CHAPTER FIVE

The pleasure paradox: nirvana and death dependency

Scope

In the chapter on milk and creation myths I attempted to show that there is a dynamic fusion that unconsciously connects birth, destruction, and intoxication. I then tried to discern how we might understand this fusion in terms of craving and addictive appetites. In proposing a specific syndrome, based on the myth of Prometheus, I drew attention to the way in which the psychological intricacies of drug ingestion might be seen to bind together at the point where the creation of euphoric mental states hovers close to a repeating urge towards death. In this chapter I develop the idea further with a theory that I call the "pleasure paradox", where I try to show how the pleasurable effects of a mind-altering act such as drug ingestion might run a close parallel with its dangerous consequences. Although my focus is on substance abuse, I would say that the idea of the "pleasure paradox" might meaningfully be applied to other compulsive acts of self-harm, such as cutting, vomiting, overeating, gambling, and other addictions where indulgence or overindulgence in the pleasure from an act brings about potentially deleterious consequences. My thesis is that at the very nub of the pleasure

paradox there is a life and death struggle, a battle between Eros and Thanatos for the supremacy of the soul.

Attempts to modify compulsive behaviours fall short of addressing the submerged motivations towards self-destructivity. A deeply felt lack of pleasure or anhedonia is described by many addicts. Self-harming young people may also appear to experience life similarly, for instance describing boredom as a reason for cutting. The subsequent hedonistic search for pleasure, and even cutting can be pleasurable, appears to be an attempt to retreat from reality. Freud speculated that we were inclined to search for the blissful in-utero state that we once enjoyed, and that this urge was innate and universal. He called it the "nirvana principle", an escape to an earlier life stage where pleasure pre-dated consciousness. For some people, this search for nirvana can be occasional, for others it may become dangerously compelling, where ever more elaborate sado-masochistic behaviours aredeployed to bring about a desired state of bliss. In worst case scenarios, this urge towards pleasure might even be an attempt to vitalize a state of pleasure that has never really formed at all. The process of therapy is characterized by a shift from pleasure seeking to relationship seeking, where reality is embraced and not escaped.

Smoking kills

Several months into twice-weekly outpatient psychotherapy, one of my patients, a woman in her mid-twenties, told me she had given up smoking. The news initially passed me by, and it was only some months later that I thought about it. When I reflected on my lack of response, I wondered whether it was because she delivered the information in a rather matter-of-fact manner, as if it was not that important. I wondered whether my lack of response was a reflection of her complacency. But actually, I had no reason to assume she was complacent. It occurred to me that the news might have passed me by because I had more pressing concerns with her, with regard to that fact that she had, at least until lately, been fairly set on the idea that she was going to kill herself. After several months of twice-weekly psychotherapy, quitting smoking seemed less consequential than the fact that she was no longer feeling suicidal.

Of course hindsight is a great thing and, on reflection, I understood that there would be a link between smoking cessation and the

diminishment of her suicidal feelings. That is to say, smoking was a symptom of her self-destructiveness and suicidality, albeit that smoking was expressed as an act as pleasurable or soothing. Her decision to stop smoking was therefore part of a deeper psychological shift towards life affirmation. In her battle between the love of life or Eros, and the love of death or Thanatos, it appeared that Eros had gained the upper hand. We know that Thanatos can be outwitted: Hesiod tells the story of how King Sisyphus twice outwitted Thanatos and his twin brother Hypnos (sleep), when it was his time to die. So how was it that my patient had come to give up smoking?

What had I done to help, or indeed had I done anything at all? At first glance at least it seemed that apart from making a note in her initial assessment that she smoked, the topic had never featured in our work together. And given the fact that smoking was rarely if ever spoken about in any of our sessions, it is at least a possibility that *not* talking about her habit had somehow had a paradoxical effect. The idea of paradoxical injunction has well-known currency in therapy. In marital therapy where couples present with sexual problems the therapist may begin by suggesting that the couples cease any sexual relations. The authoritative embargo seems to have a speedy effect in some cases when the couple find the sexual prohibition excites their desire for intimacy: a reverse outcome if you like. So was there a paradoxical effect of not talking about smoking with my client?

I think probably not. Instead, we talked about a tangled weave of life trajectories, her absent father, and the divorce of her parents when she was a young teen, her jealousy of her father's new girlfriend, and then the discovery that for several years before the divorce her father had been involved in a string of affairs. It was difficult to know whether she was more furious with his deceit or whether it was her mother's complacency that she really despised. Although she survived the worst effects of this emotional upheaval with occasional bouts of feeling like killing herself during her adolescence and had settled into a good professional career after university, when her boyfriend broke off their relationship all the old feelings came flooding back. She became suicidal, was prescribed anti-depressants, and referred to psychotherapy. She did cease taking anti-depressants during therapy too; this was planned, and I do not think her use of anti-depressants was compulsive, as can be the case, but rather for my client they seemed more a symptom of her general practitioner's anxiety.

Of course there was no paradoxical injunction in the case of my client that brought about smoking cessation. For it to be a proper intervention I would have needed to tell her to continue smoking. Nonetheless, the fact remains that we had not talked about smoking. I was interested enough to audit my most recent case load, at the time of sixteen clients, all of whom had been referred to the NHS for outpatient psychotherapy. I noticed that out of fourteen smokers at the start of therapy the majority had actually quit smoking during the course of their therapy. It had rarely been an issue of any significance, so the question as to what did happen to change their self-destructiveness came into focus. In each case, like the case described above, therapy was an opportunity to explore relationships, past and present; to examine feelings and experiences in regard to family, friends, colleagues, peers, and so forth. And finally, therapy was an opportunity to explore "then and there feelings" in the "here and now", in a transitional relationship with their therapist.

In treating addicts of illicit substances I have come to understand that telling drug users "not to take drugs" is futile. Indeed, it may even have the opposite effect. The idea of a campaign which runs "Smoking kills" might unwittingly be the best advertising a tobacco company could ask for. "Smoking kills" appeals to the unconscious allure of death that might be at the core of the appetite to smoke. Talking to addicts about the dangers of drug use is ineffective, and may even *increase* the likelihood that some users will take drugs. We might do well to start from an axiom that drug users take drugs because they *are* dangerous. It is one of the problems with "health education", where the aim is to discourage drug use, which begins with a sort of aversion therapy approach.

The dangers of misguided health education messages was apparent in a 2006 advertising campaign in Scotland where a television advert was broadcast on several occasions during the early weeks of August. I was in Edinburgh for the festival and I surmised that the advert was meant to coincide with the festival, and was therefore targeting young people in their early twenties who might be tempted to take heroin. In the advert a man was shown seated on a chair inhaling smoke rising from a square of silver foil. When the man reclined in a state of intoxication, various objects in the room, including the television, video, music player, and so forth began to disappear. In the end the man was left seated in a rather sparse environment. The intended message seemed

clear enough: if you use drugs you will sell your belongings to pay for your habit. But given that at the beginning the flat looked messy and cluttered, by the time goods had disappeared the space began to look rather more habitable. Bad enough was the fact that the advert was instructive about how to smoke heroin—by showing us how to "chase the Dragon" (smoking heroin from the foil)—worse still was the suggestion that the clutter in your life could be dispersed by heroin. It was dangerously seductive, a sort of anti-kitsch ergonomic fashion statement on the creation of new urban living spaces. And to top it all off, the intoxicated repose of the user in the advert may have suggested a blissful sleepy state or Hypnos that might have appealed to people over-burdened by the strains of modernity. All in all, this was an expensive advert that may have done much more to sell heroin than to deter the market.

Perhaps we should begin by facing the possibility that engaging with drug users about the dangerousness of their drug use may appeal to their appetite for the alluring brinkmanship of life and death. This is Betty Joseph's (1982) thesis, that people can become addicted to death. She is less interested in their chosen compulsions which could be drugs, gambling, overeating, overwork, and so on, but rather she notes the common objective whereby death seems to have a certain allure. Nonetheless, we have seen an entire health industry and profession emerging over the last two decades which has predominantly been concerned with an aversion paradigm of approach that seeks to scare people away from drugs. Clearly it has not worked. There is a question as to whether we should be talking about drugs at all, either in prevention campaigns or in treatment.

The idea that we might not talk about drugs, as it was in the cases where I did not talk about smoking and yet smoking cessation was a clinical outcome, is at least a worthwhile hypothesis. Over the last thirty years, we have seen a drug treatment industry which seems intent on keeping the drug itself at the very centre of the conversation. I am thinking about the philosophy of harm-minimization programmes where dose stabilization and maintenance prescribing has been one of backbones of health education. I have lost count of the thousands of hours I have spent in micro negotiations with addicts about what their stabilization dose should be. It seems to me that the direction of harm minimization has been largely futile. With the ever continuing

escalation of drug use, we must conclude that the philosophy of health education has been massively ineffective in curbing the spread of the drug epidemic.

So what should we be talking about with our addicted clients? Drug users are only too keen to talk about their dangerous drug habit. Getting addicts to talk about anything else other than drugs, like feelings or relationships, is the challenge. The simple "not talking about" theorem of the smoking cure in my audited cases belies the more arduous task of contemplating the other things that need to be talked about. But herein lies the rub; how do you get addicts to talk about something else?

"Drug talk" is second only in popularity to talk about "stopping". The same might be said about talking about dieting for people who have compulsive food appetites, that is to say, much more time is spent talking about dieting than dieting itself. A good example of the addict talking about his habit is J. M. Barrie's (1928) collection of smoking stories in *My Lady Nicotine*. The book portrays the way in which the smoker savours his nicotine but also the minutiae of detail associated in discussing the habitual activities and paraphernalia of the committed smoker. Barrie illustrates how he and his friends especially like to talk about the "evils" of smoking, and how they should stop. But instead of stopping, talking about nicotine became a compulsive activity that fuels the urge to smoke rather than rescinding it.

Perhaps the difficulty of getting drug users to talk about feelings starts to account for the fact that many psychotherapists are reluctant to see drug users. It has always been something of an anathema that many psychotherapists, including those working in the NHS, have said that they will not see an addict until they have been "clean" for two years. In the space vacated by psychotherapists it appears that behaviour therapists have occasionally entered the fray. The work of behaviour therapy from the mid 1970s onwards has promised to offer quick and cheap solutions to a whole raft of mental health problems, including drug addiction. For instance, there have been experiments with "cue exposure" for addiction. Cue exposure has been found to be valuable in the treatment of some anxiety conditions and some phobias and compulsions too. For example, in the treatment of a spider phobia the therapist uses a technique of gradual "exposure" to the spider (the cue), firstly getting the patient to look at pictures of a spider before looking at real spiders in a jar for instance, and then after some

weeks of preparation the client will touch the spider and hereupon the client is cured. Having worked for some time on Isaac Marks's unit at the Bethlem and Maudsley hospital, I have seen this "cue exposure" method applied to all manner of obsessive and anxiety disorders from psychotic delusions to paedophilia.

The wide acclaim for the method of behaviour therapy in the 1970s and early 1980s lent impetus to a trial where a behavioural approach was applied to treating drug users. The experiment involved re-trying the cue exposure method, with a similar set of premises as the spider phobia programme. I was working on the inpatient drug dependency unit at the Bethlem Royal Hospital in 1981 where the programme was trialled. The programme was planned to run over six week and went like this: over the first two weeks the client was shown pictures of drugs and asked to rate levels of anxiety and excitation which were monitored and recorded by the research psychologist on each occasion before, during, and after the exposure. For example, the client was asked to look at a picture of drugs and asked to talk about feelings, and this was maintained until the anxiety and craving had diminished. These sessions were repeated with increasing exposure to the patient's drug of choice over weeks three and four, touching pictures and then actual assorted paraphernalia like spoons, needles, and so forth. The real drug (or a mimic powder) was finally introduced, with the patient looking and touching the drug.

The programme culminated in the research psychologist leaving the patient alone in the room with the drug. The aim was the hope that the simulation of a real-time exposure would mean that the client would not experience a level of urge to use, and would therefore be able to desist from taking the drug. The longer-term aim was that this would be good preparation for non laboratory conditions after discharge.

One of the first cue exposure subjects was Richard. Richard seemed much younger than his twenty years, prone to bad-tempered outbursts and even head-banging when things became difficult. He had a difficult time with the other residents on the unit and did not seem to be able to fit in with them at all. The fact that Richard had been mostly addicted to cough mixture did not endear himself with his peers who rather treated him as "not a real addict". When Richard volunteered to do the cue exposure programme, it was not clear to many of us that he had had much of a problem with heroin at all, despite his claims to the contrary. Nonetheless, he was recruited by the psychology research team and he

took to the cue exposure programme rather enthusiastically. Richard enjoyed his individual time with the psychologist; perhaps he was made to feel that engaging in an innovative new programme of therapy was going to be the answer to how best to treat drug users. The sessions gave Richard something to talk about in group sessions, as he fed back the detail of the exposure programme to other residents. The sessions with the psychologist ran to plan, step by step, pictures, paraphernalia, talking about craving, and so on. After the six week stepped programme came the session when Richard would be exposed to the drug, and be left in the lab on his own. Amid great anticipation, Richard soon returned to the ward with his face dappled in powder, grinning like a kid who had just dipped his head in a packet of sherbet.

In spite of our disappointment, not all seemed to have been lost, because while the cue exposure may have failed, Richard's act of delinquency met with a hearty degree of approval among his fellow patients. Possibly for the first time in his life, Richard seemed to experience some sense of what it was to be accepted as "one of us". I think I understood that there is one thing worse than being a member of an anti-group, and that not being a member of any group. The cue exposure programme continued for a short while afterwards, but soon died away. I am not sure it can be said to be entirely assigned to a place of embarrassing archival interest in the history of psychiatry, along with bloodletting and brain surgery, because some of these methods are prone to coming in and out of fashion. To be fair, further studies finally proved that the extra effort (and not inconsiderable expense) of cognitive behaviour therapy effected no more change than treatment as usual (Dawe et al., 1993). Perhaps more importantly, research did show that the craving levels achieved in the "laboratory" did not bear any resemblance to the craving that patients experienced when they left the inpatient unit (Powell et al., 1993). It was folly to promise too much in the first place and the experiments showed that progress might be best achieved via the elimination of hypotheses and misconceptions.

The pleasure paradox of addiction

If behavioural attempts to tackle addiction fall short then the alternative might be to develop approaches that can interrogate the deeper motivations of using. Herein, it seems to me that the alternative to a model of diversion or aversion therapy is one that starts by considering the allure

of the addiction in the first place. The will to pleasure in drug use is that which is compelling. But there appears to be a palpable tension inherent in misuse, whereby the peak experience of pleasure exists at a threshold of danger or risk. There appears to be a pleasure-pain dichotomy where the oppositional drives of life and death, connoted by Freud as Eros and Thanatos respectively, push and pull in different directions. I have listened to many conversations among groups of addicts, where the discussion has turned from sentimental reminiscences of old haunts and habits, to an almost obligatory contest as to who has been on the most dangerous binge, who has lost the most money, or who has endured the most horrific overdose, and so on. These life and death stories possess a kind of perverse exhibitionism, the bravado of courting danger.

When we consider these dangerous activities in the pursuit of sensual and psychic hedonism, we seem to be in the domain of human experience that is beyond the pleasure principle (Freud, 1920). That is to say, pleasure is not the endgame, rather it exists in relation to an urge to pain and even death. Death defying feats of ingestion, or the repetition of pain in self-puncturing with a needle; these are the moments where danger weaves with rapture. The prospect of a life-threatening disease or sudden death from overdosing on an adulterated intoxicant can seemingly be considered in the same orbit. It is the ecstatic feeling of intoxication that runs the user into the pathway of self-destructiveness and sometimes death. Giving up the urge to pleasure may be less challenging than alleviating the urge to danger and death. This is apparent in the habitual act of self-cutting. For some people, cutting becomes a way of alleviating tension and an array of feelings that are otherwise unwanted. Rage and anger in particular seem to feature in cases of cutting, where fury at another person can be controlled and honed into an act of self-cutting and bloodletting. Cutting can become highly compulsive, and clients can find it difficult to give it up, much in the same way that a drug addict finds it difficult to give up their drug of choice.

The worst consequences of the pleasure paradox are all too apparent. Spike was a heroin user in his late forties. He had been nicknamed by those who knew him because he had been injecting for so long. He had become the collapse between his signifier (his name) and his signified (his preoccupation with intravenous drugs). Spike was a symbolic equation; the needle was no longer external to him, rather he was the thing itself. Spike was reminiscent of Cocteau's (1930) sketches in *Opium* where the craving for opium was so strong that figures were morphed

into a plethora of opium pipes, with orifices and limbs resembling pipes. It was as if Cocteau could not see beyond his craving, and that such was the intensity of appetite for opium that he imagined himself as a body of pipes ready to smoke. In the same way, Spike's body seemed to be the consequence of craving, except for Spike it was not pipes but injecting wounds and infections that covered his body.

I worked with Spike for several months as an outpatient until he eventually gave in and gathered himself to come in for an admission to the inpatient unit. On the day of his admission I met him at the hospital reception. The inpatient unit was a five minute walk from the reception through the lovely grounds of the Bethlem Hospital. On the way back Spike was limping badly, and said he'd had pain in his leg for some days. Upon examination his leg was swollen like a balloon and the injecting site in his groin, one of the few remaining accessible veins, was badly infected, the size of a tennis ball and seeping puss like a mini volcano. An ambulance was called and Spike was taken off to Accident & Emergency forthwith, and a deep vein thrombosis was confirmed a few hours later. On return to the hospital, Spike seemed ebullient. He told us: "The doctor said that *one more* injection might have killed me."

To describe Spike's condition in terms of "self-harm" rather belies thesocial impact of his condition. Within hours of an initial contact with Spike, I worked out that the ripple effect of his condition had touched the lives of some twenty or so health staff: the hospital porter who had helped Spike limp to the unit, the two nurses who assessed him on arrival, the ambulance controller, the two ambulance staff, the Accident & Emergency receptionist, and other attending doctors and nurses that saw him. That was before he was admitted to a ward where another array of staff would have seen Spike. And all of this without taking into account the other patients and staff on the inpatient drug unit who had met Spike and seen him whisked off in no time, left with anxiety about his crisis. Over a period of one week from admission, Spike's affliction was vicariously, and not so subtly, inflicted on numerous others.

The notion of self-harm in this sense seems a poor explanation of the phenomena of the event. We might think of it rather as a sort of "butterfly-spike-effect", that is to say the more serious the act of self-harm, the greater the impact on others (a statistical "spike"). The butterfly-spike-effect conjures up an image of a sharp injection that at first appears to be surgically interior to the injector but in the consequences erupts into

a toxic entanglement that seeps outwards, as in the butterfly effect of chaos theory, where a butterfly flaps its wings in the east, a wind blows in the west. In envisaging the weeping damage from a needlestick wound we can contemplate the potential for the risk of infection from damaged skin, either by *skin popping* (subcutaneous injecting) or intravenous injecting. Drug users may use the same ever blunting needles and syringe several times, failing to clean the site before injecting takes place. Complications arising from non-aseptic injecting practice include: abscesses, allergic reactions, endocarditis, osteomyelitis, septicaemia, thrombophlebitis, and gangrene. These are often considered as private hazards, but more crucially, such self-damage is implicit to the risk of cross-infection through the process of sharing drugs and injecting equipment.

Death in Spike's case oozed from his very psychic and physical pores. The idea of a pleasurable ingestion of a drug in his case, like many others, collapses into an array of pain and hurt. We might say that there is *no such thing as an act of self-harm*. Instead, the harm always has consequences and impact on others. The idea of self-in-constant flow with others is not new of course. Winnicott tells us there is no such thing as baby; show me a baby, he says, and there will be a mother. There is empirical evidence that the self-harm of the drug user is not an isolated event, rather it is derived from a long-standing self-other system of harm. In a detailed doctoral study, Christine English (2011) has drawn attention to the fact that among her study cohort of thirty drug addicts, all the subjects had experienced some considerable level of violence and cruelty during childhood. English's findings indicate that, at least among her study cohort, drug use in adulthood is a recycling of prior experiences of hurt and harm in childhood.

Negotiating the terrain of pleasure through infancy to adulthood is a problem for most of us at some time or other in our lives. Many people develop occasional excessive appetites if not more elongated dependencies, to substances that have mind-altering potential such as tea, caffeine, cigarettes, alcohol, and chocolate. Taken to excess, indulgence in these pleasures of ingestion can have serious long-term consequences which may be life-threatening. Other people become "hooked" on different indulgences that may not cause immediate or long-term physical danger but can produce serious emotional difficulties. For instance, the pleasurable pursuit of gambling can become an all-consuming destructive pastime. Gamblers Anonymous offers a successful support network

following the same model of support as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). Other recreational pursuits such as fast cars, rock climbing, parachute jumping and more lately bungee jumping are notable as all having a high degree of social acceptance and a high degree of risk.

Some of these extreme activities stimulate the production of endorphins, the body's own natural opiates, and participants often refer to becoming addicted to experiencing the "buzz" of participation in extreme sports. *The Face* magazine in March 1997 had an article called "Climbing versus Clubbing" in which they invited a group of drug-taking club-goers and a group of climbers to swap activities for a weekend. The "chemical kick" of getting high in a club was compared to the adrenaline kick of literally getting geographically high, suggesting cognate psychobiological processes. However, one of the climbers said that the buzz from scaling a mountain was preferable to the chemical high because the climbing high could last for months whereas the high from taking a drug only felt "good for eight hours and then shitty for forty".

The relationship between legal acts of extreme pleasure-seeking and more dangerous compulsions sit along a "pleasure abuse continuum". At one end there are the more innocuous compulsions where harm is less or slower over a longer period, and at the other extreme there is addiction to powerfully volatile substances and mind-altering experiences that carry a greater immediate threat of dangerousness. In-between these poles there are a range of drug and non-drug pursuits, no less pathological, which might be considered with varying degrees of risk. The willing flirtation with dangerousness and self-destruction characterizes the drift from one end of the spectrum to the other. It is the nature of this envelopment in death at the far reach of the spectrum that is worth unpicking in order to extrapolate back to the other less immediate, though no less worrying, addictions such as smoking.

Freud's "nirvana principle" and dependency on death

Death is so indubitably bound up with drug addiction that it is idiosyncratically a fact of life for many users. My aim in this next section is to try to unfold the phenomenon of death's allure in drug addiction, tracing back concepts derived from Freud's (1920) model of the death instinct through to Fairbairn's (1930) idea of a "death impulse". Even though there are divergences in these models they each converge in practice

where there can be no avoiding the clinical reality of the dangerous drug user seemingly keeping death as a close companion.

Drug use offers an ideal mechanism for "splitting off" bad and negative feelings. That is to say, chemical intoxication brings about euphoric states that can hold unwanted feelings states at bay. In *Go Ask Alice*, the diary based on the real chronicles of a teenage drug user, we can see from one day to the next how the pharmaceutical intoxication creating a sense of "being on top of the world" can supersede the feelings of hopelessness and distress caused by the upheaval that the diarist is facing in moving house, changing schools, and so on, at a critical time in her adolescent life. The process of splitting off the bad feelings is an attempt to nullify all feelings and thoughts through the creation of a chemically induced pleasurable state of mind. This "retreat" from reality might be compared to a schizoid type mental state where the chemical state of mind becomes a defence against reality (Steiner, 1993). Intoxication as a state of unthinkingness, as a psychotic retreat from the social world, was something which appealed to both Rosenfeld and Bion in their work in the 1960s when they started to see drug users alongside their case loads of schizophrenics (which I discuss in more detail in chapter Six).

But one of the features of the psychotic retreat that we seem to overlook is the lurch towards death. More than any other psychiatric patient group, drug users exemplify Henri Rey's (1994) observation that clinical presentations are littered with images and identifications with death. Rey was describing the fact that so many of his clients seemed to bring dreams of graveyards, or dreams of people dying, to talk about in therapy. Part of the challenge in therapy is to help the addict de-identify from the allure of death. For example, Elaine was 41 years old when she was admitted for detoxification and rehabilitation. She had a twenty-year history of substance abuse and was admitted for inpatient treatment a few months after the deaths of her husband, who had died of a drug overdose, and her father, both within a few days of each other. She was isolated from her own family and the family of her husband too and, without any consideration to her feelings, both funerals were arranged on the same day. In the end Elaine went to the funeral of her husband.

Her admission for inpatient treatment coincided with the first anniversary of both deaths. As she withdrew from heroin the mental pain associated with the losses resurfaced with great force. Her use of

opiates had numbed not only her body but also her mind. Whereas she had been preoccupied with ingesting drugs, without the cushion of opiates she now found herself ruminating about dying in order to be reunited with her husband. She spoke about her and her husband's habit of frequenting graveyards when they were taking drugs; she said they had been "happy among the dead" and that they used to listen to "songs from the grave". And now she longed to be with her husband again. She seemed to literally "love him to death". She became suicidal and needed around the clock care and observation, which was delivered by staff and fellow residents (an innovation for the hospital at the time, and something which was ethically thorny, but very successful). As Elaine's feelings subsided she asked if she could visit the graves of both her husband and father and this was organized; and with the support of her key worker, Sarah Robson, Elaine took flowers to the graves and read words she had chosen beforehand. Over subsequent weeks the intensity of her suicidal feelings abated.

Elaine's over-identification with her dead husband and father was a fractured point in mourning which was manifest in a malady of self-homicidal urges. It was through a new synthesis of mourning, some guided by the staff, that she was able to begin the process of facing up to the losses and then working through them to the point of de-identification. The original mourning had been thwarted by the use of drugs at the time of the funerals and the period after. The sober revisiting of the graves during treatment seemed to act as a new location point from mourning and recovery. The mourning ritual needed to be repeated following detoxification when the impact of the loss could be more realistically emotionally encountered. In Elaine's case it seemed that the source of death's identification had been located and there was then a possibility that her unconscious urge towards self-homicide could be quelled. This was the beginning for a review of other losses in her life, the first stage of a rigorous inventory going back beyond the years of her drug use to the losses that appeared to be the prequel to addiction.

Rey (1994) argues that these types of dead objects are continually resurrected in imaginings and dreams in order that they can be subject to reparation. This repetitive act of living-death resurrection, as I described earlier, can be denoted as a specific object-relations syndrome deriving from the myth of Prometheus. A more general supposition about the phenomenon of identification with death might lead us to consider the way a drug invokes a sort of death-sleep. In addiction treatments, death

appears like a tangible object: dream images in individual and group psychotherapy, headstones, crosses, skulls, and so on represented in creative therapies, music that celebrates death, tattoos that depict death—in the next chapter we will hear about Lucy's skull tattoo called the Holey Ghost (sic)—and so on. Many patients carry jarring images of the corpses of fellow addicts and memories of overdoses. The spectre of fatal diseases such as HIV and hepatitis hover over addiction and impress further the threshold of life and death that characterizes chronic drug use. The milieu of an addictions unit is so infused with death sometimes that it often seems like an object floating in the very spaces between people. Elaine's case above suggests that the urge towards death needs to be faced, understood, and worked through.

Working in the shadow of death

The identification with death may also be resonant for staff who are drawn to work in the field. It always seems a noteworthy career choice to elect to work with drug users, especially as it stands out in terms of the number of young casualties that one is likely to encounter. Alison was in her early twenties when she started working on an inpatient drug dependency treatment unit. Not long after she had begun on the unit one of the staff team died unexpectedly. And then a few weeks later one of the inpatients died on the ward. While most of Alison's workmates attended the funeral of the colleague and then later the memorial service for the patient, Alison did not go to either, saying she wanted to deal with her grief in her own way. Over the next few months Alison increasingly struggled with her work. On night duty one time, Alison reported that she had felt so ill at ease that she had run past the room where the patient had died. In supervision she described feeling "bad vibes, chills, and superstitions". It was a bad time on the ward: one of the patients had reported seeing a ghost and there were whisperings about the room where the patient had died as being somehow jinxed. There was a general uncanny atmosphere hanging over the community, and Alison seemed most susceptible. In clinical supervision Alison explored her urge to run away from what she called the "haunted room". She said she had become aware that the recent deaths had reawakened her feelings about the death of her best friend who, at the age of nine had been knocked down and killed on the way to school. Alison said that she had not been allowed to go to the funeral. As Alison's supervisor,

I felt obliged to point out the parallel: as she had not been allowed to go to the funeral of her friend, she had not allowed herself to attend the funeral and memorial service of the colleague and the patient. She became furious with me and said it was "all sick, sick" and stormed out of the session.

A few months later, after a week's annual leave, Alison returned to work. In supervision she told me that she had visited the grave of her best friend while she was on holiday. She explained how there was a picture of her best friend (aged nine) waxed onto the headstone. Alison described the experience of visiting the grave had "brought things flooding back". We talked further about her friend. She said she had often imagined what would her friend be like, what job she would be doing, what height she would be, and so on. Alison seemed to have kept her friend growing up with her. I said it seemed that rather than bear the loss of the young friend it was as if she had kept her alive like a ghost. It was as if Alison had not been able to bury her friend. But the return to the grave, and the image of the friend waxed onto the headstone had jolted a new process of mourning. Over subsequent months Alison reported feeling relief from the previous anxieties she had felt at work. Not long afterwards Alison left the unit and went on to another field of mental health work. It was as if the repeating death of the friend could be laid to rest, and she could at last move on.

I think Alison's experience illuminates for us a ubiquitous dynamic that begs the question: how do we understand the nature of this type of compulsive or repeating identification with death? Freud's (1920) thesis in *Beyond the Pleasure Principle* was that the pursuit of finding pleasure in life was confounded by an innate tendency to repeat masochistic acts, that the will to pleasure was countered by a drive towards destruction. He made the bold and controversial assertion that this dual drive operated at the cusp of a biological imperative that influenced the mind and the action of the organism, and he described it as an instinctual drive which he called "the death instinct". Evidence for the death instinct, said Freud, had its basis in the molecular investigations of biologists at the time who had found that the life cycle of cells innately compelled them to return to inorganic status. Freud hypothesized that this cellular activity had a manifest impact on the total organism, leading to a psychic desire for quietude and removal of all tension to point zero, inertia, an overlay of experience at the meeting point of sleep and death. This was an apt poetical designation on Freud's part that evoked the last

reckoning of the romantic poets, like Keats and Shelley, who vividly described sleep and death conjoined in joyous union. In order to convey the strange euphoric dualism of life and death, Freud adopted the term "nirvana principle".

The idea of the nirvana principle was quickly developed by Barbara Low (1920), one of the founder members of the London Institute of Psychoanalysis, who published one of the first introductory books on psychoanalysis. Low (1920) used the idea of nirvana to depict the ordinary desire to return to an omnipotent state of bliss in infancy. But in adopting the term himself, Freud reloaded the concept with an altogether darker hue, alluding to the tension in Buddhist philosophy where the idea of nirvana can mean both a perfected meditative state of harmonious contemplation of the self with nature, but also complete annihilation. The term was apposite and true to the complexities of the organism's instinctive wish to reach a point of extinction, a final return to the inorganic (Freud, 1920, p. 50). If Freud had at first oscillated as to whether this principle might be more inclined towards the life-preserving forces of Eros, a few years later in his paper "The Economic Problem of Masochism" (1924) he finally posited the nirvana principle in the service of the death instinct. It is of note that Freud began the paper by suggesting that perplexities of masochism were such that they seemed instinctually to overhaul the ordinary search for pleasure in a manner which he compared to the effects of a drug:

> The existence of a masochistic trend in the instinctual life of human beings may justly be described as mysterious from the economic point of view. For if mental processes are governed by the pleasure principle in such a way that their first aim is the avoidance of unpleasure and the obtaining of pleasure, masochism is incomprehensible. If pain and unpleasure can not be simply warnings but actually aims, the pleasure is paralysed—it is as though the watchmen over our mental life were put out of action by a drug (Freud, 1924, p. 155).

It was the fact that even the most considered psychoanalytic endeavours were not reaching some of his patients who, quite beyond reason, continued their steady spiral of repetitious self-harm in spite of Freud's best efforts. Freud was drawn to postulate that there was a force of death, a primal masochism, patrolling the reservoir of the id. Freud surmised

that his new theory might be "incomprehensible" to his students but he nonetheless "pushed forward ever unsubdued" (1920, fn. p. 36). It was ultimately a depressing diagnosis in that he finally saw that mankind was destined to grapple with the instinct for death because as far as he could see there was no such thing as an instinct for perfection. Of course, the context of Freud's bleak prognosis needs to be located against the dark backdrop of the First World War where his anxieties about his two soldier sons were ever present. And perhaps more importantly, the theory of the death instinct emerged in the aftermath of the death of his beloved and precious daughter Sophie. But the context of the theory in this sense, albeit of terrible loss, does not undermine its voracity, rather we might say Freud grasps close the truth of human nature at an exceedingly dark hour.

Freud encountered death agitating his theories and all previous axioms were thrown into question in light of new thoughts on death. The theoretical path of the death instinct was uneasy, even for many of his most faithful followers. Though the idea for some was seen to be of useful clinical utility in adducing the biological and psychological exchange of organic entropy (Bernfeld & Feitlberg, 1931), for Fairbairn (1930) it did not sit so comfortably. Fairbairn offered a studious critical rebuttal of the death instinct theory, arguing that the instinct of animals in the wild was not so much driven by a death instinct to kill, rather the process of killing was for food and therefore death was an incidental consequence of a self-preservation drive for life. Fairbairn felt that the being of man was likewise driven by the need for sustenance and that all instincts were essentially expressions of life (1930, p. 122). Sadism was therefore not driven by a death instinct and nor was death the object of a sadistic aim (1930, p. 123). In considering the concept of cellular death, from which Freud began, Fairbairn preferred to follow Freud's own observation that tissue culture experiments had demonstrated that in favourable circumstances, a community of cells would assure tissue multiplication *ad infinitum*. Fairbairn argued that Freud was too much in the grip of his own theory of "auto-eroticism"—an account of the individual as inwardly folded with the pleasures of the world as self-derivative—to embrace any alternative notion that might be more object related.

Fairbairn felt that the death drive in essence was more like an impulse directed towards an external environment and that this impulse towards death was the result of experience rather than an innate drive.

He concluded that Freud's theory was fundamentally flawed because it was "derived not from psychology but biology" (1930, p. 127). Thus, Fairbairn postulated his own praxis: "Would it not be more natural to regard death impulses as instances of the instinct of aggression being deflected inwards from external objects to the ego than to regard aggressive impulses as instances of death instincts being deflected outwards from the ego to external objects?" (1930, p. 127).

Klein (1946) began by accepting Freud's given of the existence of the death instinct, arguing that the infant's death instinct was the source of inner anxiety that could be projected and become attached to external objects. The infant then believed that external objects would retaliate and thus the infant phantasized that it would be annihilated. Ostensibly, the maelstrom of primitive trauma Klein saw as populating the external world of objects around the infant were derived from the death instinct. She noted that the earliest objects were experienced as parts of the whole, such as the breast, the nipple, or the penis, which became the feared objects of death, if initially only through their absence. It was within this exchange between the mind of the infant and the sense of death in the outside world, that was formed the crux in which healthy maturation and growth needed to take place. Insofar as the mother internalized the unthinkable anxiety about death in the infant's instinctive mind, the mother offered a sense of protection and triumph of the life instinct. That is to say, as the infant externalized its fear and anxiety the mother contained the anxiety before returning it in a diluted and less frightening form. Thus the mother reassured the infant that the world was not going to end.

In Klein's model, the death instinct existed from the beginning and was therefore adumbrated by a process of parental containment. She followed Freud's idea that Eros triumphed over Thanatos but in describing the death instinct in terms of a fluid interchange between internal and external states, she arbitrated a bridge between Freud (too preoccupied with auto-eroticism) and Fairbairn who was mostly concerned with the externality of object relations.

Addicted to near life: shifting dependencies, from pleasure to persons

It is not uncommon when the addict seeks professional help in the first place that they deny that they need "people" to help them; they say all

they are looking for is a prescription, and an endless supply of their drug. The need or desire for interpersonal affiliation is denied. I have worked with many addicts as outpatients in preparation for inpatient treatment and the most common complaint is that they do not want to have to talk to anyone. Methadone maintenance programmes have been a key hinge in drug treatment services, debatably serving a function in enticing clients into treatment. We might say that the desire for a script somatically represents the exchange between the therapist and the addict. It may take months or years before the identified need for the drug is converted from its biological and chemical basis to its psychological substrate. From the perspective of examining the symbolism of the triangular relationship between the therapist, the addicted patient, and the drug, there are a some helpful reference points that offer a psychodynamic prolegomenon that would be useful reading for any student or practitioner (Abraham, 1927; Glover, 1932; Fenichel, 1945; Rosenfeld, 1960; Kohut, 1971; Wurmser, 1974; Limentani, 1986; Kaufman, 1991; Rosenfeld, 1992; Van Schoor, 1992; Hopper, 1995).

The shift from this chemical dependency to human dependency is characterized by increasing reliance either on a therapist or on a group of fellow patients in recovery. This is the case during the process of residential treatment in a therapeutic community, or in Narcotics Anonymous where the group becomes the key point of attachment. I will try to illustrate this process of shifting dependency with reference to a clinical case. Ahmed was a heroin addict in his early thirties. He was a reserved man whose manner tended to give the impression that he felt himself to be somehow superior. He had been treated in private clinics but with little success. On admission to an NHS inpatient unit he said he was not convinced that his residential treatment was a good use of his hard-pressed time. His withdrawal from heroin was probably no more difficult than usual, with a range of physical and psychological withdrawal symptoms: cramps, sleep deprivation, anxiety, sickness, appetite loss, and so on. It was, however, searing headaches that bothered Ahmed the most. Attempts to control the headaches using hot baths, tiger balm, massage and herbal teas, as well as support in therapy sessions, all proved unsuccessful in alleviating them. After five days of his ten-day methadone withdrawal Ahmed was on the verge of leaving the unit. As a last resort Ahmed was prescribed paracetamol. It was a rare event for paracetamol to be prescribed on the unit so it was subject to much discussion in the therapy groups for some days afterwards.

Ahmed took paracetamol on two separate occasions. His headaches lessened in intensity and he stayed to complete his withdrawal, and he embarked on a programme of intensive therapy and rehabilitation of up to six weeks.

After several weeks he had begun to settle well into the treatment programme. He progressed on to the pass system which enabled him to gradually increase the time he spent away from the unit on his own, starting with a few hours before moving on to longer passes week by week up to a day pass and finally weekend leave. On return from his first day pass Ahmed reported that he had been craving more than he had anticipated and admitted that having returned to "an old haunt" he had come close to using. His specimen result later confirmed that he had not used. He said he had refrained from using because at the point when he had been tempted he had been surprised by an image that had come quite unexpectedly into his mind. The image was this: he said he saw his key therapist "running down the corridor of the ward with two paracetamol in a beaker". Ahmed said that this image in his mind had given him the resolve not to use because he did not want to let his key worker down.

The image summoned up in Ahmed's mind may represent something of how a process of internalizing a human relationship can come to replace the allure of chemicals. Ahmed's key worker had indeed dispensed paracetamol to him, although she had certainly not "run down the corridor". We might say that the ordinary professional concern of the key worker, who was very experienced, had become a rather idealized item in Ahmed's mind; she had of course been mindful of Ahmed's urge to leave the unit prematurely but had taken this as usual in her stride. In Ahmed's mind he had turned this into a running delivery of his painkillers. Nonetheless, this imago of concern appeared strong enough to prevent him from using drugs, at least on this occasion. We might say that the key worker had come to represent something of a transitional person or object that mediated between Ahmed's drug hunger and his desire for what would appear to be a doting carer in his time of need. That is to say, in Ahmed's mind, there was *an inter-relationship between the objects of the beaker, the drugs, and the key therapist*. In the first place the objects were the hard pills which we might think of in terms of being autistic type objects (Rosenfeld, 1992), characterized by cold and inhuman sensual states, which were connected in his mind to the caring urgency of the key worker. The image was suggestive of the

bargaining that was going on in Ahmed's mind between his addicted self that believed that he could only be in a reliable relationship with a chemical and a new synthesis of self connected and receptive to human exchange. Having "split off" and denied the real significance of the care and support that he might receive from someone else (beginning with the staff and his key worker), his therapy was a process of discovering that relationships might be potentially life sustaining.

The way in which clients shift their attachment or dependency from drugs onto their therapist and peers during treatment might even be described as a default process in a good outcome in therapy. This default dynamic is not just limited to working with addicts, rather it is the basis of many interpersonal procedures of talking treatments in counselling, psychotherapy, and psychoanalysis. Balint (1968) described how a therapeutic relationship has the potential to engender an addiction-like dependency in the patient. We might say that in relation to patients who are trying to give up their compulsive behaviours, the intensity of their attachment to their obsessions is switched to their intensity of attachment to their therapist. In the first place the therapist is often perceived as an omnipotent and gratifying object, but then like a drug object that is craved the therapist is seen as depriving in their absence. The therapist needs to contemplate how to manage the initial establishment of the therapeutic alliance, which is paramount in laying the foundations for ongoing work, in regard to the intense attachment and dependency that may emerge. In light of the need for informed consent to treatment, the therapist should outline for the new patient the likelihood of an intense attachment occurring. In my experience I have yet to see a patient successfully complete a detoxification and an initial period of recovery without the emergence of an intense attachment. The attachment may emerge between a pair of patients, and while this is not always problematic, it has always seemed preferable that the attachment is directed towards a group of patients or a member of staff.

Building a rapport offers the patient a safe place to begin, a place to discuss feelings which have remained repressed, often for many years. This rapport, when set within consistent frames of time and place becomes a "potential space" within which the therapy may unfold (Winnicott, 1971). Thus, if a patient is frightened about physical withdrawal or craving drugs, but not yet able to put these fears into words, then the nonverbal or unconscious network of communication is imperative and the therapist needs to have some understanding of

these unconscious forms of communication. The therapist uses their own reaction to the patient as a tool for understanding how the patient might be feeling. The patient's primary projective processes, the externalization of feeling states that are not always modified by mature articulation, are considered as healthy and adaptive forms of communication in the early stages of treatment where the patient can not find the words to communicate how they are feeling (Sandler, 1988). The patient may also use concrete issues to convey their distress where psychic complaint can become somatized, as in Ahmed's case. Thus, early interventions during the withdrawal phase of treatment see the staff in a holding role which often has the air of a maternal engagement, making sure the patient eats and hydrates, even when their appetite is poor, offering comfort and reassurance and so forth when anxiety becomes unbearable. Dynamic or analytical approaches are often criticized for drawing attention to the interpersonal dependency needs of the patient but I think this criticism is misplaced because it is by recognizing and managing dependency needs that they can be worked through.

While it cannot be entirely dismissed that some therapists may indeed be seduced by the dependency of the patient, most psychodynamic counselling and psychotherapy trainings in the UK require therapists to be in therapy themselves as part of the training. One hopes that the narcissistic urges of the therapist, a need to be needed so to speak, have been addressed in personal therapy. It should be added that even in therapeutic approaches where the issue of the patient's relationship to the therapist is not focused on, this does not preclude that these therapists might have a pathological wish for their patient to be dependent on them. Indeed, a period of personal therapy and ongoing clinical supervision would be indicated for all professionals including nurses, psychiatrists, social workers, psychologists, and others, where there is an opportunity to have a training experience of tackling and understanding their own dependency needs. In my experience where there has been this experience there is less likelihood that these therapists will engender a pathological dependency among their patients.

The therapist's *acceptance* of the patient's need for a new experience of benign dependency is imperative if the patient is to replace their prior notion of malignant dependency which will have formed across many years, finally becoming embedded in the rituals of chemical dependency. The *fear* of interpersonal dependency is therefore encased in the patient's response to treatment, but it is also a preponderant anxiety

that undermines many psychiatric treatments. This anxiety emerged during the 1980s when there was a determined effort by government to dilute what was felt to be a "nanny" approach to welfare in the UK. Patients were encouraged to spend less time in hospital and become more inclined towards self-care and less reliant or dependent on professional. While some of this philosophy in psychiatric services may have been attuned towards a progressive agenda of deconstructing the unnecessary of ills of institutionalization for some psychiatric patients, the government agenda was largely determined by economic forces rather than coherent service configuration (Barham, 1992). Pedder (2010) has argued that the attempt to eradicate patient dependency was misguided, arguing it arose from a much wider Western cultural proclivity towards individualism. Pedder further suggested that the model of mature dependency in Eastern cultures like Japan might offer much that the West might learn from.

It is tricky to negotiate through the philosophic intricacies of dependency. But we might say that the starting point of recovery from addictions, compulsions, and other mental disorders for that matter, is not one of fostering dependency but rather one of *allowing* it to emerge as a treatment concomitant. This becomes a different model to the outmoded idea of "regression therapy" which was practised more widely in the 1960s and 1970s (though some remnants of the approach still exist in some schools of psychotherapy), where the patient was encouraged to return to earlier developmental stages where trauma might have first occurred. The idea of allowing issues of dependency to occur of their own volition is a very different frame within which to approach the concept of dependency. The dynamics of shifting malign dependencies and the emergence of a new synthesis of benign dependency exists in the fulcrum of the interpersonal relationship between the therapist and the patient. It has been suggested that there is a valid role of the "therapist as friend" in addiction programmes that can be cast in terms of a modified aspect of "transference" (Strang, 1982).

However, while a "positive transference" (Freud, 1912) may be the basis of establishing a milieu conducive to treatment, I have mostly found it is in the working through of the negative transference where the most therapeutic purchase can be located. It is where the therapist is seen *more like a fiend than a friend* where the gains are truly made. We might say that the preferred positive transference is that which has been earned through overcoming the negative transference, so to speak. The

negative transference does not have to be forced to exist; it is enough that the therapist is alert and attuned to the possibility of the patient's negative emotional states and these will, sure enough, be forthcoming. Most substance misusers struggle to deal with negative emotional states, feelings of sadness, loss, and separation and these feeling have been shown to be those which are most likely to be the cause of a relapse following sobriety (Marlatt & Gordon, 1985). The process of therapy therefore involves a rehabilitation in the experience of being with these negative emotional states without the nullifying prop of chemical support. Events that involve facing sadness and loss are opportunities for therapeutic encounters: real life in small doses, so to speak. It is inevitable that during the course of treatment these negative emotional states, communicated somatically in the first place perhaps, as was the case with Ahmed, are eventually raised to the level of interpersonal exploratory therapy. Bad and unwanted aspects of the self may be contained either by the individual therapist or the group (or both in treatment centres that offer a combined treatment approach of group and individual therapy) before being re-integrated by a patient in a way that exerts less disturbance.