child at birth, placing "her" in care. All are both relieved and deeply disappointed. Once again, good work has been destroyed, and a devastated Mia collapses on her drug worker, putting herself at her mercy. Again there is a split in the team. The "rules" state that Mia is no longer entitled to the services of her female worker because she has chosen to return to drugs and because her child is now in safe hands. But what is her worker to do with the painful and desperate feelings of bereavement and increased neediness that Mia has successfully communicated to her via more projective identification? The worker, unlike Mia, can cry about it, but she has no clear remit to maintain her relationship with Mia. It is only through exploring these feelings in the context of the team's work that it is possible for all to face the frightening possibility that if Mia is dropped by her worker, then she is most likely to do what she knows and repeat all the trauma by finding a man who will provide a shoulder to cry on as well as punishing and abusing her. Mia thinks she deserves this and further drug abuse will numb the pain, but, of course, she may well become pregnant again.

> There are people in whose lives the same reactions are perpetually being repeated uncorrected, to their detriment, or others who seem to be pursued by a relentless fate, though closer investigation teaches us that they are unwittingly bringing this fate on themselves. In such cases we attribute a "daemonic" character to the compulsion to repeat. [Freud, 1933a, pp. 106–107]

Deprivation × 4: Repetition through generations

Were Mia to succeed in keeping a baby, the neglect and its accompanying pathology would most likely be passed on to the next generation. Most addicted mothers are neglectful because the care and attention they provide is inconsistent; moreover, those who act

perversely towards their own bodies are at risk of being actively cruel and abusive to their children. The baby's needs, demands, and distress would awaken Mia's own unmet needs and her painful, unbearable memories. Mia hates these feelings and, projecting them into her baby, then punishes "her" for this and for facing Mia with her fear and inadequacy as a mother. Motz states that "Reactivation of traumatic memories can lead to violence towards an infant, and dissociation as a psychological defence against pain, can protect the violent mother from fully recognising her actions" (2008, p. 71[5]). She also stresses that this is happening unconsciously. Mia, we know, consciously wants to provide better parenting than she herself received, but, faced with the reality of a needy child and her own unmet needs, she fails to cope. Thus Mia's child grows up with "her" needs both unmet and punished and learns, like Mia, to hate this neediness and punish herself for it. Also, like Mia, this child may well be witness to domestic violence. A male child, though differently identified, would not fare well either.

One addict who killed her daughter has been presented to me over many years. While she is now aware of the danger to children who carry the projections of their mothers (as hers did), she holds on to the fantasy that her next baby will enable her to make reparation. But, of course, she is not allowed to keep any subsequent babies, so further pregnancies and the terrible repeated experiences of dashed hopes, loss, and deprivation continue.

Deprivation × 5: Repetition in societal responses

As a society we, too, appear to have "a compulsion to repeat" the same limited treatment models, seemingly unable, like Mia, to learn from our failures or take into account the enormous cost socially and financially of doing so. It is the idealization of motherhood that causes us to reject and punish women who don't conform.

The impact of parental substance misuse on their children varies depending on the degree of disturbance in the parents and their social and economic situations; however, it is a factor in the majority of child-care cases, and research indicates that the detrimental effects are chronic, not temporary (see Kroll & Taylor, 2003). The

services working jointly with Mia during her pregnancy recognize the risks of neglect and physical harm to children of addicted mothers and aim to provide a non-stigmatizing, coordinated response; however, this is not easy. Adult services and those for children have different remits, and mothers with histories of drug addiction, wanting to keep their children, are likely to distrust and conceal the truth about their drug use from child-care services. Additionally, women like Sue and Mia are (as I have shown) seductive and able to keep their perverse pathology hidden until their defences break down. Kroll and Taylor (2003) advocate the provision of family-focused multi-agency interventions as a way of overcoming these difficulties, but if this process ends with the removal of her children, the needs of the mother often remain unaddressed.

A new way forward

The Family Drug and Alcohol Court (FDAC), a recent initiative, is a pilot project that aims to address parental substance misuse and, where possible, keep families together through an intensive, holistic care programme delivered by a multidisciplinary team. An implicit aim is, no doubt, the saving of lives, time, and money. Clients have to choose to enter the tightly structured programme, but there is no requirement that they are drug-free as they will be helped to stabilize their drug use or work towards abstinence. The team consists of drug and alcohol treatment specialists, clinical nurses, social workers, child and adult psychiatrists, a family therapist, and judges. Additional support is available from parent mentors, ex-drug and alcohol abusers with experience of their children being taken into care, and through prompt linking with other community resources—housing, benefits, health, mental health, domestic violence, and nursery/schooling services where necessary.

Once the process has started, there are formal court hearings with the same judge and care team every 2–4 weeks until the final review. The whole process will take around 9–12 months but may be shorter, depending on the progress. It is a process of continuous assessment of needs, interventions, and progress in which some

clients are discharged and others discharge themselves, but the majority stay the course. (For detailed information including the interim outcomes of the evaluation research by Brunel University, see FDAC, 2011.)

Unsurprisingly, team members meet all the same transference and countertransference dynamics described earlier. The judge has a key role here in that he (the two current judges are both men) represents an authoritative, engaged, and caring father figure, something most long-term drug users have not experienced previously either in their families or in court hearings and something they do not expect to encounter. New experiences are challenging to people like Mia, who expect and provoke repetition of the old patterns of rejection and abuse; consequently much of the staff time is spent doing the important and essential work of struggling to maintain effective engagement and repairing breaks in this. Many of the clients relapse during the process, and it is a widely held view that relapse is part of recovery, enabling further work to recognize and understand the triggers leading into consideration of strategies for relapse prevention. The team will also continue to work with parents should their children be removed and, importantly, can, once their ego is insufficiently integrated, facilitate access to long-term support and psychotherapeutic help to promote increased self-awareness and self-management (personal communication, Steve Bambrough, General Manager). If Mia were offered and accepted by a service like FDAC and embarked on the process, she may well be one of those who drop out, but, alternatively, she might recognize something that was more appropriate to her needs and allow herself to be held by the team as she embarks on a different journey into new territory.

It is particularly difficult to do effective therapeutic work with someone like Mia, but she is one of many who are known to substance misuse, mental health, and child-care services. Essentially my argument is that we need multiagency cooperation and multidisciplinary teams supported by social policies that will enable staff to provide longer-term interventions, because if we fail (just like Mia) to recognize unmet need and if we respond inadequately to the entrenched perversion in the form of the violence that she, and other women like her, repeatedly inflict on themselves, then

we are complicit in perpetuating a very costly cycle of deprivation. Of course Mia, and the others like her, may be too damaged to see such a process through, but until workers in the field are supported by their agencies, through good supervision, to persevere in the struggle with these clients rather than discharge them prematurely, they, too, are left with feelings of guilt and failure.

In conclusion

What I am arguing is that we correct by this recognizing the particular needs of many female addicts through

- finding a way of thinking about the complex, perverse, and disturbing individual and interpersonal dynamics that clients, workers, policymakers, and society often prefer not to think about
- legitimizing and funding longer-term care in which staff will be supported in managing the enormous challenges posed by their female clients
- recognizing the need for psychoanalytically informed supervision to enable workers to process violent and complex projections and survive inevitable attack and rejection from clients without acting on their countertransference desires to retaliate with further rejection
- recognizing that many clients need to test to the limit the caring capacities of their workers before they can trust in them sufficiently to give up drugs and develop the capacity for more mature relationships
- believing in the value of this seeing this process through in the knowledge that no one is guaranteed a successful outcome.

Notes

1. See also the special issue of the *British Journal of Psychotherapy* (BJP, 2009).
2. See also Chasseguet-Smirgel, 1970.

3. Chodorow, 1978, ch. 7 ("Object relations and the female Oedipal configuration"), discusses the work of J. Chasseguet-Smirgel (1964) on feminine guilt.

4. Cited in Chodorow, 1978. Also quoted in chapter entitled "Early origins of envy and devaluation of women: Implications for sex-role stereotypes", in Lerner, Howell, & Bayes, 1981.

5. See also Motz, 2009.

CHAPTER SIX

Flying a kite: psychopathy as a defence against psychosis—observations on dual (and triple) diagnosis

Rob Hale & Rajeev Dhar

Rob Hale is a psychiatrist and psychoanalyst who works at the Portman Clinic. He has many years' experience of consulting to medium- and high-secure units. He was the medical member of the Buchanan Homicide Enquiry. This chapter, which emerged from clinical discussions with Raj Dhar, is based on these experiences.

Hale's chapter focuses on a type of patient who is typically given a triple diagnosis—schizophrenia, drug and/or alcohol addiction, and personality disorder. Hale suggests that it is more useful to consider these categories as a single entity. The underlying cause is a breakdown of the mother–infant relationship, followed by disruptions of care and often abuse. This leads to an underlying psychotic state from which there is no real progression and to which the person will always be vulnerable. In the people on whom Hale focuses here, the defences employed against this are psychopathy and drug and alcohol addiction.

Hale suggests that people like this turn early to drugs and alcohol as self-medication. He suggests that cannabis is the most dangerous. With continuous use and progression to a stronger form of the drug,