DANCING AMONG THE MAENADS

FROM MYTHOLOGY TO CASE HISTORY

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if he were possessed of some superhuman energy, and lethargy and withdrawal. More than likely his drug use enhanced this cycle. Nevertheless, towards the end of his life, Hendrix seemed increasingly more exhausted and withdrawn, as well as confused. For the first time in his life, he lacked energy on stage. His last recording from a concert at the Isle of Wight displays a despair and urgency that would be readily apparent to anyone who has worked with the deeply pathological. It is almost a cry for release from psychic bondage to his internalized bad objects.

Perhaps unconsciously, he did commit suicide—a last ditch attempt to destroy the bad objects trapped inside himself.

The Case of Elvis Presley

Elvis Aaron Presley was born to a poor white southern family. Elvis was the younger of a set of twins. His brother who preceded him by a few minutes was stillborn. Elvis' young parents were devastated by the loss of their first child and had not realized that there were two babies. Consequently, Elvis' normal birth was greeted with much happiness.

By most accounts Elvis was well cared for and perhaps even spoiled. Although his family was poor, Elvis' parents, especially his mother, indulged him. Elvis grew up as a polite and respectful child.

Because of the Presley's poverty, the family lived in close proximity and Elvis shared a bed with his parents until his teens. Elvis remained close to his parents throughout his life. According to Hammontree (1985),

> An often repeated part of the Elvis legend is his closeness to his parents. It is quite true that a strong bond existed among them. Vernon Presley stated after Elvis' death "It is hard to describe the feelings Elvis, his mother, and I had for each other. The three of us formed our own private world"...This closeness was a powerful influence in Elvis' life. (p. 7)

Elvis was also close to his extended family and surrounded himself with family and friends throughout his life. In fact, Elvis generally preferred to stay at home surrounded by a retinue of family and friends rather than going into the world outside. This pattern of having 'gatherings' at his home began when Elvis was a young man and continued until his death.

Elvis did not stand out as a teenager or a young man with the exception of his clothes and hair. Later on Elvis' clothes, hairstyle and use of makeup would lend him some flair and distinction. Rather than seeking popularity or isolation at school, Elvis had his own group of friends with whom he spent time. He had picked up the guitar a few years earlier and enjoyed playing and singing for his family and friends. Much of Elvis' interest in music can be traced to his family's involvement with a somewhat charismatic church sect in which strong emotions

would be experienced and expressed during the service. Music was an integral part of the church service. It is, therefore, not surprising to find that for Elvis, the expression of emotion was intimately related to music. Elvis eventually got a chance to make a record. Due in part to talent, luck, and the marketability of a white singer who could successfully imitate black music, Elvis began a meteoric rise to stardom.

Off-stage Elvis was shy and withdrawn. Once on stage, however, Elvis became possessed by the emotion of the music resulting in the gyrations that were to become his trademark. An interesting aspect of Elvis' musical career was his association with his manager Tom Parker. While Elvis was generally soft-spoken, generous, hard-working and respectful of those around him, Parker was “an obese, crude, cigar-smoking man" (Hammontree, 1985, p.15). It was reported that Parker hated music and musicians and was clearly in it only for the money. Elvis, on the other hand, was fairly indifferent to money matters and somewhat of a musical perfectionist, concerned primarily with putting on a good show for his fans.

Elvis connected with audiences in such a way as to guarantee that their interaction became almost a mystical experience of oneness. No doubt Elvis' ability to communicate and bond with his fans accounts for his tremendous popularity. It is said that Elvis lived to perform and that

audience contact recharged and invigorated him. It is strange, therefore, that for close to ten years, Elvis gave up live performances to make movies. From 1960 to 1970 Elvis made over 30 movies at an astonishing rate of 2-3 per year. At the end of this period Elvis returned to live performances, both in Las Vegas and on tour around the country (Cotten, 1985).

During the 1970's Elvis maintained his touring schedule. When he was not performing, he lived at Graceland with a large extended family made up of relations and a retinue of close friends. As Hammontree (1985) comments,

> Elvis' intense need to surround himself with the familiar ironically contributed a destructive element to his life: he was too much insulated from reality...leading a kind of fantasy existence without financial or household worries of any kind. (p. 28)

It is sometime during Elvis' “fantasy existence" that he began to use drugs. Although no exact date for the beginning of Elvis' drug use has been recorded it is possible to guess that his drug use probably became increasingly frequent throughout his career. Elvis had a paradoxical attitude towards drugs. He was strongly opposed to the use of illegal drugs. Yet, at the same time, he compulsively used a wide variety of prescription drugs which included amphetamines, tranquilizers, and steroids. Hammontree (1985) describes this split in Elvis' view of drugs,

> An irony was Elvis' intense opposition to recreational drugs, often called 'street' drugs...He thought the use of recreational drugs despicable. When his stepbrother Rick Stanley became a heroin addict, Elvis expressed anger and frustration at Stanley's use of the drug. Stanley considered it astonishing that Elvis would take him to task, force him to enter a drug rehabilitation center to detoxify, while Elvis was at the same time daily taking large doses of tranquilizers, pain-killing drugs, and stimulants...Elvis rationalized his chemical dependence as acceptable because his drugs were all prescription drugs. In his view, taking prescription drugs bore no relationship to drug addiction, (p. 90)

Elvis became very knowledgeable about the drugs he took and probably had a good intellectual understanding of the long-term side-effects of his drug use. Nevertheless, this intellectual knowledge did nothing to reduce Elvis' drug consumption, although it no doubt served to give Elvis the illusion of control of his habit.

Beginning in the 1970's, Elvis' health began to deteriorate. In addition to his physical weakening, Elvis also began to have less energy and to become emotionally detached. Although he was hospitalized a number of times, Elvis insisted on maintaining his exhausting touring schedule. It can be speculated that the worse Elvis felt, the more drugs he took to maintain his ability to perform. Finally, on the morning of August 16, 1977, Elvis' body and perhaps his mind, could no longer stand the strain.

Elvis demonstrated many characteristics common to compulsive

drug users. At first, it appears that Elvis' relatively stable family life and good relationship with his mother and father would contraindicate the development of a drug habit. Closer scrutiny, however, reveals that Elvis may have suffered early object trauma. A little known fact is that Elvis' father was arrested and jailed on a check forgery charge when Elvis was three years old (Cotten, 1985). Elvis' father was in prison for three years during a crucial period in Elvis' development. Given the fact that Elvis was already regarded as special by his mother and pampered almost beyond the means of his family's modest income, the loss of his father during his infancy resulted in a strong identification with his mother. Elvis' obvious latent homosexuality, evident from his use of makeup, clothes and intimacy with his closest male friends (whom Elvis kept around him at all times) are signs of his mother-identification. Elvis remained fixated at the separation-individuation stage of development. While Elvis was driven to succeed and try new adventures, he worked diligently to maintain a constant emotional environment in which he was nurtured and cared for in every way. Like a small child who wanders away from its mother for a moment, only to run back and make sure she is still there, Elvis would strike out on tour, make movies, travel to Hawaii and then turn back to his familiar environment for support. Elvis brought this familiar environment with him at all times. At first it consisted of his parents. Later, after the death of his mother, Elvis

surrounded himself with a retinue of male friends, family members and hanger-ons whose job it was to keep Elvis' emotional life stable and unchanging. Whether he was in Memphis, Hawaii, or Hollywood, Elvis was always in a situation which was controlled and stable.

The loss of his mother was an extreme blow to Elvis and it can be guessed that his drug use escalated after her death. Drugs came to play a role in the maintenance of a constant environment around Elvis in a more reliable way than his family and friends. The main advantage was that drugs (possibly along with musical performing) maintained Elvis' internal psychic environment, allowing Elvis to be in control of his affective states.

Elvis displayed primitive defenses such as splitting. His views on illegal and prescription drugs is a clear case as was his relationship with his manager Tom Parker. Elvis was also capable of demonstrating narcissistic rage, although he could not be deemed a true narcissist (Dodes, 1990). Elvis could very easily put himself into the position of the 'common man' and sought his approval. This attitude came out in his great effort to put on a good performance, even when it drove him to physical collapse. Elvis' concerts, and indeed much of his interaction with others often included the distribution of gifts. This gift distribution was reminiscent of Elvis' childhood which was marked by much gift-giving by

his mother (Cotten, 1985).

Elvis' mother-identification may have also been responsible for his popularity and the almost mystical experience of his concert presence. As a great all-powerful mother figure, Elvis could induce his fans to a religious-regressed state of infancy marked by hysterical ecstasy and a sense of identification with someone greater than oneself. This is the same feeling an infant has towards its mother which Elvis was able to recreate over and over again for his fans. Elvis' sexuality also seems to have had a peculiar tinge of motherliness to it, being more related to inclusion in his extended family than phallic-narcissist penetration as seen in so many other rock stars.

Elvis' life is truly fertile ground for the psychopathographer. Although many other aspects of Elvis' life would make for an interesting psychoanalytic exploration, this will be left for another essay. It is enough to comment that Elvis' compulsive drug use had its beginnings in his arrested object relations development and that Elvis' object relations dynamics are similar to those of other compulsive drug users.

Anaclitic Amphetamine-Using Women

This case example comes from an interesting paper by Lidz, Lidz and Rubenstein (1976). In this paper, the authors describe an anaclitic

syndrome related to drug use and other compensatory symptoms. Five case histories of female adolescent drug users are presented. These cases are fascinating both in the level of detail on the family histories of the young women and the striking similarities in the phenomenology of each case.

In order to outline and support the points of the present text, the cases will divided into two groups. The first group, consisting of three of the cases presented in the paper, will describe a basic, composite syndrome related to amphetamine use. Two other cases in the same study will demonstrate more unusual, extreme features of the syndrome. A brief summary of the family histories and the object relations constellations will be presented here. For a full reading of the cases the reader is directed to the original paper.

The cases of Oona L., Nancy C., and Helen L. will be presented as a composite. Indeed, the histories, symptoms and phenomenology of these cases are very similar, differing in only a few small details. Each of these patients were in early-to-middle adolescence when their histories were taken. All three young women were confirmed amphetamine abusers and had taken many other substances as well. Amphetamines, however, were the drug of choice for these patients who reported that the drug relieved feelings of depression and emptiness. These three patients also

presented what was characterized as borderline or slightly psychotic symptoms and were suicidal to varying degrees. A description of Oona L. will serve to give a flavor of the diagnosis of each of these three patients.

Oona, a 16 year old girl, had used a number of different drugs in large amounts, but had increasingly begun to rely on methedrine as her drug of choice. In addition to her use of drugs, Oona also had personality problems such as a tendency toward paranoia and fantasy life. Nevertheless, Oona was able to communicate well with others, capable of forming friendships, and seemed fairly intelligent. Oona was admitted to the hospital as an in-patient because of her increasing paranoid fears and suicidal tendencies. Lidz, Lidz, and Rubenstein's (1976) description of Oona could possibly be applied to all the girls in the study. She was characterized as 'waif-like', drawing other people to her through this demeanor. Both the clinical impression and psychological testing indicated fright, despair and suicidal tendencies. The psychological testing also gave an impression of schizophrenia, but this diagnosis was not confirmed.

The girls' parents were without exception disorganized. Their fathers were generally unavailable or somehow removed from the families. The fathers were also occasional drug users, sexually promiscuous, and in some cases seductive towards their daughters. All

the fathers presented elements of a narcissistic personality disorder. Nancy C.'s father is illustrative of the typical father of these patients. He appeared rather intimate and seductive towards Nancy, who reported that she had slept and took showers with him until the age of seven. At the time of her hospitalization Nancy's father would touch and kiss her quite a bit during his visits. Nancy had some degree of awareness of her father's pathology (as did her brother who was a heroin addict).

The mothers were also not generally available to their children on an affective level and likely to be depressed and needy. Oona L.'s mother was typical. She attempted to play the role of a loving mother, but was incapable of giving anything to her children. She was unable to set limits, often used the children as confidants, and was generally needy towards them. Oona's mother was also a 'heavy' user of tranquilizers. She had become depressed during her pregnancy with Oona and had remained in a depressed state for at least a year after Oona was born.

The mothers all had difficulty showing love or affection to their daughters, and setting limits for them. They often appeared unconcerned about their daughters' behavior with regard to drugs and sex. The mothers were often disorganized, hostile, promiscuous and used drugs themselves. All of the mothers had infantile characters and treated their daughters like a parent. The daughters were expected to take care of the

mothers, who took on dependent roles in relationship to their children.

When the patients entered puberty, or during latency, the fathers became even more emotionally removed, either due to remarriage, withdrawal of affectionate behavior, or through a general withdrawal from the family. During this time period the mothers became increasingly dependent upon the daughters. As soon as the patients entered into adolescence they became involved in sexualized relationships with males on whom they became intensely dependent. This excessive dependency generally caused the males to end the relationships. The end of these relationships marked the beginning of a period of serious drug use and sexual promiscuity. Due to heavy amphetamine use, the patients eventually decompensated to the point of acute psychiatric illness or attempted suicide, at which time they were hospitalized. Helen L.'s case is representative of this pattern.

Helen first began to use amphetamines at 14 because she thought she was overweight. Interestingly enough, her father had a hatred for fat people. It is likely that Helen's envy of thin, sleek girls was related to her father's attitudes. Helen developed an intensely dependent relationship with a boy a few years older than her. Not only did she gratify him sexually, but she sought to spend all her time with him as well. She demanded his attention, was possessive and overly jealous. This was

apparently too much for the boy and he broke off the relationship. The boyfriend worked as a bartender and

> ...was heavily into drugs. In order to go along with his crowd, Helen started snorting methedrine. She was soon hospitalized with a methedrine psychosis...At times, she was flagrantly promiscuous. Ever since her suicidal attempt she had a fear of sleeping alone, related to a dread of death. She continued to nave frequent suicidal urges, and believed that ultimately she would kill herself, (pp. 333-334)

The composite picture created from these cases shows a pathology of object relations development. It is extremely clear that object relations development in these three patients did not proceed normally and that this can be traced to an insufficient relationship of the infants with their parents. All the mothers were unavailable to their infants. The patients were unable to integrate or internalize the good aspects of their primary objects. The mothers were unable to modulate the transitional object phase of development for their daughters. As a result each patient suffered from anaclitic depression. Because these patients did not successfully resolve the transitional object phase, they remained somewhat in symbiosis with their mothers. Later in life, there was clear evidence of rather nebulous self-object boundaries. The fathers were not able to play their roles in facilitating the child's individuation from the mother. This later was evident in the weak triangulation (or oedipalization) of the parent-child relationships. During the original

oedipal stage of development, the fathers compensated for the lack of mothering. The patients, who were not strongly individuated from their mothers, became strongly attached to their fathers. The fathers did not play a normal oedipal role but instead were expected to fulfill anaclitic needs. Later, in adolescence, when oedipal conflicts were reactivated, the fathers were unavailable. Therefore, the patients sought out compensatory objects in the form of a boyfriend. The relationships with these boyfriends were only superficially oedipal in that the relationships were sexual and with males who were sometimes older than the patients. The compensatory nature of the relationships was soon revealed in the extreme dependency of the patients upon their boyfriends. The boyfriends almost certainly compensated for the father, who in turn compensated for the mother. Another way of conceptualizing the dynamics of these patients is to say that the oedipal conflict with the father was mixed up with the preoedipal anaclitic needs of the patients for mothering. These patients reported that having sex was less interesting to them than having someone who would hold them and be with them at night. For instance,

> Nancy, then began to sleep with men simply to be held and because of her fear of sleeping alone. She did not care who the man was, or whether she knew him or not. (p. 328)

Clearly the boyfriends were used to provide nurturing and

mothering. When the boyfriends ended the relationships, the patients sought out more reliable compensation and began to use drugs. Although some of the patients became sexually promiscuous at this time, this was a secondary compensation which probably served to keep the patients in a community of drug users. The drugs now became the true compensatory device. Drugs turned out to be superior to either boyfriend or father as compensatory objects. Unlike a boyfriend who cannot tolerate dependence, drugs foster this state in their users. Drugs also more closely represent the longed for maternal care in both its gratifying and frustrating aspects.

Although all five cases presented by Lidz, Lidz and Rubenstein share similar pathological phenomenology, two of the cases contain additional material which is of interest. These cases are those of Sarah A. and Gail T. While the family histories of these two patients are similar to the other three cases discussed above, they are different in that their fathers actually died. The death of the father led to a more profound pathology. This is evident from a brief description as in the case of Sarah A.

> Sarah A. entered the hospital at the age of 18 after having spent eight months in the counterculture, living in numerous pads, heavily involved with drugs, particularly intravenous methedrine, and sleeping with virtually any man who wanted her. She was the only member of the series [of cases] who was clearly a "speed freak". (pp. 329-330)

For Sarah A. the almost complete lack of a father caused her to seek greater compensation and then lapse into greater decompensation. This is apparent when Sarah A.'s first sexual relationship is examined,

> ...at 16 she became infatuated and sexually involved with a music teacher who was older than her parents, an intense experience that lasted for six months. When he dropped her, she felt abandoned but soon took up with a musician in his 30s, and started using "speed" with him.
>
> (p. 331)

Sarah A. had a relationship with a man who was old enough to be her father, while Gail T. had a relationship with an older male soon after her father's death. Both of these patients had sought gratification of their anaclitic needs from their fathers because the mothers had not been available. Therefore, the actual loss of the father was experienced as a preoedipal object loss. In these two cases the decompensation to a grave pathological condition seems to have occurred more quickly and with greater severity than in the other three cases. For instance, Gail T. subsequently attempted suicide on the anniversary of her father's death, which led to her hospitalization. Gail also used LSD along with amphetamines, which may have been related to a belated mourning process. Sarah A. appeared to show the most overt borderline characteristics of the group. She lived more 'on the edge' and seemed to require more stimulus in order to experience affect,

> She told of her life in a succession of pads, often with confirmed addicts, criminals, and drug dealers. She narrowly escaped death on several occasions, as when she stepped in front of a man just as another man, who she knew had previously committed murder, was about to shoot him. She found the exciting, dangerous existence pleasurable as it made her feel alive, (p. 331)

Although Sarah A. took up with confirmed criminals, put herself into extremely dangerous situations, and was generally impulsive, she also had another side to her personality,

> She was welcomed in various pads and communes because she was fun to be with when stimulated by drugs, and she was a good cook who was also willing to care for other people s children, (p. 331)

This suggests some level of splitting, which is not surprising given Sarah A.'s borderline characteristics.

The Successful Analysis of a Heroin Addict

Berthelsdorf (1976) describes in detail his analysis of a nineteen-year-old male college student who was addicted to heroin. The patient was seen for four years of analytic work, which ranged from 3 to 7 days per week. This case is interesting in that it was successful and is almost an ideal model of the use of classical psychoanalysis in the treatment of drug addiction.

The patient, Don, was referred to Berthelsdorf because of his

addiction. An initial *House-Tree-Person* test revealed object relations deficits with regard to the mother. Don's family history was somewhat scant. His family consisted of a father, mother and an elder sister. The family appeared to be intact and not disorganized. There was some indication, however, that Don's mother may have had drug use problems herself, and that she may have been emotionally distant.

Don's drug use started when his mother gave him a tranquilizer and showed him where they were kept. He immediately began using these drugs without telling anyone about it. Don soon began to sell drugs and built up a secret bank account from these endeavors. He eventually was arrested for selling drugs and was expelled from school. Nevertheless, Don studied at home and was able to earn a high school diploma and gain entrance into college. Don did quite well in college despite his drug use and was highly intelligent.

Don was at times markedly self-critical and would have outbursts of hostility towards others. Nevertheless, he did not appear disaffected and could express both sadness and rage during his treatment. His affect, however, was somewhat labile. Don's psychopathology clearly demonstrated both preoedipal object relations and oedipal lines of development. In an initial session he described a dream that gives an indication of both lines of conflict:

> In the first part he was with his father, who had his arm about Don, giving a sense of comfort and intimacy. In the second part, Don was buying some heroin from an untrustworthy drug pusher, and felt he was putting himself in the hands of a man who could betray him. That man indeed had recently sold Don some very poor-quality marijuana. (Berthelsdorf, 1976, p. 170)

This dream shows an oedipal conflict with an underlying anaclitic component. Berthelsdorf responded to the dream by commenting that Don needed a comforting, nurturing relationship with other people including his analyst, but that he feared the consequences of such a relationship. This interpretation was confirmed later when Don brought up a fantasy of performing oral sex on his analyst. Berthelsdorf's interpretation focused on the underlying meaning rather than the overt content of the fantasy. This deeper meaning was that the analyst was a nursing mother and that Don was a suckling infant, wanting the pleasurable feeling from the analyst that he had been receiving from the heroin. This interpretation proved to pivotal in deepening the analysis.

Don's anaclitic needs for nurturing were also accompanied by separation-individuation issues as well as problems in maintaining a sense of object constancy. Don also showed some signs of defensive splitting. For instance, he had a strong need to be with other people, but subsequently felt trapped by his relationships with them. Also, when Don was parting with an acquaintance, he would compulsively want to know when he would see the person again, even if it was someone he did not

like. Don also felt very strongly that his life with his drug-using friends was at odds with his life with his parents. It was as if "...he had to cope with two alien worlds, each to be denied the existence in the other" (p. 171).

Overall, Don's addiction can be understood as a result of his identification with his mother. This identification was originally carried out by Don taking his mother's drugs. Later, the drugs came to represent, or compensate for his mother. Clearly, Don's addictive pathology was due to a preoedipal problem. Fortunately, Don demonstrated a lack of impulsivity which gave him a reasonably good prognosis with classical psychoanalytic treatment.

Berthelsdorf's strategy in this case can be likened to a replacement of the drug by the analyst. In this strategy the analyst becomes a transitional object for the addicted patient. Compensating affects and the control of affect are slowly transferred to the analyst, and then even more slowly internalized by the patient. In Don's case, he became pacified after the initial hour, assuming all of his problems were solved, as if by magic. He also understood the analyst, however, as dangerous, threatening to upset the status quo. Don, therefore, sought out more comfort or pacification from Berthelsdorf during the analytic hour, while continuing to use drugs between therapy sessions.

Eventually, the process of analysis became extremely intense as the analyst took on more of the object role than the drug. Berthelsdorf began at this time to see Don seven days a week. The object relations characteristics of the analysis became more obvious, as Don regressed in therapy to a ravenous infant, feeding off the analyst. In this state Don was able to express anger at Berthelsdorf, while maintaining a feeling of security from his destructive urge to swallow the analyst.

It is interesting to note the oedipal conflict in Don's case. The oedipal situation provided a barometer of Don's development throughout his analysis. Don's relationships moved during his analysis from decidedly dyadic modes to more triangular ones. In the beginning of the analytic work, Don's oedipal conflict was presented more in terms of anaclitic needs, which were similar to those seen in the five cases of female amphetamine addicts described previously. As Don progressed, his conflicts became increasingly triangulated. For example, early in his analysis Don recalled his first sexual experience,

> Don had his first heterosexual experience as a freshman in college, after years of attempts and failures caused by the loss of erection. On this occasion he was staying overnight with a fellow and his girlfriend. He decided to go to the bathroom just as the two were finishing the act of intercourse and he was passing by their bed. He stopped, humbly asked the young man if "it" would be all right with him and the girl. They agreed and Don succeeded. Subsequently he was only occasionally concerned about his impotence, (p. 179)

This experience clearly shows Don's inability to resolve separation-individuation issues. Similar sexual experiences have also been reported by other compulsive drug using patients (Fine, 1972; Savitt, 1954). Don could not achieve potency under normal conditions, indicating a weak identification with the father. Don is unable to be a rival and win the woman/mother for himself, in essence to be on his own. Instead, he approaches a weak father-figure and "humbly" requests that his desires be gratified. There is no need to separate from the mother because the father-figure at this point is like the mother, magically taking care of the infant's needs. It is not surprising that Don was preoccupied about homosexuality, as his identification with a male father-figure was a thin screen for his symbiotic relationship to the mother. Compare the above scenario to a similar scene which occurred later in Don's analysis. He was visiting some friends, a couple and gave them some heroin. The women injected herself and went out of the room to have sex with her boyfriend. After they had left, Don gave himself an injection,

> ...I learned that he was at that moment reminded of his mother and father leaving for an evening, and of their giving him his "reward for bravery!"...The next thing he knew, his friend was giving him mouth-to-mouth respiration, and someone else was shaking and slapping him, talking to him to keep him awake. He was told he had stopped breathing...Over a year later a final fragment of this episode came to light; the girl had exposed her breasts to him when she gave herself the injection just before leaving the room; and he could hear them making love in the next room as he gave himself all the heroin he had left. (p. 181)

This description confirms the symbolism of the couple as representing father and mother. This time, however, Don was more on his own, more individuated. The father-figure this time did not magically fulfill Don's needs, but instead took the mother for himself. Don was in a more classical oedipal position in this situation. Although, the mother-figure was clearly present and available (with breasts exposed), Don could not possess her without conflict. The father-figure was now a potent rival unlike the previous scenario. This possibly engendered feelings of rage and guilt in Don. His response to these feelings was to take an overdose of heroin. This use of drugs was, therefore, both an attempt to possess the mother (through the incorporation of her substitute, heroin) and an attempt to control intolerable affect (guilt and rage).

Still later in the analysis the oedipal conflict became more central to the treatment as the analyst was seen more as the father in the transference. Berthelsdorf reports that this stage occurred after 360 hours of therapy. This stage of the analysis was characterized by the analyst being experienced more as a competitor or rival.

Eventually, Don was able to resolve his separation-individuation conflict, resulting in the ability to relinquish the use of drugs. It seems that Don was then able to work with his oedipal conflict to some degree

and achieve a healthy integration of appropriate parental objects into his personality.

Summary and Conclusions

These case histories of compulsive drug users point quite clearly to a pathology of object relations. Most of the compulsive drug users described in this chapter demonstrate defenses like splitting, omnipotent narcissism and other borderline-level defenses. Compulsive drug users can seem to lack object constancy and be highly self-critical. In most cases, the drug itself is used as a reactivated transitional object in an attempt to repair early object relations deficits. From the cases cited above, it seems as if these early object relations deficits can be traced to somewhat specific dynamics between the infant and its parents.

The mothers of compulsive drug users generally appear weak and depressed and have many unmet needs of their own. Their children are starved emotionally and the transitional object phase is not successfully negotiated. Yet, these mothers cling to their children with the hope that their offspring will somehow magically take care them and alleviate their pain. This effectively prevents the separation of the child from its mother. In Winnicott's terminology, these are not 'good enough mothers'.

Nevertheless, the blame does not entirely rest with the mother. In

many instances the mother's problems are caused or exacerbated by the fathers. These men are often physically or emotionally unavailable. When they are present, they are often narcissistic, expecting both mother and child to gratify their needs. The fathers, therefore, do not fulfill their role in helping their children separate from the mother. In some cases, the father takes over the mothering role for the child, but usually is emotionally distant or uses the role to get the child to gratify his narcissistic needs. As a result, the apparent oedipal conflicts seen among compulsive drug users often thinly veil earlier object relations conflicts. In other words, the child tries to resolve its object relations needs (caused by inadequate mothering) through a relationship with the father. When this fails, the child (or possibly by now young adult) may turn to other people or fetish-like objects to mediate their internal object relations conflicts.

Clearly, environmental influences come into play during this time. If the child is in an environment where the use of drugs is accepted or tolerated, they will be more likely to use drugs to compensate for their problems. From the review of the literature in Chapter Two, we know that most drug prevention efforts attempt to intervene at this point. Unfortunately, the personality problems underlying the compulsive use of drugs are already well-established. Even if the child were dissuaded from using drugs through educational or other preventive methods, it is

highly likely they would turn to some other destructive and compulsive behavior using fetish-like objects.

If the fetish-like object is a drug, a powerful, temporary defensive repair of the object relations deficits is effected following the cycle I outlined in Chapter Four. This drug use becomes compulsive as the physiological properties of the drug catalyzes the borderline-level defenses. This leaves the compulsive drug user to live out a disaffected, dysphoric and pathologically repetitive existence dominated by the good and bad aspects of the drug.

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