HEROIN ADDICTION

FROM A PROCESS-ORIENTED PSYCHOLOGICAL VIEWPOINT

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by

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Abstract

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This study sought to determine what the process of heroin addiction means to the individual. Particularly three aspects of the problem were researched: 1) whether using heroin serves a purpose and has an intrapsychic function for the individual; 2) whether, when the pattern behind the state sought is discovered and its contents are integrated, the use of heroin becomes unnecessary; 3) if reaccessing the drug state is a useful method for finding out more about the state which the drug abuser is seeking when he takes heroin.

Two individuals (one man and one woman) were studied with the aim of analyzing their process structures and the process behind the former heroin addiction. One of them now has an alcohol problem.

The results show 1) that using heroin elicited an altered state in which there was a temporary identification with an inner critical dream figure; in both cases this figure was related to the negative father complex. Being ''high'' for these subjects was equivalent to a state where they felt themselves to have qualities (being unemotional, distanced, etc.) which were otherwise missing and for which lack they were under constant attack from the inner figure. It was also illustrated 2) that one can find the pattern for helping the individual work through and integrate the negative figure in their subjective experience of what heroin does for them. Acting out the critical figure in taking heroin had not brought these subjects to the state which they were seeking. After treatment, this study found that to the extent to which the subjects had integrated into their lives, in a positive way, the inner capacities represented by the father figure, need for heroin had greatly diminished (both were drug-free, although one was found to be repressing strong cravings). There were indications 3) that reaccessing is useful in finding out information about the state sought when taking heroin. With only one of the cases was it possible to reaccess the drug state. The researcher was able to access (without drugs) an altered state very similar to the heroin state; in this way the background pattern became clear.

Dedication

I wish to dedicate this work to Sarah and Bob, who I think are two very courageous people. I wish to thank them for being so open and for allowing me to take such a careful look at them.

I also wish to dedicate this work to Teta Larsson, my friend, who had the capacity to be loving and supportive, while also being demanding; qualities I badly needed in a friend in the writing of this dissertation.

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CHAPTER 1

Introduction to the Problem

Background

The desire to write on the subject of heroin addiction grew out of a sense of strong personal engagement in and a high degree of frustration and dissatisfaction with the work which the author and her colleagues did during 2 1/2 years of involvement in a heroin rehabilitation clinic in Switzerland. The feeling of helplessness and lack of knowledge often pervaded the staff when dealing with patients. In many cases the author felt that the patients' problems were not handled adequately; in fact, in some cases she felt that the strategy was wrong, to the extent that some patients were hindered rather than helped. The author felt little effort was given to thinking about and planning which specific interventions would be proper for a specific patient; rather, the main intervention of the clinic, as in many other therapeutic communities treating addicts, confrontation, was usually used without much reflection. In this dissertation the author will stress that there is no one general treatment for addicts, but that for every individual - depending on his or her process - a specific therapy needs to be created.

Statement of the Problem

The word addiction comes from the Latin ''ad dicere,'' meaning to give oneself up or over. The definition of addiction creating drugs used by the World Health Organization (WHO) contains the following points:

1) any drug which creates an over-proportioned desire for the drug in an individual;
2) any drug which, with repeated use, needs a higher dose;
3) any drug in which there is a psychic or physical dependence on the way the drug works (such as the feeling experienced when taken);
4) any drug which creates withdrawal symptoms when the drug is no longer used (Weitbrecht, 1979).

In discussions with many individuals working in therapeutic communities in America (8th World Conference on Therapeutic Communities, Rome, September, 1984) the author found that the main concern of these therapeutic communities was no longer heroin addiction; the problem drugs at that time were phencyclidin (Angel Dust) and cocaine. The drug seems to change, while the problem of addiction remains. In Switzerland, the drug of ''choice'' is heroin, with growing use of cocaine. Phencyclidin, for example, is relatively unknown. One could speculate that a) on a sociological level the popularity of various drugs in these two countries is due to cultural differences; b) psychologically the main problem under discussion concerns the personality structure of the addict or the phenomenon of ''addiction'' and the compulsive use of any drug; or c) that there is a meaning behind the compulsive use of drugs for each individual, driving him into addiction. The last of these questions is presently of most interest to the author and will be focused upon in this dissertation.

An application of process-oriented psychotherapeutic methods for dealing with addiction problems will be presented here, with heroin addiction the main focus drug. The basic philosophy applies to many different addictions, as can be seen in the study of the second session with Bob, one of the cases presented here.

The problem of addiction remains unsolved. The world-wide average success rate for therapeutic communities is only about 30%, which the author thinks is very low, considering the amount of time and money involved. Switzerland, especially its cities, is experiencing fast growth in the rate of drug addiction among adolescents and young adults (16-24 years). The Canton of Zurich (Switzerland) is renovating and adding on to its prison; one of the additions is a new wing, especially for addicts. At the same time, available therapy centers remain underpopulated.

The literature about drug addiction portrays an amazing array of differing attitudes, theories and treatment methods. It is difficult to know how effective interventions are because good treatment-outcome research is rarely done for any program. In this field one also finds much discussion of how to define ''successful'' treatment. Sometimes a therapy is considered to be a success when the client ceases to use the target drug. For instance, in certain evaluations, the therapeutic goal is considered to have been attained if the client is off heroin; he is considered ''clean'' even if he continues to use alcohol and/or hashish. In other therapies very strict rules of evaluation apply - the further use of alcohol or hashish would negate the success.

Assumption and Objectives

In this dissertation heroin addiction will be discussed from a process-oriented viewpoint. Process-oriented psychology is not simply one more method of treating people, but rather also an attitude: the individual's problem is seen as something meaningful and a carrier of information which the person needs. Out of this attitude the specific method is developed which can best help the person in the discovery and integration of his process. At this moment the reader might exclaim, ''What, shooting heroin is meaningful?'' To that, a process worker would answer, ''Yes, for some people at certain times in their lives, shooting heroin serves a purpose for them.'' Since it also has destructive effects, the assumption of process work is that the meaningful content is not being expressed fully in drug-taking and needs help in unfolding itself completely. The expectation, based on experience, is that this content will then prove to be something highly valuable and constructive, indeed, just what the addict needs in order to live a drug free life.

The purpose of this dissertation is to add to the general fund of knowledge about why people become addicted to heroin and to suggest another possible way of to helping them deal with the addiction. Why people become addicted to heroin, or other drugs, will be treated finalistically in this dissertation, a viewpoint which tends not to be treated elsewhere in the literature.

This study is exploratory in nature, since not enough data have yet been gathered to present a statistical study. At this stage in the research, the process-oriented viewpoint toward addiction can be seen as a useful method for finding out more about addictions. With added study and research, the author hopes to present these methods as a new therapeutic technique for treating addiction.

Working Hypotheses

First working hypothesis: Heroin serves a purpose and has an intrapsychic function for the individuals taking it. They temporarily find themselves in a state in which they feel they obtain qualities (such as: being unemotional, being distanced) otherwise missing. The drug protects them by warding off dysphoric feelings (their normal everyday feeling about themselves: feeling weak, incompetent, too emotional), caused by constant attacks from inner negative dream figures. Instead of being the victim of these attacks, they become identified with the attacker.

Second working hypothesis: By taking drugs, the individual tries to get into a certain state, which does not quite happen, but nearly, so he takes the drug again, thinking: this time it will work. Because the state cannot come to its conclusion, this behavior perseverates in the form of an addiction. By discovering the background pattern, its information content becomes clear. This information is unconsciously being sought when using heroin, which in itself contains only the raw, primitive form of the complete pattern. If this pattern is not processed (brought to consciousness and integrated), it remains autonomous - not under the individual's control - and will continuously repeat itself. It can take different forms, such as, switching the addiction to another drug or repression of the drug taking behavior with a continuing fascination for the drug, resisting which uses up much of the individual's energy.

Third working hypothesis: Reaccessing the drug state is a useful method for treating drug addiction. Reaccessing is done by using process-oriented techniques to help the client into and through the drug state, in other words, to complete the process which is trying to happen in the use of drugs. Reaccessing also indicates that the effects of drugs are not purely a chemical phenomenon.

Nature of the Study

Two cases of heroin-addicted individuals will be studied in detail, including: Anamnesis of the personal situation and drug addiction; childhood dream; sensory-grounded information; analysis of a video-taped therapeutic session from the clinic stay; and analysis of a video-taped therapeutic session taken 2 to 3 years after the first video. Finally an analysis of the process structure of each case will be presented, with the purpose of connecting the above-mentioned process elements into a coherent picture of each individual's process. Both clients are now free of the heroin addiction. One (Bob) has an alcohol problem, the other (Sarah) is drug free, using alcohol only occasionally.

Scope and Limitations

The two individuals' processes and the background meaning of their addictions will be brought to light. In the case of Bob, the changing of addiction will be illustrated and possible reasons why this change took place will be given. This is interesting because a large number of ''growing-out'' cases, in which heroin addicts change their main addiction to alcohol around the age of 30, have been reported in the literature. In contrast, Sarah's addiction problem seems to be overcome (she has been ''clean'' for three years).

As a study of process-oriented psychology, the first set of videos are not especially good examples. The author was inexperienced, and sometimes because of conflicts with the outer clinic setting it was impossible to do process work as the author thought it should be done. Many possible mistakes that a thera pist can make, and a description of more useful interventions, will be presented.

The second set of videos, while no longer in the same setting as the first, enables the study to be expanded to include a study of long-term processes. The limitations presented by the clinic are also excluded. The author is more experienced and has had time to reach a new understanding of how to work with addiction processes. The process work is more fluid in these videos and the reaccessing of the drug state is illustrated.

The two individuals studied here were not typical of the general population which the author treated in the clinic. They both came from middle-class families while generally, patients treated in the clinic were from working-class families. They were chosen because, out of the 9 video-taped sessions the author originally made, they were the only clients the author could contact and who agreed to having a further therapeutic session.

Procedure

The following is an exploratory study of two individuals who were addicted to heroin, among other drugs. This dissertation consists of four main sections:

1) a description of process-oriented psychology
2) a review of the relevant literature
3) a study of cases
4) a conclusion.

CHAPTER 2

Process-oriented Psychology

In this section a brief overview of the basic philosophy and main concepts of process-oriented psychology will be presented. This section is written to enable the reader to understand the case work section. There are other, more detailed works available for a deeper understanding of process-oriented psychology (Mindell, 1982, 1985a, 1985b and 1987 and Goodbread, 1987).

Process-oriented psychology is the formal name given to the methods and theory which Dr. A.P. Mindell originally developed to work with physical symptoms and psychological processes as two mutually interdependent aspects of the system which he called ''the dreambody'', a ''term for the total, multi-channeled personality'' (Mindell, 1985a p. 39). It is also known as dreambodywork or simply, process work. Over the years the concepts have been extended into a wide spectrum of psychological fields, including psychiatry, interpersonal relationship (couple, family, group) processes, and work with critical illness. Process work is more than just another psychotherapy:

> It is a methodological approach to observing the complex and subtle interactions of perception and behavior in human beings in a manner which makes the results of that observation directly accessible to those people being observed. Experience has shown that this process has therapeutic effects; connecting people to parts of themselves of which they are unaware tends to make those parts less problematical (Goodbread, 1987).

A process-oriented psychologist works from the standpoint of what Zen Buddhism calls ''beginner's mind''; he approaches the client with no set goals as to what should be happening. His fundamental law is that what is happening is right in some sense and should be encouraged to happen in a way that will unfold its meaning. If it looks wrong, then the content and pattern are not sufficiently understood. What this means is that the individual or group is experiencing something, or has a symptom, which has meaning and purpose; it only seems confusing or dysfunctional because the reason for its existence is not perceived. This is a viewpoint such as C.G. Jung (CW, vol.8) described, in which symptoms have a finalistic function compensating a one-sided conscious attitude. For him wholeness was implicit in the psyche. Therefore, if the ego excluded certain tendencies, they would appear from the unconscious in the form of symptoms.

The therapist needs a great deal of skill in order to do process work. He must be able to observe his client accurately until the elements of the process, both those more and less conscious, and their interaction with each other become clear. In this way the manifestations of the client's process and their meaning become apparent. The therapist must be able to tolerate a good deal of seeming chaos until he can help the client come to a resolution of the conflict between these two parts. Through accurate observation the therapist develops the kind of therapy which is most useful to the client. Process-oriented psychology often looks like other psychotherapies; in fact, elements of many other forms of therapy have been incorporated into process work. The difference is that a process-oriented psychologist studies and follows nature, while normally a psychotherapist has a particular method which he uses. A basic principle of process-oriented psychology is that the individual's process knows what is best for him; that if one observes accurately and with a high degree of awareness, the process will guide what wants to happen next.

What is it exactly that the process worker observes? He observes 1) the client - what his presenting problem is, what he says (content) or does not say, how he says it, his body position, movements and facial expression, and 2) himself - his posture and movements and his inward and outward reactions to what the client is saying and doing.

Usually we limit our focus and attention to listening to the content of what people say. In process work, one not only listens to the content but also focuses on the overall process: tone of voice, facial expression, position of limbs, physical motion and its tempo. The process worker is also aware of his own signals plus any inner body sensations he may have in reaction to what the client presents. He is also aware of the position and distance between himself and the client. Then he notices if what the client says (content) fits or is congruent with the rest of his process. Congruence can be explained with a simple example. Suppose a client is talking about her dissertation and saying how excited about it she is. If her speech is rapid, she is leaning slightly forward and is perhaps gesturing with her hands, one could say the content is congruent with the rest of what she is doing. If she is leaning back, speaking in a slow and monotonous voice and talking about her excitement, she is not congruent. She may be tired, or not feeling like talking, or even lying. She is sending out two different signals: a double signal. Her primary process - that with which she identifies herself, in this case being excited about her dissertation - is at odds with her secondary process - the ''not-I,'' that which happens to her and which she cannot control, in this case the slow and monotone voice and slack posture. This lack of congruency shows that she is in some kind of conflict, of which she might not even be aware, and is giving off signals which represent both sides of the conflict.

If this situation comes up in an analytical hour, the process worker now has the information that there is a conflict around, because the client is incongruent. Now what does he do? He has many possibilities and only a few basic ones will be discussed here (for more detail see Goodbread, 1987). Because he believes that what is happening with the client contains more wisdom than any notion of his own, the process-oriented therapist will not apply some preconceived method to make the client behave the

way the therapist thinks the client ought to behave. Also he will not give an interpretation of the client's behavior, at least not until he has some idea of where the process is tending, at which point he may interpret the process to the client in the process's own terms.

What he will do is to use his curiosity about human behavior and try to find out why his client is acting the way she does, what is behind the incongruency and what is the meaning of the client's split. His only goal is to help the client come into contact with those parts of herself of which she is unaware and help her to make some kind of relationship to them, so that their meaning becomes clear and perhaps a resolution to the conflict can be found.

First the process worker will wait a while to make sure that the signal is strong. A short signal or one which comes just once is difficult to work with. It might even be a mistake in the therapist's perception and will only complicate matters. So the therapist needs to have a certain amount of patience and then checks out if the client also notices the signal. One possibility would be for the therapist to take a guess at the meaning of the double signal, ''I think what you are saying is not true, you're not excited about your dissertation, you are depressed about it.'' This might work but it is a bit risky, it might also get him into a fight with his client. It is also not entirely true: to some extent, at least in her primary process, the client is in fact excited about her dissertation.

Another possibility would be for the therapist to switch places with the client and act out how the client behaves as she is talking about her dissertation, so that she can see how she looks. One of the best ways to work with a double signal is to amplify it or make it stronger. The therapist could ask his client to try to speak more slowly or more in monotone about her excitement, or to lean even further back. If the tone of voice is a strong signal, the therapist could even ask his client to stop using words and just make the sound. If the client's posture is a strong signal, one way to work with it is to have her do the opposite (in this case to lean forward) and then to switch back to how she was sitting in the first place and ask her what the difference is. If the client had been sitting with her hands crossed over her chest, the therapist could work with this signal by forbidding it. This will usually make the client want to do what she was originally doing even more. What happens by using one of these techniques is that the client may suddenly have an insight into why she is doing that particular behavior. She might suddenly say while leaning further back, ''Oh, I'm so tired!'' Or while speaking in a stronger monotone, ''Oh, I don't feel like talking about my work, it's so depressing.'' Or with hands uncrossed, ''I've been hiding the fact that I don't want to be here today.'' In these ways the conflict can be helped to come up into the client's awareness.

Double signalling usually indicates that one is at an edge. The term edge means, quite literally, the edge of ones' primary identity, beyond which one feels one just cannot go. (''I couldn't possibly give a speech in public, I'm much too shy.'') Working at and around the edge is a very important aspect of integrating secondary process material. If one can work effectively with edges, the primary and secondary processes come into relationship with each other and integration will follow almost as a matter of course. One is at an edge when the flow of the process seems to stop. The client will sometimes say they feel blocked or stuck or that they are in a ''complex''. They will start to make a lot of superfluous movements, smile or giggle for seemingly no reason. In some ways edge phenomena look like double signals. Double signals are more persistent and create a kind of background annoyance, while edge phenomena are distinctly uncomfortable. A therapist with little experience in working with edges might think that the client at an edge is giving negative feedback. Negative feedback responses are slow and the energy level is low. Edge responses are certainly resistive, but they are vigorous and full of energy. Fluidly differentiating edge phenomena is a skill which takes a good bit of experience to learn. In the above example, the client's edge might be to admit that she's tired today, because she thinks that she is supposed to be awake when she comes to her therapy hour. Or she might have an edge against being depressed. Or she might not want to hurt her therapist's feelings by saying that she is not interested in being in therapy. An edge usually has something of the quality of avoidance in it. It is a ''belief that the primary, human, social processes are the only way to be'' (Mindell, 1982b). This compares with Jung's idea that it is apparently impossible for the individual to affirm his own total nature (Jung, CW, vol. 8). This seeming impossibility becomes a double signal which operates independently of one's consciousness. When one is working with a double signal one is working directly with the person's unconscious. For this reason double signals should be treated with respect. The client is usually not aware that she is double signalling; such signals are very useful in finding out what is in conflict with her consciousness.

Suppose that while talking about her excitement about her dissertation, the client scratches herself a lot. In this case the therapist might simply say, ''I notice that you scratch your arm.'' ''Yes,'' the client might say, ''I have this mad itch. I've even been to the doctor about it,'' she says. ''I have very dry skin, and it doesn't go away in spite of treatment.'' A process-oriented psychologist will not think, at this point, that the client's physical symptom should be treated only by her doctor. A person's physical symptoms, as well as their relationship problems and world problems (for instance, with their school, with the police or with the fact that they cannot find an apartment), besides the more conventional psychic problems, are experiences of the dreambody trying to increase the person's awareness.

A process worker looks at the different aspects of a person's process holographically. As the reader may know, a hologram is a photograph taken on glass with a laser. If one breaks the glass, the same picture appears on each splinter; if all the pieces are put back together, one ends up with a single picture again. A process is like a hologram. One can find the client's body symptoms in his dreams; if one works with a body symptom, often a dream will be reported

spontaneously. The same patterns which appear in his dreams and body symptoms appear in his relationships as well as in events around him or situations he encounters in the world. ''When the dreambody signals to you through a dream we call it a symbol, when it signals through a body-problem, a symptom'' (Mindell, 1985a). This mirroring is what Mindell calls the dreambody - it is dream and body at once. The process worker does not ''even need the terms dream, body, matter or psyche, but instead works with processes as they appear'' (Mindell, 1985a). The only tool a process worker needs is his ability to observe processes. He studies and follows nature and lets the dreambody process tell what it is which wants to happen and what to do next. Mindell uses the analogy of a train in order to describe process. It stops at certain stations, states of being, which, among many others, could be called ''sick,'' ''taking exams,'' ''falling in love,'' ''marriage'' or ''dying'' as it moves along the track.

The different traintracks on which one can travel are referred to in process-oriented psychology as channels. A channel is a mode of perception or representation of a signal. The term comes from communications theory, where a channel is a discrete carrier of information. The channels most commonly used in process work are:

1) Visual
2) Auditory (hearing, paralinguistic elements of speech)
3) Proprioceptive (internal feelings, pain, pressure)
4) Kinesthetic (expression through movement)
5) Relationship (expression through another person)
6) World (expression through the world at large, institutions, nature, etc.)

Channel occupancy can be identified by the way one uses verbs. If a person uses verbs such as ''see'' or ''look'' in the active voice, his occupied channel is visual. If he uses metaphors involving hearing or describes how something sounds, he is in the auditory channel. Examples of the proprioceptive channel are ''I press myself so hard'' or ''I feel cold.'' A statement such as ''I throw myself into my work'' indicates that the kinesthetic channel is occupied. When one speaks in an active verb tense about one's partner, teacher or neighbor, the relationship channel is indicated. The world channel is occupied when one speaks actively about what one is doing in the world at large (as opposed to speaking about a specific person in the relationship channel).

A channel can also be unoccupied, meaning the person has very little contact with that channel. This is usually indicated by the person's use of passive verbs or when he is talking about things which just ''happen'' to him in a certain channel. Some examples of phenomena which occur in an unoccupied channel are:

1) Visual: autonomous fantasies, nightmares, daydreams
2) Auditory: constant internal dialogues, disturbance by noise in the environment
3) Proprioceptive: physical symptoms, disease states, over-powering feelings
4) Kinesthetic: twitches, spontaneous body movements, strange body postures, disorders of muscular coordination
5) Relationship: fights, arguments, attacks, jealousies, love and hate experienced as originating with others
6) World: legal problems, war, being an outcast or member of a fringe group in a way that causes one problems

A basic principle of process-oriented psychology is that one works on what is in front of one, on whatever it is that comes up and with the channel in which a process appears.

One speaks about one's primary process in one's accessible or occupied channel. This channel is often like an old friend; it is well known and there are not too many surprises in it. The secondary process will be spoken about in terms of an unoccupied channel. Looking at the examples above it is easy to say that when a channel is unoccupied it is usually experienced as frightening or unpleasant, much the way the secondary process is often experienced. This is an interesting point. It could be that secondary processes are so difficult to get in touch with because they are represented in a channel which is generally inaccessible to the person's everyday awareness.

It is possible for several channels to be occupied or unoccupied at the same time. During the course of a therapeutic hour the process usually flows from one channel to another with, for instance, the client visualizing an inner figure, talking to the figure and hearing its response, and then perhaps moving as that figure would move. Mindell says that ''the dreambody seems to want one to develop awareness of the various channels. The dreambody signals in one channel and then switches channels because it realizes that you have either come to the limits of what you can bear in one channel or else that you are on the wrong track and need to perceive things in a totally new light'' (1985a p. 45). The process seems to change channels automatically; it is up to the therapist's fluidity to help the client to follow this changing flow. When the process suddenly gets blocked, usually a channel change is trying to happen. This occurs when the client reaches a really big edge. One way the therapist can help is to use the client's occupied channel to approach the edge. That would mean, with someone who has an occupied visual channel, to show them how they act or let them look at a video of the hour or, if in a group setting, to let other members of the group act out the client at his edge and let the client direct and give suggestions as to what the actors should do next. When they are able to see themselves (or someone acting as them), they will most often be able to take over whatever it is they were unable to do or say just moments before. ''When situations become too extreme or painful in one perceptual channel, when they reach their limit or edge, the experience switches suddenly and automatically from one channel to the other'' (Mindell, 1985a, p. 38).

In order to help the client become aware of his two processes it is often necessary to split or polarize them even further into the two entities that they are. In doing this, it is interesting to see that people generally have an edge to their primary

process as well as to their secondary process. The primary process is closer to consciousness; it is closer to the person's identity, but it is not the identity as subjectively experienced. As an example, imagine a client who comes to therapy to get help in becoming a warmer person. In other words, he identifies himself as being too cold. If the therapist asks him to be really cold the client probably will not be able to do it. He will be too embarrassed or say something such as, ''Are you crazy? I come to you for help not to be cold!'' He probably will not even be able to spontaneously act cold even if the therapist askes him to try it for just one minute. He has an edge against his primary process. With some encouragement and explanation on the therapist's part he might be able to consciously act cold for a while. What is interesting here is not whether he actually goes over his edge to the primary process and becomes cold with awareness, or over his edge to his secondary process and becomes a warm person, but rather the phenomena around his edges. What holds him back? What is his personal philosophy which has something against coldness and thinks that being warm is a good goal? Perhaps he really does need to be warmer. Maybe he needs to be warmer with himself and could attain that by being ''colder'' in his relationships. His statement would have to be explored more to find out in which direction his process wants him to go. The point here is to bring the two sides into relation with each other. If one can help these contrasting tendencies into relationship, they are no longer meaningless and are therefore not as painful. It is simply through the process that the goal is reached. As Mindell says in his book, Working with the Dreaming Body: ''Diseases can be self-healing; the dreambody is its own solution. ... Discover the process, amplify its channel, and a symptom can turn into a medicine.'' He was talking about somatic disease when he made that statement, but it applies just as well to other secondary-process phenomena.

When the client's two processes are polarized, they take on the quality of two entities which can communicate with each other. There is even a third ''entity'' which can communicate about the process, called a metacommunicator. This part has the role of a ''fair observer'' - having an overview of the situation and capable of talking about it. When one takes over a part, representing either the primary or secondary process, one discovers that the part thinks its way of being is the only way. A solution to a given conflict is often only possible when one can stand outside and see in which ways each part is being too extreme and that both processes have some points which are sensible. There are cases in which no metacommunicator can be found, such as in psychosis. In many cases of drug addiction, very little ability to metacommunicate is common.

The process structure consists of the following: primary and secondary process, occupied and unoccupied channels, edges and dream figures. Studying the client's process structure is helpful because, when the process elements are clear, a good indication of how to proceed with the therapy is apparent and the therapist will be aware of how the client's process wants to evolve.

An individual will feel stuck with a problem or conflict as long as he identifies with a certain pattern of behavior. Processes want to be completed; as long as a behavior pattern remains unconscious and unfinished, the individual's process will cycle at the edge. A process worker will often recommend that his client should continue his disturbing behavior, but with awareness and in even more detail, so that he can become aware of exactly what he is doing and why. After awareness has been reached, change may occur.

So far, process work has been explained in terms of individual psychology. Now the scope will be broadened to relationships and the concept of the universal dreambody.

There is a paradox in process-oriented psychology, namely that one's dreambody belongs to oneself and yet it does not. What does this mean? It should be clear by now that one's secondary process is reflected in dreams as well as in body symptoms. Whenever there are double signals there are dreams (whether normal night dreams or the body's dreaming in the form of symptoms), which fill in the hole around the edge that splits the personality into two parts. If one looks closely, the double signal forms an information-rich intelligence, a communication from one's unconscious. Jung described this carrier of information as a ''splinter psyche'' (Jung, CW, vol.8). In process work one refers to these splinter personalities as dream figures. They are either actual figures appearing in dreams or are the personified parts of a double signal. ''All incomplete motions of the hands and feet are secondary unconscious signals, dream figures trying to express themselves more completely'' (Mindell, 1987, p. 35). Each dream figure has a specific pattern of behavior connected with it which, as long as it remains unconscious, has a compulsive, repetitive quality. Double signals influence their environment.

Imagine two women who meet for the first time, called Blond and Brunette for simplicity's sake. The setting is a psychological seminar and there are a lot of people around. Blond is very extroverted and knows most of the people; she has been to many of these seminars before. Brunette is a rather shy, quiet person and is arriving for her first seminar. Blond comes over to Brunette and introduces herself. She talks rather loudly and her body is slightly turned away from Brunette, toward the door. During the short conversation (Blond has asked where Brunette comes from), Blond has greeted two other people whom she obviously knows well. Brunette stands with her shoulders slightly pressed forward, arms crossed in front of her stomach and gradually turns slightly, to face more into the part of the room which is empty. After a short time Blond excuses herself, explaining that she has promised to get the dinner organized. They part, both feeling a bit odd about the meeting. What happened? Both were giving off double signals: Blond's voice is a bit too loud for the situation and her body is turned toward the door and Brunette's shoulders are pressed forward, her arms are crossed, and her body is turned away. While they had their polite introductory conversation, their bodies were having another conversation. Blond's was saying, ''I am not too interested in you right now, I want to greet my friends and I have other things to do,'' while

Brunette's body was saying, ''I'm feeling shy and uptight and I notice you don't want to talk to me, so I'd rather be alone.''

As in communication theory (Watzlawick, 1967), process-oriented psychology has dropped the idea that he does something to her causing her to do something back to him. Or, to take the example above, Blond did not cause Brunette to double signal, nor did Brunette cause Blond to double signal. Instead, the focus is on the overall relationship process and therefore it is impossible to determine who is doing what to whom. One looks at the field. Jung has called this field the collective unconscious (Jung, CW, vol. 8 & 9i). Blond and Brunette are simply two points in this field.

We now arrive at process work's interface with physics, a subject which is beyond the scope of this paper. This area of process-oriented psychology will be treated very superficially here; Mindell's River's Way is recommended to readers seeking a more extensive discussion of this subject.

Thinking of Blond and Brunette as two points in a field compares with field thinking in physics. There, each particle is an aspect of the field and not separate from it. A particle is neither pushed nor pulled by another but is rather an energetic intensity, a characteristic of the field. In fact, particles either do not exist or else are characterized by a constant interaction with each other. This is also true in psychological field thinking. There, concepts of cause and effect are replaced by the idea of intercommunications, which no longer locates which object causes another to do this or that. In ''universal'' work, one works on the field, in other words, on the signal interactions which are disturbed by edges and on the dreams which bond the conflicting sides. The universal dreambody is ''composed of the primary intentions of all the people involved and the primary signals which reflect the messages of these intentions plus a group of secondary processes which are outside of awareness and which are composed of dream images as well as their body equivalents in the form of gesturing, postures and processes'' (Mindell, 1982b).

If one were to take the above example of the two women and explore both sets of double signals and both persons' dreams, one would find that the two individuals share a common edge: when they are alone each has an inner conflict, which appears in their dreams and body symptoms; when they are together, each one takes over the side which is closer to her primary consciousness.

The author is fortunate that these two women met in a process-oriented training seminar and also that they are both courageous people, because they decided to work with each other in the group on why they both immediately disliked each other, so both sets of dreams can be recorded here. To make it short, Brunette dreamt that there was a woman sticking pins into her breasts, while Blond had a dream about the devil. Brunette had a negative dream figure or part in herself which was constantly attacking her for her sensitivity. The next step in her development was to learn to express her feelings of pain when she was hurt by someone and to be more open about her shyness and sensitivity. Blond had a dream figure which wanted her to be more devilish; this meant for her being less related and not such a ''nice'' person. She needed to learn to be more direct with people, even when she thought that she might be hurtful in her directness. Blond was being the ''devil'' or the ''tormentor with pins'' in the interaction with Brunette, while Brunette took over the role of the victim.

In process work, one also says that the two women were dreamed up by each other. ''Every time a dreamer tells a dream, the dream interpreter typically has reactions to the dreamer, which dream figures have toward the dreamer himself. These reactions occur before, during and even after the dream is told. The reactions of the therapist are 'dreamed up', so to speak, by the dreamer'' (Mindell, 1985b, p. 41). As can be seen in the above example, dreaming up occurs not only between therapist and client but every time a person is split by an edge and is incongruent, because he is dreaming and sending out double signals. There is an unconscious dream figure which is signalling to the environment. ''The majority of dreamed-up reactions occur because the therapist has not consciously picked up the client's double signals and therefore reacts to them without even realizing what his reactions are due to. These double body signals are dreamlike, they are unconscious to the client and call forth communications and reactions in the therapist just as they call forth similar reactions in the client's dreams'' (Mindell, 1987, p. 42).

A differentiation between dreaming up and projection needs to be made. A dreamed up reaction is short-lived and lasts only as long as one is in the vicinity of the dreamer. One has none of the apparent affects toward the dreamer before or after the contact and as soon as the dreamer has integrated and understood his dream material, the affects disappear. A projection, on the other hand, is long lasting; it remains even after the contact has ended and cannot be found in the dreamer's dreams or body work. It belongs to the projector and needs to be worked on by himself.

As has been illustrated in the example of Blond and Brunette, individuals carry their dreams with them in their waking life. The dreambody is the underlying structure of each person's process and functions as a hologram. In its universal or global form, it organizes relationships, family and group processes. The group takes over the individual's unoccupied process, which - in the individual - might be found as a body symptom. When Brunette is interacting with the seminar group, the group as a whole might be dreamed up to be insensitive to her needs. In this way, the group becomes a part of Brunette's dreambody. Conversely, from a field view, Brunette's behavior can be seen as a part of the group's process. If Brunette had really been treated insensitively by the group, this would show that the group's process until then was lack of sensitivity. In an interaction that would follow from this, Brunette might learn to show her shyness and sensitivity more openly, while the group might learn to be more open to the needs of the individual. In this way an individual becomes a channel for the

group, and the group a channel for the individual. Who occupies which part depends on availability. If Brunette is married to a man who is even more shy than she is, she will take over the other side and her husband will experience her as insensitive to his needs.

Each single person's process is represented: by his or her dreams and body phenomena; in his relationships, in his world processes, by the double signals of the individuals concerned; by messages from the environment in the form of other people or synchronistic events which seem to disrupt or disagree with whatever is being done consciously. According to Mindell, ''individuation means awareness of your complexes and obsessions when you are alone, and awareness of your double signals, their origins, and the double signals of others when you are together with them'' Mindell, 1982b).

The Father Complex and Negative Dream Figures

Similarly to Jung (CW, vol. 9.1), process-oriented psychology uses the term ''father complex'' to describe a certain constellation of psychic energy. This constellation depicts the father as a source of energy for actions, drives, and opinions. It is the main dream figure found in connection with an individual's relationship to authority, measuring up to standards and striving for a place in the world. There are two aspects of this figure, a positive and a negative one. The negative aspects of the father complex will be focused on here, because it appears to be central to the problem of addictions.

A negative father figure causes trouble for both of the cases presented here and was usually the problematical dream figure behind other cases in the author's experience. Occasionally a negative mother figure could be found, but this was only in individuals who had a missing or very weak father. In these cases, it was the mother who did the actual ''fathering'' in the family.

The father complex is a basic psychological characteristic, which in its negative aspect creates a feeling of inadequacy in the individual. In its raw form, this dream figure is critical and challenging in a very global manner. ''Everything you do is wrong!'' Observing an individual with a negative father complex, one has a sense that they must fight against a vague ''something,'' that they must be in constant opposition to all authority, criticism and expectations. Until this figure has been worked on and brought into consciousness, there is a compulsive quality to the above behaviors. Working with this figure, bringing it into consciousness, reveals its positive aspects. It is a figure which challenges and pushes the individual to develop; it forces one to work and attain. It is a big drive in the background which wants to be lived out. If one goes behind the global criticisms and works on the details of the criticism, valuable information is to be had. The individual is never completely perfect, there is always some aspect which could be improved or further developed.

This is a painful process. Before it comes into consciousness, it is perfectly natural to want to avoid this constantly negative figure at all costs. One is always under pressure if one has such a dream figure. The individual feels like a victim, who is constantly being mistreated and wronged. Often, as a means of defense, one tries to become like the negative father (e.g. Sarah's striving to become detached and unemotional).

When first beginning to work with such a figure, the individual needs help in struggling with it. The primary process, i.e. fighting the father, needs to be supported. Only later, after the person has had some relief from this negativity, is it possible to begin listening to what this figure has to say and start the process of integrating aspects of this figure into everyday life. Heroin seems to be an antidote against the negative father complex - an attempt, but an insufficient and positively harmful one, to fight against the feelings of inadequacy, inferiority, and pressures to conform, which go along with such a complex. One could say the use of heroin is the first step on the way to dealing with a negative father complex, but, although it is an extreme step, it is only the first one. There is no integration and resolution of the negative father complex in the use of heroin. Heroin use is only a temporary reprieve from this complex. As soon as the drug effects wear off, the negativity of this complex comes back.

As will be shown in the case studies, taking heroin results in the individual's temporarily taking over the figure of the father. It is interesting to observe that the effects of heroin and the description of the individual's father are very similar (at least in the two individuals studied here). In other words, heroin seems to be serving the function of the father. This might seem a very radical statement, but the reason for making it will become clear after the reader studies the cases presented here.

Reaccessing the drug state (see section: Reaccessing the Drug State) is an effective way for the addict to begin dealing with the negative father complex. Through a reaccessing experience, he realizes that the feelings of negativity which he is constantly experiencing are the germ of some valuable guidance. The drug and the process behind it are autonomous until they are brought into consciousness and can be integrated as a part of the personality.

Reaccessing the Drug State

Why Reaccess Drug States?

Some people can stop using a drug through an act of will. They can do this alone, with the help of a conventional therapy, or by going to a therapeutic community. For these people the drug use and experience is then finished, they can put it behind them. Others can stop using the drug, only to exchange it for another one, sometimes a more acceptable or a less dangerous one. Still others go through a therapy and soon after go back on drugs. The question here is, why do they go back? One reason is that there is something in the drug use or drug state which is unconsciously useful to the individual, something which they need. This is especially true for people who seem to be motivated to stop using the drug and then suffer repeated relapses. Through the taking of drugs, the experience which wants to happen in the background cannot unfold, therefore it perseverates in the form of an addiction.

There is a high degree of recidivism among addicts and also much changing from one addiction to another. In certain individuals physical symptoms develop which have similar effects to the drug state - one person described the symptoms of his brain tumor as being like his former drunken state: dizziness and then collapsing unconscious. In this case, after the state had been processed, the tumor disappeared (Mindell, personal communication). Simply stopping the drug use by force of will, without finding the solution which was being pursued, will cause the behavior to repeat, sometimes even in another channel, because the background state has not yet been reached and processed.

In order to avoid recidivism or change of addiction, the meaning behind the addiction needs to be found. This can be accomplished by reaccessing the state of being high and following it through to its completion. For someone who has stopped using the drug but is having trouble with relapses this can be done without the use of drugs. With someone still addicted to taking the drug, working with them when they are high or even going through the process of the client taking the drug in the presence of his therapist, is probably necessary because of their projection on the drug (Mindell, personal communication).

Reaccessing the state is not very difficult; it happens often spontaneously, as when the person suddenly gets a strong desire to use the drug - ''I can almost taste it in my mouth'' - or when they start acting as if they were on the drug. (This can be seen in body postures and speech patterns, such as slurring words together in a ''stoned'' way.) These desires and behaviors indicate that the drug state is still secondarily present and that the individual needs help to access it and find out what is trying to happen.

What Is Reaccessing the Drug State?

Reaccessing the drug state is the same as any kind of process work, except that the drug state is specifically focused upon. It is done by following the person's process as it appears in the present. This means the therapist is aware of, and follows the client's channels and body signals. One must be aware of the occupied and unoccupied channels and any double signals which come up. These are worked with in the usual way (see section: Process-oriented Psychology). The easiest way into the drug state is to ask the client what they experience on the drug, what it does to them, how they feel on the drug, what happens in their body when taking the drug and how they take the drug. The details are important. The state of being high is not always most important in a given moment; sometimes the necessary information is contained in the way the drug is taken or the way it is breathed into the lungs (if smoking the drug). The ritual aspects of drug taking are significant and need to be paid attention to - for some individuals putting the needle in their arm is psychologically more relevant than the effects of the drug per se. It is important for the therapist to be open to the client's momentary process and not to have a set idea of what should happen. There are detailed examples of reaccessing the state in the second part of each case, one in which reaccessing the state was important to the individual (Sarah) and one where the edge was too large (Bob).

With Whom Is Reaccessing the Drug State Helpful?

Reaccessing a drug state seems to be most helpful with individuals who are interested in stopping using a drug or in finding out why they used the drug in the first place. The author thinks this method would not be helpful unless there is a certain amount of motivation already present. Even when motivation and interest are present, reaccessing the drug state is often frightening to the client. In these cases these fears need to be worked through first.

There is a certain type of client who says they do not have a problem with a drug ''yet''. They are very difficult to work with because they do not identify with having a problem. This type of person waits and waits until the ''yet'' becomes ''now'' and then are overwhelmed by it. Suddenly the ''not yet'' problem grabs them. Trying to work on a problem with which the primary process does not identify, is very difficult. The client might even be afraid he would get the problem more quickly. One possibility would be for the therapist to say, ''How would it be if you had the problem?'' This could possibly work. Dr. Mindell suggests the fastest way to help this type of person is to say, ''It's not a serious problem,'' and then to talk about the weather or politics. In this way, the therapist should try to drive the client to boredom; then he will suddenly claim that the therapist is not being consequential or not taking the problem seriously. This seems to be the quickest tactic. These clients are terrified of getting into their problems and need help with this (Mindell, personal communication).

CHAPTER 3

Literature Introduction

To collect and write about the literature on drug addiction is a difficult task. There is much conflict and controversy within this field and very few reports relate theory to practice at all. The field of addictions is in a preparadigmatic state; there is no operative paradigm generally accepted as valid. The etiology of addiction has not even been agreed upon; much less has a consensus as to the proper course of treatment been reached.

The author has chosen literature from four main therapy directions often used in addictions work (Psychoanalytic, Gestalt, Family and Group therapy). It is possible that these four therapies are not the most widely used in drug addiction therapy, but they were the most widely represented in a thorough literature search. Literature about alcoholism was largely excluded, as were techniques in which the use of methadone played a main role, since these areas are less pertinent to this study.

Psychoanalysis

Freud (1905) and Abraham (1915) mainly viewed addictive problems from the instinct dynamic viewpoint. They stressed oral fixation, latent homosexuality and manic mechanisms. Unconscious conflicts and tendencies were considered to be at the base of the addiction; the desire to use the drug was an effect, not vice versa.

Rado (1926) worked out the first true theoretical analysis of the problem of drug addiction, which not only took into account the libidinous aspects of addiction but also the development of affect, ego and defense mechanisms. The addition of the above aspects was necessary in trying to explain why an oral fixation would lead in one case to addiction, while in another, a neurotic disturbance would develop.

According to Rado, the main effects of a drug on an individual were 1) help in repression and 2) pleasure. Rado acknowledged the underlying depression and the pain-removing action of narcotics but stressed the pleasurable aspects of drugs as the main etiologic factor in addiction. For Rado, the factors which lead to a drug addiction were all forms of actual failure besides the already formed neuroses. His way of explaining why drug use was still an oral phenomenon - even when the drug was being injected - was that it provided a feeling of satiation or ''alimentary orgasm''.

Glover (1933) felt that explaining drug addiction only from the oral level of libidinal development was too simple, and pointed to the influence of the early oedipal conflict. He claimed that the disposition to drug addiction comes from a fixation at a stage between a more ''paranoid-schizoid'' state (paranoia or melancholic fears) and a more advanced, late oedipal obsessional neurosis (compulsion reaction). The fixation at this level comes from insurmountable failures; there is a tendency toward sadistic, aggressive reactions which, even though they are less violent than those associated with paranoia, are more intense than the sadistic charges met with in obsessional formations. The addiction serves as a defense against these paranoid-sadistic reactions and a block against the threatened psychotic destruction of the ego in this regression.

The drug represents a special object which has both good and evil (mother) aspects. By taking drugs, the body is cut off from the outer world. In this way instinctual tensions and desires are overcome - and especially aggressive impulses, which result from frustration, are warded off.

By following this theory one can explain the self-destructive addiction cycle in the following way: Through the repression of sadistic impulses a depression is created, which during the high becomes a false mania. This decreases the contact to the outer world and aggression becomes even more difficult to deal with, leading to deeper depression, which creates renewed desire to get high. The regressive-sadistic superego threatens the ego of the addict and

influences his strong self-destructive tendencies; heavy drug dependence has the appearance of a veiled or drawn-out suicide.

Fenichel (1946) classified drug addiction as an impulse neurosis. Impulse neuroses are characterized by irrepressible impulsive instinctual acts which are experienced as belonging to the ego (ego-syntonic), as opposed to compulsions which are experienced as ego-dystonic. Those who have a disposition to addiction have fixations on passive-narcissistic goals, which means they are dependent on being loved and recognized. The special personality of an object is not important to this type, but rather, that he gets attention from his object. Tension, pain and frustration cannot be tolerated. This type cannot resist instinct demands for the possibility of long-term satisfaction. These archaic-oral desires combine positively with the effect of the drugs.

Fenichel placed the oral fixation of the addict in the middle point of his theory but says that the raised level of self-worth is more important than erogenous pleasure. What is important here is that narcissistic and erotic satisfaction are joined. He also stressed the relationship to manic-depression. Especially in the later stages of drug addiction, the depressive mood dominates; the goal then becomes the avoidance of pain, no longer the attainment of pleasure.

The above mentioned psychoanalytic theories contain a broad definition of addiction. Newer psychoanalytic thought uses a much narrower definition of drug dependency. This most dangerous type of dependence demonstrates in a typical fashion the psychodynamics of the development of addiction. There must be specific characteristics in early ego development and later ego-maturation, as well as in affect development, which create a fixation and accompanying aggression leading to such a self-destructive addiction as can be seen in opiate or amphetamine dependency.

Krystal and Raskin (1970) explained that because of a missing or inadequate motherly object relationship, the drug addict is unable to develop a ''normal'' affect tolerance or, in fact, develops a special kind of frustration intolerance, which makes it impossible for him to work through fear and depression. This means that in later life, the individual finds himself fixated at a stage of latent helplessness. Everyday annoyances and difficult disagreements appear to him as unbearable frustrations. Because these pain stimuli are unavoidable, on an unconscious level the most primitive affect - that of complete disintegration, the fear of total destruction - will be reexperienced. The addict reacts to this unbearable tension as does an infant, with rejecting anger and at the same time demands of absolute security. Because these childish demands cannot be fulfilled by the social environment, the soothing effects of the drug replace human relationships.

The damaged motherly object relation also creates a disturbed development of the ego and superego. Out of this results a feeling of dependency and helplessness, a fear of separation, and on the other hand an intense aggressive catharsis. These aggressive impulses are forbidden because they would lead to an even greater fear of losing the object. The addict keeps this ambivalent early childhood stance; he constantly longs for fusion with the outer object while at the same time fearing it greatly. This ambivalence is an important factor in the tie to the drug, at one point it can be fled from, at another it can be wished for.

Some psychoanalytic researchers have developed a new outlook on narcissism (Jacobson, 1964 & 1967, Kohut, 1971, 1975 & 1977, and Kernberg, 1975) which places more emphasis on the conflicts within the personality as a whole, the self. According to Kohut (1975), drug dependence is a failed attempt to correct a defect in the structure of the self, in other words, an effort in self-healing.

If, during the symbiotic phase, the mother (who is experienced as a self-object in the psychic structure of the child) is missing or unable to treat feelingly the needs of the child, the gradual integration of this psychic structure, the self, will fail to occur. The fact that this structure, the self-object, is missing, is experienced as a trauma; this means that the archaic forms of the grandiose self and the idealized object (parents) remain. The child, in an attempt to avoid this trauma, tries to replace the missing self-object through self-stimulation (oral, anal, and phallic masturbation) and so to correct the defect in his psychic structure.

In this light, the taking of drugs by the addict is seen as a repeated attempt to replace the missing self-object and give himself the absent warmth, safety and security. Without narcissistic balance the prerequisites are lacking for building up a fairly stable identity and gaining the possibility of autonomous functioning. The drug serves the illusion of fusion with the narcissistically loaded object. The continuing dependency wishes, which can neither be fulfilled by the parents nor in other social relationships, are satisfied through the effects of the drug.

Chein, Gerard, Lee and Rosenfeld (1964) studied the sociological, economic and personality variables associated with narcotic addiction. Their judgment was that heroin addiction is the result of a long, severe personality disturbance and maladjustment. They stressed the addict's limitations in interacting with his environment in ongoing and constructive ways. Chein et al. found addiction to be adaptive and functional; the addict used drugs to help himself cope with his emotions and the outside world. They described how narcotics helped their subjects (adolescent boys) function sexually by dampening anxiety. While stressing the adaptive function of heroin, they also emphasized a ''nirvana-type pleasure associated with heroin.'' Chein (1980) described 3 kinds of motivations from the abuser's viewpoint:

1) The psychopharmacological effects of the drug (Chein believes that the effect sought after is detachment and the relief from overwhelming distress which comes along with it).
2) Motivation connected with taking the drug other

than its effects per se (here Chein means that it provides social benefits to urban opiate users as an answer to their felt emptiness).
   a) Gaining an identity which is simple to live up to.
   b) Gaining a place in a subsociety where he is accepted as a peer.
   c) Acquiring a career at which he is fairly competent (this also applies for those times when he is institutionalized, whether in jail or hospital).

3) Motivation which has to do with the counternormative behavior involved in drug use (the more condemned a drug is by respectable society, the more attractive it is to one who is alienated from society, but still has enough inner resources left to want to hit back).

Wurmser has written extensively about drug use being a protective system (1974, 1975, 1980, 1980-81 and 1984). ''Drug use is preeminently a pharmacologically reinforced denial - an attempt to get rid of the feeling import of more or less extensive portions of undesirable inner and outer reality'' (1980, p. 71). The defense works by making unconscious, inoperative or irrelevant the emotional perception of the inner or outer reality. The drug is used as a way of blocking or smoothing over affective storms or dysphoric moods. He accents that the constellation behind drug use is a defense, not a defect.

> The choice of drugs shows some fairly typical correlations with otherwise unmanageable affects - narcotics and hypnotics are deployed against rage, shame, jealousy, and particularly the anxiety related to these feelings; stimulants against depression and weakness; psychedelics against boredom and disillusionment; alcohol against guilt, loneliness, and related anxiety. This means we immediately recognize the following layering: 1) drug use; 2) affective storms or chronic dysphoria representing such unpleasant affects; 3) underlying pathology of a hysterical or obsessive-compulsive, of a phobic or depressive, or occasionally of a psychotic or organic nature. Symptom and character neuroses usually coexist (Wurmser, 1980, p. 72).

Wurmser found narcissism to be prominent in the majority of compulsive drug users and alcoholics. ''Such pathological narcissism may appear as entitlement or as sovereign disregard for the limits of physical or social reality, or it may be studied in its manifestation as exaggerated self-expectations with severe dysphoria, rage and shame, when these expectations are thwarted'' (1984, p. 38).

In the psychodynamic make-up of addicts Wurmser found 3 major strata. The most superficial is the sociopathological and paranoid stratum. Here one finds lying and violent behavior, narcissistic demands of omnipotence, fantasies of invulnerability and the conviction that all limits can be/must be violated. Paranoid attitudes such as ''the world is against me, I have to fight back'' are found here.

The second, depressive layer, is much less accessible. In addicts, Wurmser found this depressive system to be different from the more usual guilt-oriented depression. ''It has more of a lethargic, apathetic, strongly shame-ridden nature - a narcissistic letdown of the grandiosity of the self'' (1980-81, p.313). He believes that a traumatic loss of self-esteem due to overwhelming helplessness and exposure are the cause of this type of depression. Most of his patients suffered from traumatic and repeated experiences of extreme aggression and sexual overstimulation throughout their childhood.

In most of his drug addict cases, Wurmser found a third layer, which he called the phobic layer. This system is antecedent to the current drug problem. He believes that a neurosis of the phobic type is the infantile neurosis underneath the later pathology, specifically a claustrophobia combined with other developmental impairments, mostly ego and superego defects. There is pervasive and massive anxiety which is vague and unstructured; it is not attached to definable or avoidable objects. Addictions and phobias are parallel although inverted. ''While the phobic neurotic compulsively avoids the condensed and projected symbol for his anxiety on the outside, the toxicomanic compulsively seeks the condensed and projected symbols of protection against uncontrollable, overwhelming affects, again on the outside'' (1980-81, p. 323).

He has found that child abuse is one of the most important factors in later drug abuse. Drug use is a defense against feelings of extreme helplessness. Typical forms which this defense takes are: 1) narcissism, with its grandiosity, haughty arrogance and deep withdrawal of feelings from the environment; 2) turning passive into active, the addict suffers and fears disappointment so he or she first does everything possible to enlist help and then does everything possible to make the helper (therapist) helpless and defeated, and 3) externalization (opposite of denial) - in order to support the denial of inner conflict, an outer conflict is provoked (examples: ridicule, rejection and punishment). This is action for action's sake; limit-setting is provoked and demanded and then endlessly fought against.

The underlying claustrophobia presents difficulties in therapy. The claustrum is both dreaded and desired. The drug serves the purpose of doing away with boundaries and limits, but leads to even more confining ones. The same applies for therapy; a balance between the wish and dread to mature has to be found. When a patient is withdrawn from the drug he has a tendency to flee from the fear of independence and unprotectedness into an increased dependency on the therapist. But just this closeness, intimacy and dependence brings up the fear of being confined and swallowed up. If the therapy becomes too intense and protective, it will be followed by paranoid rage and flight from treatment. Some kind of balance needs to be found in order to help these ''very sick patients who struggle in vain against overwhelming anguish, pain, rage, and terror'' (1980-81, p. 333-334).

Khantzian (1974, 1975, 1977, 1978, 1980, and McKenna and Khantzian, 1980), like Wurmser, tied drug dependence to an attempt to cope with the internal emotional, as well as external social and physical environment of the individual. He examined how a person's ego organization and sense of self play a role in this attempt and how the effects of drugs serve or block this attempt. His theory is that because of severe ego impairments and disturbances in the sense of self, drug dependent people have trouble

with drive and affect defenses, self-care, dependency and need satisfaction. ''The central problem for most people who have become addicted to opiates is that they have failed to develop effective symptomatic, characterologic, or other adaptive solutions in response to developmental crises, stress, deprivation, and other forms of emotional pain which may not in themselves be extraordinary. Their response has been to revert repeatedly to the use of opiates as an all-powerful device, thereby precluding other solutions that would normally develop and that might better sustain them'' (1980, p. 30).

Khantzian thinks that heroin addicts use opiates specifically as an antiaggression drug because of their histories of difficulty with feelings and impulses associated with aggression. They use opiates for short-term relief of dysphoric feelings associated with anger, rage and restlessness. He noticed how aggression and restlessness subsided in patients stabilized on methadone. Khantzian (1980, p. 30) stressed ''the disorganizing influence of aggression on ego functions in individuals whose ego stability was already subject to dysfunction and impairment as a result of developmental arrest or regression.''

Khantzian focused on self pathology (relating to troubled attitudes and experiences about the self and others) in contrast to ego pathology (with emphasis on disturbance in structure and function in coping with drives and emotions) when discussing the psychodynamics of addiction. In his work with compensated addicts (either drug free or on drug maintenance), Khantzian noticed characteristic traits which are related to underlying narcissistic processes and disturbances (i.e. problems in accepting dependency, acknowledging and pursuing goals and satisfactions related to needs and wants. He ''proposed that the rigid character traits and alternating defenses employed by addicts were adopted against underlying needs and dependency in order to maintain a costly psychological equilibrium'' (1980 p. 31).

Like Wurmser, Khantzian concluded that addicts self-select a certain drug for its specific effect, in the case of opiates because of their antiaggression action. Furthermore, he thinks that the ''high'' or euphoria which addicts claim to get on taking heroin is more a relief of dysphoria. ''A significant portion of these individuals become addicted to opiates because they discover that the drug acts specifically to reverse regressive states by attenuating, and making more bearable, dysphoric feeling involving aggression, rage, and related depression'' (1974, p. 65).

Gestalt

Sideroff (1979) wrote about the basis for using a Gestalt therapy approach in drug treatment, dealing with four aspects of the rehabilitative process.

1) relationship between therapist and patient
2) development of self-support and taking responsibility
3) dealing with anxiety
4) avoidance, primarily manifested in lack of contact

1) In Gestalt, the therapist tries to relate on an equal basis and tries to develop a trusting relationship with his client. In Sideroff's opinion, most addicts are wary of people in authority. He tries to make himself believable as someone who can be trusted by not coming across as an authority figure, by being completely honest, by expressing his own feelings in an encounter and by generally being available to the patient.

The therapist also tries to avoid interpretations. The belief behind this is that the patient knows better than anyone else the reasons for his actions. If the therapist has an idea about the cause of the patients' behavior, he asks if it is correct. The reasons for this are to put at least part of the responsibility of understanding on the patient (so that he does not rely so much on others) and to help create an equal type of relationship (as opposed to an authoritarian one).

2) The process of going from environmental support to self-support is an important part of Gestalt therapy (Perls, 1973). Sideroff (1979, p. 351) reflects that most addicts have experienced ''some form of early environmental rejection,'' which often has to do with the way they were treated by one or both of their parents. He found that ''by not receiving the normal environmental support as a child the development of self-support is inhibited, resulting in low self-esteem'' (1979, p. 351). As a young adult the addict still looks for environmental support and finds this in drugs and the drug subculture (peer relations, identity, as well as orientation and structure in his life). In working with the support issue, Sideroff often uncovered repressed feelings such as anger toward one or both parents. Using Gestalt techniques, he has his patients express this anger in the present. This present-centered approach intensifies the feelings and the patients are more fully able to experience the anger and then get beyond it. What commonly occurs next is that the patient experiences deep sadness. Through this method the patient is able to 1) release a lot of pent-up emotion (unfinished business) and 2) start realizing that it was not his fault that his parent(s) rejected him and he experienced a lack of love. Once the patient comes to this point, non-drug ways of fulfilling his needs for affection and love can be explored. Sideroff believes that helping the addict to develop a sense of self-support is one of the most important issues in getting (and keeping) the patient off drugs. This is partly because of the transitoriness of the support found in therapy, but primarily because he finds that

addicts use the ''fix'' as their source of support.

3) The addict's weak ego development and lack of self-support leads to anxiety. Sideroff explained this as an inability to deal with the conflict between two parts of the addict, one part which sets up unrealistic goals and the other which does not have the ability to fulfill them. This conflict leads to anxiety. According to the Gestalt lexicon, anxiety is excitement without adequate support. Excitement for addicts is what they want from their lives. The lack of support is the lack of tools, training and background which would make the goals a reality. They have no outlet for this energy and thus anxiety results. They use drugs to control this feeling. Heroin is an excuse for not being able to reach the goal and at the same time is a substitute goal.

The method for dealing with this problem is to bring the conflict into the patients awareness, most often through a dialogue between the two parts. After further polarizing these parts the addict has the possibility of seeing 1) how unrealistic the goals of the one side are and 2) how the other side sabotages these plans and goals and also avoids the possibility of failure through using heroin. It is then possible for the addict to set up goals which are more reasonable at the moment, thus helping to break up the cycle of ''excitement - no support'' which creates the anxiety. This creates further possibilities for the addict besides shooting up heroin.

4) Sideroff describes the trouble he had during his early work with addicts and his eventual discovery that at the root of his problems was the lack of contact with his patients. He noticed the very subtle ways in which they avoided relationship and the reason behind it; it helped the addict to escape. He found that his patients saw him, the therapist, as a judge who would either tell them what they should do or tell them they were no good. Sideroff had them describe him and talk about him; through this the patients were able to differentiate between Sideroff himself and those who had judged them in the past. To be able to risk making this much contact, the addict needs to have developed some degree of self-support already.

Besides this personal issue, the addict has other motives for not making contact and many methods of accomplishing this. The patient uses story-telling and other forms of monologue, or talks about events in the past or outside of themselves to avoid momentary feelings and relationship with the therapist. The therapist's most difficult task is to notice what is going on and then be firm and not let the patient get away with it. In this way the patient gradually learns how he avoids feelings and the length of time that he is in contact with the therapist gradually increases.

Zarcone (1980) described an Eclectic Therapeutic Community (TC) in which the Jonesian TC is modified to fit the immature character defenses of many addicts. There is an emphasis on structures; rules, policies, staff roles, therapeutic forums, program phases and clear expectations. The idea is to create ''living and learning'' situations whereby the newer patients can model themselves after staff and senior residents. The goal is that patients develop a new perceptual style and can better perceive their own behavior and the behaviors of others in emotional situations. The structures are also a protection of staff and patients against externalization and narcissistic injury. A Gestalt therapeutic approach was chosen because of its focus on perception of the ''here and now'' in social learning situations and its focus on clear perception while in an emotional state.

Zarcone depicted the patients he treated in this TC as having a high degree of traits similar to the borderline traits described by Grinker, Werble and Drye (1968) and Vaillant (1971), with immature character defenses and narcissistic personality problems. Typical immature character defenses are projection, schizoid fantasy, passive-aggressiveness, hypochondriasis and acting out. This is normal in development between the ages of 3 and 16. Zarcone thinks that because most addicts begin significant drug use around the age of 12, they may become fixated at or regress to this type of character defense. His patients also note that they often act and think as they did in childhood and early adolescence, with their grandiosity and extreme sensitivity to narcissistic injury.

Zarcone stressed that ''social learning situations must be frequent and intensive enough so that modeling can occur'' (1980 p. 520). In the TC which he described, therapeutic forums and techniques were systematically planned with the immature character defenses of the patients in mind. In order to make role modeling more clear and definite they used the concept of contracts (which actually comes from Transactional Analysis and Behavior therapy). The contracts can be about virtually anything. A contract contains a statement about what is to be done, what is to be attempted and who is involved. The odds about whether the contract can be completed are also discussed, as well as the emotional reactions of the patients when making the contract and trying to fulfill it. These discussions occur in contract sessions, in groups and in individual psychotherapy.

Through these contracts, a paradoxical situation is created in which the patient begins to value negative emotional states as an opportunity for learning. It is important not to give the patient too much to handle at one time and to be careful to protect the patient's self-esteem at the same time he is being confronted. Although the starting situation of the patient is ''lower'' than that of senior residents and staff, every effort is made to change it into a symmetrical position.

The structures of this program ''create frequent living-learning situations in which the addict can increase his awareness of his own perceptual processes'' (1980 p. 523), in an attempt to develop an inhibition of action and habits, so that there is more time taken to perceive clearly. This gives the addict more opportunity to plan and rehearse his actions and receive effective feedback.

Zarcone described why Gestalt therapy techniques were chosen over psychoanalytic techniques as the mode of learning.

> 1) The theories of Gestalt and psychoanalysis are based on similar assumptions concerning mental life. These assumptions are familiar to professionals working in inpatient settings, and both techniques emphasize dreams, fantasies and memories as determinants of behavior. 2) Gestalt is a briefer form of therapy. 3)Psychoanalysis is focused on core conflicts and the genesis of those conflicts, as opposed to here-and-now behaviors. Therefore, psychoanalysis is not experiential and dramatic enough for acting-out characters. 4) The terminology and jargon of psychoanalysis are more difficult to employ than is the terminology of Gestalt therapy. 5) It is difficult to make psychoanalytic interpretations concerning recent past or crisis situations of substance abusers, because drug effects tend to deaden emotional responses prior to the acting-out behavior and it becomes almost impossible to separate realistic from neurotic determinants of acting out (1984, p. 43).

Zarcone claimed that the most important aspect in the use of Gestalt with these patients is the experiential aspect. Unless a patient is psychologically quite sophisticated, psychoanalysis is not dramatic enough to appear realistic. The act of experiencing oneself using more adaptive ego defenses in relationship with the analyst also seems to have an important therapeutic effect.

The accent on perception leads to the ability to separate the ''I'' from the ''you'' in terms of wants and feelings in the momentary action. At the same time, memories and fantasies which get in the way of satisfying interaction with other people are brought into consciousness. This is important for people with immature character defenses because they have trouble making a connection between successive emotional states. Zarcone stated that Gestalt is a direct attack on the tendency to use projection and externalization. The Gestalt method of inhibiting action while the perception is being clarified is helpful with impulsive addicts. Through the Gestalt practices of role playing and minipsychodrama, the patient gets practice in a new way of perceiving his world and is provided with alternative views to his drug taking behavior. ''The patient can learn to avoid rationalizations by thinking more clearly about what he wants and how he can get it without

Family Therapy

Viewing substance abuse within its interpersonal context, relative to other people involved such as family and peers, is a relatively new idea in the drug abuse field. Family therapy first began to be used in the late 1960's and has since come into rather widespread use.

One of the main criticisms of traditional therapeutic communities is that their patients must eventually leave and reenter the ''real'' world, often going back to their families. If the pretreatment influences remain unchanged there will be a great deal of pressure on the patient to go back to old patterns. The inclusion of the family in treatment helps with this problem (Berliner, 1966-67 and Olson 1974).

Most theories discussing drug dependence ''assume the problem to be within the addict or drug-dependent individual, rather than part of a system where behavior indicative of addiction is elicited and reinforced and about which it is a 'comment''' (Schwartzman, 1977). Schwartzman described how both the addict's family and then his treatment facility transform ''the locus of addiction to 'within' the addict and away from the social context of which he is part. This transformation results in the addict being unable to remain abstinent despite his professed desire to do so'' (p. 181). Staff in the treatment facility often begin to act similarly to how the family of origin behaved with the addict. ''All of the social systems within which the addict functions seem to have as an implicit goal the maintenance of drug use somewhere in the system, manifest in the addict's inability to tolerate abstinence'' (p. 185). Schwartzman and Kroll (1977) recommend this phenomenon be studied and worked with by taking the locus of addiction out of the patient and placing it where they feel it belongs, namely in its social context. (see also Stanton, et al., 1978).

Family Patterns

Schulz (1974) found drug addiction to be the end state of a ''unmastered family conflict chain'' (s. 84). He described two typical pedagogic styles of parents having drug addicted children and the transaction patterns which can be found in these families (although these styles do not have to lead to drug addiction).

The ''spoiling'' educational style is characterized by overwhelming the child with (mostly motherly) love. The child can do anything it wants and at the same time is overprotected; it should not be hurt or stressed and does not experience any resistance. During puberty and adolescence the youth is mostly left alone; he can go where ever he wants and is given much pocket money. Meanwhile the parents begin to feel that they cannot cope with the youth's many-sided ''modern'' desires and that they no longer can control him with formerly useful methods such as

discussion and material and financial privileges. The youth has the feeling that he is not understood, has nothing in common with his parents anymore, and that they think he is incapable and dependent. Questions, blaming and indications of disappointment from the parents are met with by rejection, defiance and tendencies of flight by the youth.

In ''neglecting'' transaction patterns the child does not get enough caring and is given the feeling of being unwished for, either through the parents behavior or through verbal-emotional messages. These children are left to fend for themselves and at a rather early age find that they have to make their own way in the world. This parenting pattern brings with it frequent and incongruent punishment, because when the child (possibly) misbehaves there is no time for observation and empathetic, soothing conflict solving. Children from such families are often very insecure because the alternating severe punishment and lack of attention happen in a sporadic and accidental way and are therefore not cognitively controllable. The psychic reaction to this type of family situation is mostly escape tendencies on the part of the children and parental resignation and lack of interaction.

These two patterns can sometimes both be found within the same family system, with one parent spoiling the child while the other neglects it, or alternately in one parent, who spoils the child when feeling guilty and neglects it when in stress.

Hirsch (1961) found that families of drug abusers reveal an unhappy marriage, the mother being ambivalent toward the children and the father relatively passive. In his studies the personalities of mother and child were found to be similar. Frankel (1975) observed that the relationship with the father was critical; he was usually perceived as being cold. Abusers felt alienated from family life and lifestyle. She found that whether the fathers were restrictive or permissive was not a significant factor in drug abuse. Baer and Corrado (1974) pointed to the unhappy childhood of the abuser, with harsh punishment and lack of parental concern for the child's goals and behaviors, as a main cause of drug abuse.

In Seldin's research (1972), mothers were perceived as dominant, emotionally immature, conflicted, and ambivalent. Seldin also found that one-third of parents and siblings of adolescent addicts needed psychiatric treatment: mothers and sisters had depressive and neurotic symptoms while fathers and brothers were involved in some kind of drug abuse.

Stanton (1979) stated that drug misuse appears initially to be an adolescent phenomenon. He tied it to the normal but often problematic process of growing up, trying out new behaviors, becoming self-assertive, developing close (usually heterosexual) relationships outside the family, and with the process of leaving home.

Stanton's prototypic drug-abuser family has the following characteristics: one parent is intensely involved with the abuser, while the other is more punitive, distant, or absent. Usually the overinvolved parent is of the opposite sex, with the overinvolvement sometimes going as far as incest. The abuser serves a function in the parents' relationship, often as a channel for their communication. The parents have heavily disturbed marital relationships, their struggles take place via the child; often they can only unite over the child's problem, so the abuser in some sense keeps them together. When the child reaches adolescence the parents are threatened with losing the child and panic sets in. ''The family then becomes stuck at this developmental stage, and a chronic, repetitive process sets in, centered on the growing up, individuation, and leaving of the ''identified'' patient. The use of drugs is a paradoxical solution to the dilemma of staying or leaving, for it allows a certain level of competence (e.g. hustling) within a framework of incompetence, i.e., it is pseudo-individuation'' (1979, p. 253).

Treatment

The first goal in family therapy with drug addicted members is to try to persuade the family to pull together to get the substance abuser off drugs, at least temporarily. If he does not stay off drugs, another withdrawal can be tried or some kind of drug-aided measure can be taken. It is strongly recommended not to have a family member distribute these medications. Several authors, especially Bowen (1974) and Berenson (1976), have presented methods where family therapy can begin while the index patient is still drinking. No references were found in the case of drug use. There is a risk of perpetuating the system which supports drug use by offering a pretense of help while no actual change occurs.

The main family therapy techniques for working with specific family problems of drug abusers include structural (Minuchin, 1975), systems (Bowen, 1974), psychodynamic (Boszormenyi-Nagy and Spark, 1973 and Zuk, 1967), communication (Bateson, 1956, Haley, 1977 and Satir, 1972), and behavioral (Stuart, 1971 and Wood, 1977) theories.

Two approaches emphasize the importance of family history in which past occurrences are inappropriately applied to present situations and thus create change through insight. Insight is gained by cognitive or affective reencounter with the past in the psychoanalytic approach. Interpretation is used directively to create immediate shifts in the family system. The cognitive is emphasized in Bowen's systems approach, where eliminating the use of affect is attempted. Using the family's past history is useful as long as there is no blaming, guilt induction or dwelling on the hopelessness of long standing, fixed patterns.

Correcting discrepancies in communication is the goal of communication-centered therapy. Methods used here are having messages clearly stated, clarifying meanings and assumptions, and permitting feedback to clarify unclear messages. The therapist acts as an

objective communications director.

Teaching extinction of responses by significant others which cause drug use in the index patient, as well as how to give positive reinforcement for desired behavior, are the techniques used by behavioral family therapists.

In working with substance abusers, most family therapists also deal with the immediate moment of experience between themselves and the family. Self-disclosure, the sharing of the therapist's feelings and experiences as a real human being, is considered to be of utmost importance.

Minuchin's structural family therapy (1975) has two major categories of therapeutic tactics, joining and restructuring. Joining is done to enhance the therapist's leverage within the family. The therapist acts as a host and provides a comfortable social setting. Flexible choice of seating and social interaction with each family member is important. The therapist should have the capacity of joining each family subsystem. Three types of joining techniques are described: maintenance, tracking and mimesis. Maintenance supports the family's present structures and rules. Tracking means actively allowing and receiving the family's verbal and nonverbal communications. Mimesis is the therapist's use of the family's style and affect, for instance, if the family communicates through touching, then the therapist also touches. In the early stages of joining, premature sharing of information is avoided to decrease the defensiveness of the family, which often feels threatened that they, rather than the identified patient, could be the problem. Restructuring involves a challenge to the family's homeostasis, in which the family's bonding and power alignments are changed. Here, the therapist uses social manipulation (the word being used in a positive sense) to create change. Minuchin recommends use of the contract, probing, actualization, marking boundaries, assigning tasks, utilizing symptoms, manipulating mood, support, education and guidance as techniques for producing change.

Some problems which typically occur in the early stages of treatment have been identified. Some parents have difficulty talking about drug use with their children, even though the children are aware of their own and their parents' abuses (Reinhart, 1974). Three problems were pointed out by Moses and Burger (1975): many parents unconsciously try to sabotage the treatment; parents may be unable to deal with a healthy relationship to the child; and little can be done to help the child without the parents' cooperation.

Typical ''later stage'' problems were presented by Meek and Kelly (1970), such as playing games with the therapist, attempting to maintain the index patient's weakness, and the fact that many individual behaviors reinforce the problem. According to Halleck (1967), the family often tries to maintain its own balance by keeping the index patient sick; the treatment must deal with these imbalances as they come up.

Group Therapy and Therapeutic Communities

The author has chosen to describe these two approaches under the same heading because small group therapy, exemplified by the encounter group, and large group therapy, by the therapeutic community (TC), have a significant interrelationship and are often found within the same institutional context. Historically they have separate developments and are structurally distinct. Most TC's use encounter group methods as therapeutic tools within the context of the community. Encounter groups in nonresidential settings described in the literature of drug abuse therapy were only used in methadone clinics and will therefore be omitted here.

The forerunner of the encounter group was developed by Kurt Lewin (1951) and was originally called a ''human relations training group'' or T-group (for training) or a ''sensitivity training group.'' The term ''encounter group'' is attributed to Carl Rogers. Charles Dederich, founder of Synanon, was the first to use encounter groups extensively in a drug addiction program (Yablonsky, 1965). The term ''therapeutic community'' was first used in the mental health field in the early 1950's by Maxwell Jones (1953). The common idea in the background of these types of group work was an effort to encourage a ''sense of community''.

> A therapeutic community is defined as a type of psychiatric hospital unit which attempts not only to maximally utilize the therapeutic potential of the entire staff, but more importantly to place the major responsibility upon the patients themselves to serve as primary change agents. The therapeutic program is designed to facilitate patients having a significant role in the rehabilitation of themselves and other patients. ... In order to assure that this occurs, a therapeutic community needs a well-defined coordinated, and structured program, so that almost any interpersonal situation in the hospital helps to transform the ''patient'' to ''change agent'' (Maxman et al., 1974).

An American Psychiatric Association Task Force Report (1970) described the characteristics of encounter groups in the following way:

> Despite widely varying formats, most of the groups share some common features: they attempt to provide an intensive group experience; they are generally small enough (six to twenty members) to permit considerable face-to-face interaction; they focus on the here-and-now (the behavior of the members as it unfolds in the group); they encourage openness, honesty, interpersonal confrontation and total self-disclosure; they encourage strong emotional expression; the participants are not labeled patients; the experience is not labeled ''therapy,'' but nonetheless the groups strive to increase inner awareness and to change behavior. The goals of the groups vary: occasionally they are explicitly entertainment - to ''turn on,'' to experience joy, etc. - but generally the goals involve some type of change - a change of behavior, a change of values, a change of being in the world.

Length of stay varies in TC's from several weeks to several years. Encounter groups which are held

on a nonresidential basis typically meet for 10 to 15 sessions, either weekly or in a more concentrated schedule.

Proponents of the TC approach to drug addiction therapy say that TC's offer the most comprehensive treatment of the social, educational and economic deficits and maladaptation of clients. This claim is based upon the interrelationship of the effects of drug use, the personality of the individual and the influence of the social environment and course of the addictive process.

Four residential programs, all having a drug-free treatment approach, will be described here. These TC's, Synanon, Phoenix House, Daytop Village, and Odyssey House, have many basic similarities and a few major differences (Casriel, 1963, Densen-Gerber, 1973, Densen-Gerber and Drassner, 1974, Edmonson, 1972, Glascote et al., 1972, Lieberman et al., 1973, Nash, 1974, O'Brien, 1978, Rosenthal, 1973 and 1974, Sugarman, 1974, Yablonsky, 1965).

Concepts of the Therapeutic Community in Residential Drug Treatment Programs

1) These TC's are based upon a self-help group format. Synanon was the first to be established and has influenced the other TC's described here. Odyssey House differs the most from the original program.

2) All believe that a total 24-hour residential community is necessary to resocialize drug addicts.

3) Each of these TC's is a hierarchical organization with an autocratic leadership.

4) The activities of residents are structured from morning to night, with most of their time spent in group settings. There are very limited possibilities for solitary activity.

5) New residents are initially totally isolated from their former life, including family and friends who are considered to be part of the addict's problem. Any breaking of these rules results in different forms of punishment (see point 7). The initial isolation and intense activity schedule serve the purpose of maximizing the effect of the TC, which is to give the resident a new set of values and norms for behavior.

6) Residents can work their way up through the hierarchy to staff positions with responsibility. The requirements are: drug abstinence, no violence, industrious work, and personal growth (self-awareness, honesty, and responsibility, as well as indications of adherence to the belief system of the TC). Senior residents serve as role models for newer residents, a focal point for their hopes for rehabilitation, and also to undermine any tendency to form a ''we against them'' division between staff and ex-addicts.

7) These TC's have a rigid system of rewards and punishments which are constantly made explicit to the entering addicts. When a resident shows his growing maturity according to the values and norms of the TC, he is rewarded through promotions and increase of privileges. On the other hand, if any of the rules are broken, punishments of various severity (depending on the rule broken) are instituted. Job demotion and loss of privileges are common forms of punishment as well as blistering verbal reprimands by peers and staff, known as ''Haircuts''. The ultimate punishment is exclusion from the TC and is usually only used when one of the cardinal rules is broken. Less serious deviations from required behavior are handled in the encounter group.

8) The major therapeutic tool of the TC's is the encounter group, discussed in the next section.

Encounter Groups in Residential Drug Treatment Programs

The encounter group is the centerpiece of the TC concept. The style is most often extremely confrontational, using abrasive verbal attacks on an individual about his attitudes and behavior. The TC's have the concept of total honesty as an essential part of interpersonal behavior. The extremely aggressive techniques are supposed to cut through layers of lies, manipulation and ''tough-guy'' postures which characterize the behavior of many addicts. A gut-level response is desired, not intellectual understanding. Screaming, yelling and profanity are forbidden at other times in TC life, but in the encounter group residents are encouraged to use all three. ''Behavior and thinking are modified by verbal-sledgehammer attacks... the individual is blasted, then supported, and he seems to learn to change his behavior as a result of this positive traumatic experience'' (Yablonsky, 1965). The ''here-and-now'' of TC life is focused upon in these groups; how the resident relates to others and performs his work, and his current feeling states.

The support aspect for individuals in encounter groups is handled differently in these TC's, with Synanon having ''virtually no support, no attempt to draw similarities between members, no gentle invitation to members to engage in the group'' (Lieberman et al., 1973). Daytop Village has the most concrete norms of support during the encounter, as well as afterward, when they deliver ''human first aid'' to ''patch up'' the resident who has been focused upon during the encounter.

The encounter group seems to have two functions in the TC's. It is used as a therapeutic tool in the resocialization of the addict and as an instrument of social control in the daily functioning of the TC. At Daytop Village, Phoenix House and Odyssey House there is a formal structure in which the complaints of one resident against another are collected and brought up in the next encounter group. There is no formal structure in the Synanon encounter groups, although this type of infraction is also handled.

Membership composition of the encounter group is changed from session to session by a staff person in all four TC's. The reason for this is to prevent informal contracts between residents not to say anything against each other, which would undermine the effectiveness of the group process. It also allows the placement in the same group of a person making a complaint against another (see above). Another need which is fulfilled with this method is for residents

of the program to relate to all the members of the TC and not to just a select group, as would happen if the encounter groups had static membership. A means for social control of the residents by the organization is also provided for in this way.

In Phoenix House, Daytop Village and Odyssey House, there is a formal leader for the encounter group. This indicates that the organization wants the encounter group to progress in a certain way and that the leader will bring it back on track if it begins to stray. At Odyssey House, a professional co-leads the encounter group so other treatment approaches besides confrontation can be used, resulting in an encounter group which often resembles traditional group therapy.

The major differences between the four TC's are in the use of professional staff, emphasis on reentry, and use of individual counseling. Of the four TC's only Synanon has no professional staff at all. Phoenix House employs a doctor, a nurse, a research psychologist, a social worker and a teacher. Daytop Village uses non-ex-addicts in the administration, plus a nurse and a teacher. Odyssey House has come the furthest from the original Synanon concept of therapy for addicts by ex-addicts and is run by professionals and ex-addicts together.

Synanon is against reentry. An attempt is made to create a culture in which ex-addicts can live and grow separate from ''straight'' society. Ex-addicts leave their original TC to set up and run new Synanon TC's in other areas. Phoenix House and then Daytop Village place progressively more emphasis on reentry while Odyssey House gives it the most importance, having an education and vocational program to help in this process.

At Synanon and Phoenix House there is no individual counseling. Daytop Village has ''Gurus'' (staff ex-addicts) who serve as full - time counselors to residents. At Odyssey House a resident may have individual counseling near the time of reentry in addition to the encounter groups.

Marathons or extended encounter groups also have a place within the TC. They last at least 16 hours, sometimes as long as 36 hours. ''The word 'catharsis,' meaning a process of emotional purification and cleansing, is frequently used when describing the clinical aspects of the Marathon. Individuals in the Marathon work to see themselves as they really are. The free expression of feelings is stressed, with each person becoming aware, sometimes painfully so, of how he or she is perceived by others'' (Hoag and Gissen, 1984, p. 47).

Page (1982) described a Marathon group in which 12 residents of a TC participated in a 16 hour session. After one year, only one person from this group returned to prison. The session was analyzed using the Hill Interaction Matrix (1961 and 1965). Page found that over 50% of the time spent in this Marathon was in interactions which Hill (1965) characterized as being high in both interpersonal threat and work and rated as highly therapeutic. The work dimension has a member (or members) taking the role of patient and actively seeking self-understanding. Interpersonal threat in a group means that members discuss issues which involve interpersonal risk taking. In this way, Page showed that this group was successful in carrying out its stated goals; helping members work toward resolving personal problems and encouraging members to give and receive feedback about the ways they relate.

Rittmannsberger (1984) supported the TC concept but thinks that it is more constuctive to separate social learning and therapy because of their differing functions. He recommended that they be carried out by separate staffs. ''Damit ist auch der Konflikt zwischen dem nach Normen orientierten Alltag und der alles, auch die Normen, hinterfragen wollenden Therapie angerissen.'' (In this way the conflict between everyday life, which is oriented to social norms, and therapy, which can question everything including the social norms, comes into awareness [translation: the author].) It is then possible for the therapist to do true therapy; meaning, allowing the client develop in a secure climate. He believes this is only possible if the therapist is not responsible for questions of daily order.

Effectiveness

Retention rates in TC's are very low. In a standard TC, the median length of time spent there was 6.6 months (Sells, 1974); reported annual dropout rates are between 60 and 86% (Glaser, 1974 and Rohrs et al., 1972). Glaser found that over half the dropouts occurred in the first month, two-thirds by the end of the second month and three-quarters by the end of the third month. Rohrs et al., who studied Odyssey House, reported that 45% leave or are expelled in the first week. For the small select group which stays in the TC, outcomes regarding drug use, criminality, and employment are good (Sells, 1979).

Both graduates and dropouts from Daytop Village criticized the encounter group for not dealing with the addict's particular needs, especially with his individual problems in behaving in a socially accepted manner when separated from the TC (Collier and Hijazi, 1974). This is partially because much effort is directed toward reinforcing the values and behavior of the over-all program.

Hawkins and Walker (1983) made a study of two TC's modeled after Synanon and Daytop Village. They were interested in finding out why so many people spending a length of time in a TC appear to ''get converted''. They explored the characteristics of this ''conversion'' experience, trying to explain the high rate of relapse after treatment.

Their basic assumption was when people's talk and actions are inconsistent, their veracity, reliability and character are called into question. Normally, it is possible to explain inconsistencies by pointing to events unknown by the questioner, but in a TC, which has a restricted interactive setting, this is not possible. ''In such settings, an

individual's talk is a structure which limits, and to some extent, determines the future lines of action available to him if he wishes to avoid the stigma which accompanies detected inconsistency'' (1983, p. 284).

They described a process of conversion which begins when the new resident makes a verbal statement which conforms with the TC's expectations. For the client, it appears that his verbal performance is a way of minimizing immediate unpleasant pressure, by decreasing the group's watchfulness and increasing personal freedoms. By making a verbal statement supporting the TC's code, the new resident gets off ''grace'', which is a stage where he does not have to belong to the TC as a member (he is just ''trying it out''), but at the same time is constantly accompanied by an older resident and has no privileges. Because of the restricted setting, his future actions are actually limited by this verbal performance. His subsequent actions are monitored and judged for consistency with his verbal utterances. ''Each performance enmeshes him more deeply in a personal history as a committed client in the eyes of his new peer group. If his acts are inconsistent with his verbal presentations of commitment, he is confronted with increasingly intense negative sanctions'' (p. 294).

The TC conversion is created by selectively reinforcing desired behaviors (prescribed verbal performances) through praise of staff and other residents and consistently punishing undesired behaviors (incongruities with the verbal performances). ''The techniques involve manipulating environment reinforcements for behavior in a restrictive interactive setting to extinguish undesired behavior and reinforce desired behavior'' (p. 295). After leaving the TC, the client's talk and actions are no longer continually monitored for consistency. Outside, the client is responsible for defining limits of behavior and for monitoring his own behavior for acceptable consistency.

The authors claim that the main problem with TCs is that the behaviors learned leading to the initial conversion are inappropriate in ''straight society.'' After a commitment to living a drug free life has been obtained through the techniques of manipulating environmental reinforcements, the client should be offered specific new interactive skills which he can apply to the new situations outside the TC.

The Zurich Clinic

The clinic where the author worked for 2 1/2 years is similar in some ways to the TCs described in this chapter, while also being very different. It will be referred to in this dissertation as ''the clinic'' to protect the confidentiality of the cases studied.

It is set up as an independent-standing facility in a former children's home, outside a very small farming town. The clinic is organized as a therapeutic community under the administrative direction of a cantonal mental hospital. Financially, it is part of the cantonal administration (salaries of the staff are paid by the canton). Staff consists of: 4 administrators, 3 psychologists, 4 social workers (one each for the groups living in sub-TCs) and 7 work supervisors (pottery shop, carpentry shop, household, kitchen, bakery, caretakers and garden). There is room for a maximum of 28 residents (average number was 25 per day in 1984). Almost all of the residents come from the judiciary system, with the provision that if they complete the 18 month residential therapy program, they are freed of their prison sentence.

The differences between the concepts of the clinic and the 4 TCs (Synanon, Daytop Village, Phoenix House and Odyssey House) will be listed below; where the concepts are the same they are omitted. The numbers refer to the concepts listed under ''Concepts of the Therapeutic Community in Residential Drug Treatment Programs'' in this chapter.

1) There are no ex-addicts on the staff. The policy is against this. There is lip-service to the idea of self-help - the residents are supposed to help each other - but there is no chance of rising in the hierarchy to the role of staff in this TC. Residents are referred to by the name of the clinic plus ''er'' at the end (for instance - Daytopper), but the name of their collective meeting - without staff - is PM (patient meeting). They often refer to themselves as ''patients''.

3) The clinic is organized hierarchically with an autocratic leadership. At the top of the hierarchy is the director, with an administrator from the mental hospital above him for financial questions and a psychiatrist from the cantonal social services for therapeutic questions.

6) Residents can only work their way up to the top of the patient hierarchy. The requirements for this rise are the same as in the 4 TCs. There is sometimes a ''we against them'' division, even between senior members and staff.

Comments on the Literature

The main problem in studying the literature on drug addiction is that there are so many interesting theories, but very little description of case studies or discussion of how to actually work with the abuser. In other words, little attention is paid to the phenomenology of the psychotherapy of addictions.

The Gestalt methods described in the literature seem closest to those used in process-oriented psychology, with the exception that Gestalt therapy tends not to see a meaning in addiction.

The author had little chance to apply family therapy methods in her work in the clinic. It was considered unnecessary that the clinic provide this service since clients were discouraged from having contact

CHAPTER 4

Introduction to the Case Studies

In the following section two individual cases will be presented. The following information is contained in both cases: personal anamnesis, drug-history anamnesis, childhood dream, drug feelings and effects, sensory-grounded information, analysis of a video-taped therapeutic session (taken in the clinic), and analysis of a video-taped session (taken several years after the clinic stay), in which reaccessing the drug state was the focus. The process structure will be presented, summing up the process elements into a coherent picture of the individual's process.

The first video analysis of Bob contains much of the original video-transcript, so that the reader has a chance to get the feeling of an actual process work session.

BOB

Anamnesis

Bob is the oldest of 3 children with sisters, 2 and 4 years younger. He was born in 1955 and grew up in a middle sized town near the Lake of Zurich, Switzerland. (At the time of the first video-taped therapeutic hour Bob was 28 years old.) His father, in his middle 50's, founded and runs a successful building company. His mother, the same age as Bob's father, is a housewife.

Bob had a close relationship with his mother and used her as a go-between with his father. Bob experienced his father as very authoritative, a disciplinarian, and mostly only interested in his business. He was ''always there when help was needed to keep the family name in good light,'' but otherwise did not have much time for the family. The relationship was characterized by Bob's wonder at his father's assertiveness, success, and good business sense.

As a child, Bob felt like a king when he could make business with the neighborhood children, for instance, by pulling them up the mountain on their sleds for 10 cents. During his early school years much of his free time was taken up with caring for his pony. Bob had difficulty being as consistent and disciplined as his father expected him to be.

Bob viewed his sisters as inferior and unimportant, as ''quacking women.'' He felt he was more important because he was a man. He often terrorized his sisters. ''I was afraid they would take my place away; often I wished I didn't have any sisters.''

Education

Bob began kindergarten at the age of 5. He disliked attending it; he was often punished and locked up because he tormented the other children. His first 6 school years were in his home town. At the end of 6th grade, he broke his leg and spent 4 months in the hospital. Because of this, he decided to go to a non-classical secondary school instead of repeating a year so that he could go to normal secondary school. He still regrets that he did not repeat the year; he feels he is inferior because he did not attend the ''higher'' school. After he finished school at 16, his father decided which profession Bob should have (same as father) and where he would do his apprenticeship. He never thought about his profession because his father had firm plans for him. Bob was considered the ''star of the show'' in the office where he worked - he made the best grades of the 6 other apprentices and received the highest achievement salary. His apprenticeship lasted 4 years; at 20 he finished ''brilliantly.''

Addiction History

Bob sees the beginning of his addiction in the constellation of his peer group and in his desire to ''break out and do something different.'' He was mostly together with people older than he and did not want to be an outsider. At 14, he began to smoke hashish with his friends. At 16, he took his first trips on LSD. With a girlfriend, he tried amphetamines. ''I was completely taken by it, the power (energy) and concentration had always been a desire of mine. I like it when I'm so dynamic and when I can do so much.'' When he was 18 he sniffed heroin for the first time. He asked himself at that time where it would lead, because he saw the ''messed up'' people who were taking it too. Bob decided that he would be able to deal with it, ''you can give yourself a reward with it, because you are working so well.'' Opposition came up in him that he should be able to do what he wanted. ''They (his parents) should be happy, as long as I'm doing well in the apprenticeship.'' After he had completed the apprenticeship, Bob went into basic training in the Swiss Army (17 weeks) where he had his first shot of methadone. He says he could not stand the pressure and subservience in the army. With the drug, he felt above the others. He explained it was his way of rebelling. After basic training, Bob slid headlong into heroin and cocaine. Three-quarters of a year later Bob was fired from his job. He then began to deal drugs in larger quantities. After Bob was fired, his father offered him a job in his company, his dictum was: we will be able to make it all better. His family doctor gave him Valeron and later, Bob found a doctor who supplied him with methadone.

Legal Problems

In the winter of 1976, Bob was arrested the first time for dealing. He was in jail 14 days and received 18 months probation. In June 1981, Bob was involved in a car accident under the influence of drugs. He spent 2 months in jail for this. In the summer of 1982, Bob was tried for ''extreme trafficking with hashish.'' Thanks to his father's lawyer, Bob received the sentence of out-patient therapy for 6 months. From 1977 to 1983, Bob received legal methadone treatment. The only break in his methadone use was for a bit over one year, when Bob was in Morocco, trying to get distance from hard drugs. In 1981, Bob had a fight with his father and stopped working for him. He had temporary jobs after that and very little money. During this time he consumed a lot of cocaine. In the summer of 1983, his hashish dealing blew up and he was in jail for 2 months. In August 1983, he stood trial in which his sentence from 1977 was renewed. Added to this was 6 months for hashish dealing, breaking and entering and consumption of drugs during his methadone treatment. At this time he applied for a place in the clinic, knowing that if he completed the therapy, the jail sentence would be canceled. He underwent methadone withdrawal and entered the clinic in May 1984.

Childhood Dream

In a series of dreams, these are the main points:

I was flying completely relaxed. I would start to vibrate heavily when I was not relaxed; I had to stay relaxed. I had to try to find out how to fly so the vibrations would not come. Sometimes I could get back into the quiet flying after the vibrations started.

Drug Feelings

General: I liked the dope itself, the feeling of ''time out''. I fixed because of the ''kick'' (which he was never able to describe in words).

Cocaine: FLASH!!! Beautiful stress situation. Tension, my heart beats hard, I feel light and a bit sick. I can't compare it to anything, it's like forbidden sex, dangerous but exciting, the razor's edge.

Alcohol: People would think I'm a zero if I didn't drink at a party, they'd think I'm not a man; it's cool and refreshing but you get warm at the same time, the whole world drinks gin and tonic; it's like a vacation, a pretty girl, cool nice weather.

Methadone: 6 years on this legal drug into which he also fixed heroin: Comfortable security, crutch, wheelchair, needs always filled, everything goes relatively well, feeling of taking a break, you're the king, no one can touch you.

Sensory Grounded Information

1) tone of voice:
He spoke a bit over-loudly, with a slightly aggressive undertone, and a fast rhythm.

2) clothes and looks:
Unlike the other patients, Bob wore ''normal'' casual clothes, mostly jeans and T-shirts with stripes or solid colors. He was actually more colorful than the average patient but not more colorful than the average Swiss citizen. He did not wear the typical black junkie clothes; he was better dressed and looked neater. Actually he dressed in a very normal way for his age group. When he worked for his father he conformed to the dress style there, wearing a suit and tie, although he said he hated wearing them. Earlier he often turned up on the ''scene'' to buy drugs in a suit and tie, carrying a briefcase. Physically, Bob took better care of himself than most of the patients; he always made a clean impression. He kept his hair trimmed, shorter than most of the male patients. He had a small well-kept moustache.

3) posture and facial expressions:
During hours with the therapist, he had two main postures: either leaning back on the cushion, looking very relaxed or sitting up straight, with legs crossed, looking very attentive. In meetings, he would lie back in the chair, spreading himself out, with one leg stretched to the side and the other crossed, with his foot on his knee. He seemed to take up the whole space of the chair and then some. Often, he would have his arms on the arm rests, with hands crossed on stomach. If he was being spoken to in a public situation, he would cross his arms over his chest, while keeping his legs in the above position. Bob smiled a lot; but this smile would often not reach to his eyes. His face was mobile when he was relaxed. His eyes were often slightly staring; he did not blink much.

4) movements:
Bob's body movements were neither particularly fluid nor unusually inflexible. His slightly stiff hip region seems to be normal for men in Switzerland.

5) relationship characteristics:
Bob was very friendly, in a superficial way. He was this way with everyone, especially in the first months of his stay in the clinic. Almost everyone could get him to help them out. He was extroverted and charming. He did not make any close friends at first; later he developed a friendship with another male patient. He was emotionally fairly controlled, but when pushed, he got angry or surprised enough to shout, although even then, there was a quality of control in it. He was rather fun to be around; he told some good jokes and could be entertaining. When playing a game, he was so competitive that the author could not enjoy herself. In team games, if someone did not play very well, Bob got angry with them and often tried to play for them. Most of the patients kept him at a distance (whether he wanted to get close or not), saying that they did not trust him.

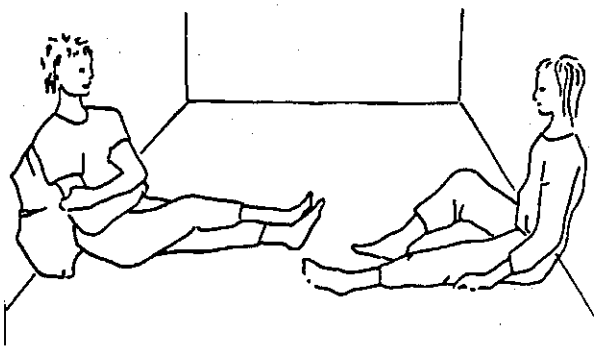
6) synchronicities and accidents which happen around him:
During his stay in the clinic Bob was blamed several times for things which he did not do. Example: The author had twice had the same tire go flat on her car and began to think that someone was letting the air out. When asked by a staff member who she thought it was, Bob came to mind. Bob got very angry when he heard this and said that he thought the author must be insane - later the author found out that the tire was defective.

7) body symptoms:
There were none known, he said he never gets sick.

Clinic Session

In this hour Bob was trying to decide whether his father should come to visit him. He had been putting off the visit for 3 months and this was the last therapy hour before the date arranged with his therapist (T) for his father's visit. He had not yet called his father; the date was three days away. His girl friend, mother and sister had already visited him on separate occasions. Bob had many day-to-day conflicts and problems with his father, which he had been avoiding straightening out (what to do with his furniture which was stored at his father's company, whether or not he would continue to work in his father's firm after his stay in the clinic, whether to keep his present occupation or to be retrained to do something he was more interested in), besides his psychic conflict and fear of his father.

The hour begins with Bob's saying he is afraid he will get run over by his father and that he has decided he wants to be diplomatic with him, so they do not have any problems together afterward. Bob gives a double signal while he says this. He leans back and talks in a calm voice as he says he is afraid he will be run over by his father. We already have an indication of Bob's process here. He primarily identifies himself as a diplomatic person and as a candidate for being run over by his father. Secondarily, i.e. in that part of himself with which he cannot identify, he is a fighter and, like his father, has the ability to dominate people. We do not yet know exactly what this means to Bob. It comes out in his behavior toward T, in that he sometimes interrupts her and overrides her verbally. This is how his father would probably act. His backward-leaning posture makes him seem more like someone who has already been run over, rather than someone who is afraid that he will be. The very idea of facing his father ''runs him over.'' The part that is not explicitly present here-and-now is ''the father''.



Bob: I'm afraid I'll get run over by my father.

Since Bob had been confronted recently by the ''house''* about his diplomatic behavior, T asks him what has been going on with him on that level. The collective opinion was that he had been cheating everyone and that he really was not interested in working on this old behavior pattern. He then

* ''House'' is the expression used in the clinic to indicate the collective of patients and staff.

explains that he has declared to the group meeting that he wants people to confront him more on his diplomatic behavior because he really does want to stop it.

> B: It's like this... earlier I was totally like that, on the one side I was a junkie and on the other, the good young man. On both sides I wanted to be in [accepted] and actually I was always in between. And I never saw before that it was necessary to do anything about it. I never wanted to be concrete and never wanted to pin myself down, that was being a diplomat. I always wanted to keep both exits open.

He is aware of this split and tells T where he is working on this behavior in the clinic. It is interesting to note that in the above passage Bob is talking about himself in the past tense, stating that he wants to change his behavior - actually this same behavior is happening in the present: he says he wants to be diplomatic with his father; in that very moment, he is being diplomatic with T - besides the fact that his declaration to the ''house'' was also diplomatic, with the goal of avoiding further confrontation on this subject. In this way, one can see that he is still trying to keep ''both exits open''. He is talking about changing, but no change is taking place.

T asks him why he wants to be diplomatic with his father.

> B: Because I don't want to have any fights with him. And I noticed that if I were to say I don't want anything more from my father, it just wouldn't be true. It would be a lie.

Fighting, especially with his father, is way beyond the range of possibilities Bob thinks he has. His quoting himself in the above passage indicates that he has a dream figure who does not want to have anything further to do with his father. Bob probably says it would be a lie because this figure is so far from his conscious identity.

From the standpoint of Bob's primary process, being anything but diplomatic with his father is extremely unreasonable. Presently, Bob has no tools for dealing with the possibility of truly being on his own. His whole power and capacity are projected onto his father.

Bob shows with this statement that he has the ability to metacommunicate about himself, to stand outside himself and observe what he is doing. This is a positive sign; it means that he might conceivably gain insight into and perhaps integrate the still fairly unconscious contents of his dream figure ''the father,'' which is talked about, but not directly and consciously lived out right now. It does appear in that his voice is stronger and more forceful here.

Moments later Bob makes a switch and asks T if she thinks he is a coward for wanting to go back to work in his father's company. The dream figure which does not want Bob to go back is now projected onto T. He also explains that if he did not somehow act diplomatically (in this case he means leaving open the possibility of going back to work in his father's company) he would be sacrificing himself. During this exchange T is beginning to get angry, because she has heard all of this repeatedly in past hours and wishes Bob would just change and stop talking about it, but she does not come out with these feelings directly. Instead she makes many small movements and her tone of voice is slightly aggressive. In other words, she is giving Bob a double signal, since she is primarily acting as if she were not angry. She asks him what would be so bad about sacrificing himself.

> B: (long pause, then very quietly) Not so bad. (looking around) I actually don't know. You know, in principle we've already talked about all of this, it must piss you off.
>
> T: No, it doesn't. Does it piss you off?

T is now fully dreamed up but is avoiding taking over the role. His ''fighter,'' the one who is not diplomatic, or his inner father, is now represented in the form of T, who is angry. At this point, if T had expressed what she was feeling, she probably would have ''run Bob over.'' Because she has an edge against behaving strongly herself, she cannot demonstrate it for Bob, and so the work will cycle. The cycling will go on until they really do have a fight or are able to metacommunicate together about the process.

Bob speaks about what he would really like to say to his father about changing his profession, but then realizes that he would not be able to work for his father anymore if he did. He is rather vague during this passage; he says ''maybe'' he would like to do something else, and that he wants to ''check it out'' in the next few months.

T suddenly asks him to turn his body away a bit more. She has noticed that he is double signalling with his body posture. He is looking at and talking to T but his legs are slightly turned away from her.

> T: [During the last passage, T said many times, ''uh huh''.] Can you help me make something clear? Could you turn away a bit more?
>
> B: WHAT? (sitting up, leaning forward)
>
> T: Could you turn away a bit more? You are sitting slightly turned away from me. Could you turn away even a bit more?
>
> B: Why? (sitting up very straight) Does it bother you?
>
> T: You should try sitting even more turned away. Not like that, facing me. Like you were before, only more so.
>
> B: Why?
>
> T: Like that, facing me, is wrong for you. (moves to amplify his old position) Try it like this.
>
> B: Why?

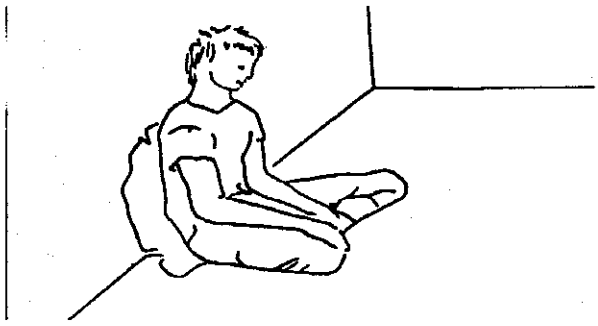
T: Because your body's doing that, with your head you are here, speaking to me and I'd be interested to know what else is going on. Let's try to find out.

B: (laughs a bit but changes position) Like this?

T: Yes, but try also putting your head and upper body in that direction. Now try feeling how it is to sit like that. How is it different from before? Try not even looking at me. How is that? What is the difference? Now try sitting up again and turn toward me and look what the difference is. (He smiles) And then go back again. You might have to do it a few times. But they are very different from each other.

B: That's very clear.

T: You're uncomfortable like that. [Bob is sitting up, facing T directly.]



Bob: To talk this way is surely better.

B: Yeah. (short pause) No! So it isn't uncomfortable! The opposite! To talk this way is surely better.

T: Maybe that's true. Though I would think, that, at the moment, the other way is better for you. What's the other like? Could you sit like that again?

B: (takes turned-away position, laughing a bit, after a few seconds blows air out through his mouth, then puts his head back on the cushion and looks up at the ceiling) HUM.

T: What? At least for me, you are much more with yourself in that position. At any rate, you aren't so related to me.

B: Yeah, it's a big difference.

T: What is it like exactly?

B: I can avoid you better this way.

T: That way? Why do you want to avoid me?

B: (Still sitting looking up at the ceiling) What makes problems for me is certainly... yeah, well, I said this before... that this must surely piss you off... when I, when I say to you that I don't want to completely break off... with the thing... with... with my father's firm. Especially after the X discussions we've had about it... after that...

Now they have come around in the cycle again to the point where Bob thinks T is angry with him. T deals with this now by taking it as a projection (although it really is not one) and asks Bob to play her, as the therapist. This might work, but it probably would have been better if T had metacommunicated about what was happening between them. For instance, ''You think I'm angry with you so I'll take that over for you. Yes, I'm angry. What do you think I'm angry about?'' Instead T pushes Bob to play her, changing places with him (he does this immediately, which indicates positive feedback) and encourages him to be her. He speaks loudly and firmly as T. His strength surprises both of them.

B: (talking louder and firmly) But I'm tired of the reaction... you know we've talked for 2 months... no, wait, it has certainly been 3 months that we've been talking about this theme... and now you come like this, 3 days before your father comes! I'm so pissed off at you... Under these circumstances I don't want your father to come here. Period!

T: (loud) Wooow!! (both laugh)

B: Gulp!

T: (as Bob) But, but T! I umm... I want my father to come, it's time now!

B: Yes, but first you have to know exactly what you want.

T: Uh, uh, why? (out of role) You have to tell me if I do Bob wrong, okay? I want to argue a bit, okay?

B: Yeah, good.

T: (back in role) But it's hard for me!

B: But you've had enough time to get yourself prepared!

T: Yes, but...

B: We haven't done anything else for the longest time.

T: But it's important for me, it's hard.

B: But you are a coward! And in this area you haven't made any progress in the past 6 months. (with feeling) That pisses me off, that makes me angry. And I'm disappointed.

They then change back and T takes over Bob's therapist figure, quoting back to him exactly what he said when he was the therapist. His reaction to the ''new'' therapist is very strong and surprised; he starts to argue about why his father should come.

He goes on to say that he is in a conflict but this time it is between wanting to be honest and using his ''Understanding.''*

T: Be the honest side for a while.

B: Honestly, I could say to my father, ''Good, I never want to come back to you,'' and wink at him and point to the psychologist and when you're not looking I'd point to my head.

T: (laughing) I like that! It's a 5 year old's trick, but, you know!

B: No, I don't want to blabber stuff to you that I can't stand behind... Oh shit! The other side, the Understanding side says that I... and I'm scared of the absoluteness when everything is settled and not to be changed when possible.

T: And concrete.

B: (mutters) And concrete... that doesn't sound so good.

T: (hands behind head) We have to change back again. (they change places, Bob in the therapist role now) Yeah, I just want to be honest, I can't tear myself in two. The one side says ah...

B: Tear yourself in two! That's what you always did earlier, the one side to Daddy and the other side you fixed. Now you have to know to which side you belong.

He nearly reached the point where he could take over the decisiveness, but backs off from it. Bob comes to an edge with the therapist's role and says he cannot go on with it. They then discuss Bob's two sides, the one who wants to be diplomatic and vague, versus the one who wants to be decisive and concrete.

Bob finally says that it takes so much energy to be strong and that he has no self-discipline. He is able to discuss this problem but cannot go over his edge to really ''doing it.'' He is hopeless about ever being able to do it either. At this point, a good intervention would have been for T to take over Bob's hopelessness and declare, ''Yes, I agree it's hopeless, you'll never be able to be disciplined.'' This would, in theory, flip Bob into the other side of his process, or at least he would have been able to talk directly about how hopeless he was feeling. Instead T tries something else.

T: From that side... the disciplined side... what would it do with your father stuff, right now in this moment?

B: (crosses arms over chest, long pause)

T: Ah ha... what happened with the phone call? How hard did you try to get hold of your father?

B: Yeah, not very hard.

T: That's what I thought.

B: To be honest... You know if he wouldn't press me... as far as I'm concerned he wouldn't have to come up here.

T: If he wouldn't press you... He presses you?

B: Once he said, ''Yeah, I'm coming up, next Sunday I'm coming.'' Like that.

T: And you wouldn't want him to come if it were up to you.

B: Well... of course there are two sides to it. In a way I'd like to avoid him, because I'm afraid... (arms down) The other side...

T: You like it without Daddy!

B: Yeah, well, then I have to make some decisions like (moves legs slightly to side) what I'm going to do with my furniture, which is in a room in his company. It pisses me off to sell it, but what else can I do with it?

T: Why do you have to decide? He needs the room?

B: Yeah. All these things that I shoved away... now they come again. Really you are right, it's more comfortable without my Daddy.

T: And what does the hard disciplined side say about it?

B: (long pause, in which he moves legs more to the side) Uh! What does it say? (pause) It's difficult. (hand to head, rubs face, supports the moving arm with other arm)

T: What's difficult? To clean it up?

B: Yeah, I don't exactly know... You know, this is such a mess. On the one hand, there are so many things which play a role... (hands down to lap) I don't want to find out.

T: Ah, come on, you want to find out.

B: No. (deep sigh, hand to head) I ask myself if he shouldn't come here.

T: Maybe your father shouldn't come?

B: (moves legs more away, stutters a bit) I don't know if I should tell you this... It's also much easier if he doesn't come... that also plays a part. It would just be pushing it away. And that would be cowardly.

During this passage the same double signal comes up again. Bob slowly turns his body away from T. He seems to be afraid to tell T exactly what he is thinking and feeling about his father. He wants to avoid being concrete again and comes once more to the same point, namely that it is cowardly to go on avoiding. He does have a strong side which pushes him in the direction of concreteness and self-discipline, but he just cannot make the step to really owning this part wholeheartedly. T notices his vagueness and her frustration is apparent in her movements.

* This word is capitalized since Bob uses it to refer to a personified aspect of himself.

T then makes a remark which Bob does not even seem to hear and he goes on with his own thoughts.

> B: Aha, T... I still think that I, that I want to tell him that I want distance from him. Very definitely distance, I need the distance and I want to sell [sic] him that. You understand what I mean?

At this point T does something completely irrational and rather uncharacteristic for her. She says she does not know what to do with Bob and wants to toss a coin to see if his father should come. In other words, she gives up, taking over Bob's hopelessness.

> B: So you think I should decide by how you throw a coin?

Then suddenly Bob is able to make the jump and become, at least momentarily, decisive.

> B: Well, my father's coming, that's clear!
>
> T: Is it clear? I think you said before that you'd rather he not come?
>
> B: I've decided that he's coming now and I'm going to leave it like that.

Comments on Clinic Session

The difficulties which came up in this hour are many and made the therapeutic work confusing and frustrating for both parties. The basic problems break down into three categories: shared edges, cycling, and "edge phenomena." The last two difficulties occur when an edge was missed by the therapist or successfully avoided by the client.

Shared Edges

This is the most basic problem that client and therapist had during this hour. It is a common problem and whether it can be overcome right then and there depends to a great extent on the awareness and capacity of the therapist. This depends not only on the momentary situation but also upon how generally well developed and aware the therapist is of his or her personal process. In this hour the therapist was not aware that she had the same edge as her client. This had more to do with the therapist's momentary situation than with her general ability.

Both had similar psychologies in that they both had had difficult relationships with their fathers and had resulting authority problems. T normally had a great deal of awareness about this and could deal with it when it came up. On the day of this hour this was not the case. They both had an edge against being concrete, hard, forceful and decisive - in other words to being fatherly. They also supported each other in not going over this edge.

> B: Will you be here already on Sunday morning?
>
> T: Yes, but I have a lot to do and I'm not sure I'll have time [to see you].
>
> B: Well, you don't have to decide now.

T did not have time to see Bob and what is more, did not <u>feel</u> like seeing him to rediscuss his father's visit. But in this moment she could not be direct and say, "If you want to discuss your father's visit, do it now." That would have pushed Bob into being more decisive.

The day before, T had been very forceful with another patient and had then been attacked heavily by a group of patients. She had not been supported by the staff members who were present, although it was obvious that the patient group was mistaken in their attack. She was still angry and disappointed about this. On this particular day, she was not feeling like working in the clinic, nor did she feel very involved with Bob. The result was that T did not push Bob very hard when he got to an edge. She was suddenly sweet, when it would have been more useful to be critical, or she gave Bob double signals, which lead him to believe that T was angry with him - which in actual fact she was, but she was not able to show it whole-heartedly.

> B: You know in principle we've already talked about all of this, it must piss you off.
>
> T: No, it doesn't. Does it piss you off?
>
> B: In a way, I have a bad feeling about it, a guilty conscience, that it's still around.
>
> T: That it's still around? Oh, you can forget about that! It will be around for a long time!

Instead of staying with Bob's bad feelings about himself and using them to help Bob push himself to clean up his act, T lets Bob off the hook, with a remark that has a lot of hopelessness in it.

This hopelessness comes up whenever T fails to take over the negative figure. As in the following example, Bob seems almost to ask her to support his negative feelings.

> B: It <u>is</u> really a back-door for me, but in the far future. Before, my back-door was (claps hands together hard) therapy and then back into the company. But I know now that I'm not going to do that, that back door I'm finally going to close now. I don't want that. But in the far future... I want to leave it as an option. Do you think I'm a coward?
>
> T: (deep sigh) No. (said with a falling tone)
>
> B: That's what I expected.

Deliberately, consciously and completely enacting this figure which thinks Bob is a coward for doubting himself so much (that he cannot be successful on his own and needs his father's company) would have helped Bob over his edge to taking over the father figure. This means he would have had to fight with T about whether he is a coward or not. He would have

had to become more like his father, concrete and decisive. This would have been more useful and most of the cycling could have been avoided.

Cycling

Therapist and client begin working on the presenting problem and suddenly the pattern repeats itself, sometimes exactly and sometimes in a slightly changed form. The flow of the hour is disturbed and the work does not progress; no transformation happens. There is no resolution of the problem being discussed. Instead the work cycles.

Patterns repeat themselves until they are completed. A pattern becomes cyclical because something is preventing it from being completed. The reason for this repetition is that there is important information contained in the pattern, which wants to be taken seriously, so to speak; it wants to become conscious. The message does not go away; its content and form may change but the pattern in the background remains the same until the information is received. ''Jeder Kanal reflektiert dasselbe Muster solange, bis wir bereit sind fuer den Empfang dessen, was nicht gelebt wird und die Erfahrung bewusst integrieren koennen'' (Hauser, 1987). (The same pattern is reflected in every channel until one is capable of receiving that which is not lived out and consciously integrating the experience [translation: the author].)

If the work starts to cycle, the therapist can assume that he is missing something: perhaps he is approaching his client in the wrong channel, or is not seeing that the client is double signalling or that one of them is at an edge. The cycling will continue until the therapist picks up what he is missing or what his client is avoiding. As soon as this problem is corrected, something new can happen; the pattern changes.

This hour cycled around Bob's edge to be concrete and his therapist's edge to push him. Bob was more or less comfortable in his primary role of being the diplomat, although he talked about the problems he was having with the rest of the community: people were complaining that he was being untruthful to them, that he was acting in such a way that no one could tell where he really stood, and that generally he could not be trusted. He claimed that he wanted to change this behavior, which he had had as a junkie.

> B: It came up once in a forum... that I didn't want to change anything, I always did well before like that and in comparison to earlier... being the diplomat... on both sides wanting to do the right thing... I actually saw it for the first time in that forum. It's like this... earlier I was totally like that, on the one side I was a junkie and on the other, the good young man. On both sides I wanted to be in and actually I was always in between. And I never saw beforethat it was necessary to do anything about it. I never wanted to be concrete and never wanted to pin myself down, that was being a diplomat. I always wanted to keep both exits open.
>
> T: And now?
>
> B: That's what I said yesterday to the group. I asked the whole group to confront me more on it because I know I'll always act like that again.
>
> T: So you said to the group that you want that?

Here we see Bob's basic conflict. It is necessary again to stress that although Bob was speaking in the past tense in the above passage, this behavior is still going on in the present. Primarily he identifies himself as being a diplomatic person. This means, for him, that he stays in the middle ground, trying to do the right thing for everyone and not being able to take a stand for himself. He acts in one way with certain people and in a completely different way with others. The result was what he called ''in between.'' His secondary process is to be concrete and definite. The community, including T, is dreamed up to push Bob in this direction. The secondary process is also represented by the figure of his father (meaning here both the inner figure and his real, ''outer'' father). This is the figure which he says he is afraid of, ''I'm afraid I'll get run over.'' When he made this statement he was speaking about the visit with his ''outer'' father, but in truth he was constantly being run over by his ''inner'' father figure. There is a conflict between two figures, the diplomat and the father. Because it is secondary, it is the ''father'' which needs to develop; this figure wants to be integrated into Bob's life. It is this figure to which Bob has a strong edge: to act toward himself as his father figure acts with him. This seemingly negative figure can actually become the answer to Bob's problems. Using Bob's various descriptions of this figure, it is the one who could be concrete, definite, disciplined, the ''hard'' therapist, can fight and think (as opposed to feeling and reacting). If Bob could integrate this figure he would have no trouble staying off drugs.

Every time this figure comes up during the hour, the flow of the process stops because Bob gets to an edge. Each time the therapist does not either metacommunicate about the presence of the figure or act out the figure herself, a new cycle begins.

Edge Phenomena

The term ''edge phenomena'' is defined here as all material extraneous to what is ostensibly going on (dialogue and movement), which happen to client and therapist when either of them cannot expand their primary identity and cross an edge. The subject of conversation, as well as the names given to the parts, rapidly change in these moments. The result is confusing for both therapist and client. When these phenomena are omitted from the transcript of the hour being discussed here, almost half the dialogue disappears and much of the confusion vanishes.

B: That's what I said yesterday to the group. I asked the whole group to confront me more on it because I know I'll always act like that again.

T: So you said to the group that you want that?

B: Yes, I want that. (pause) And I think I've already started with a few people. For instance, in a strong relationship that I have, like with Tom, I've started to... You know the fear I always had when I'd say something really tough? That he wouldn't like me anymore... That I've surely already gotten rid of. I did something there. And with other people too.

T: You sometimes have fights with Tom?

B: Well, I've never had a real fight but we've had arguments. It gets to a point where both of us back off. But a real fight, where it goes bang, and you have aversions afterward... I've never had that.

T: Never?

B: (sitting up) I don't want to, either. A friend to have fights with? Arguments are okay, but I don't want a big fight. I don't want that. (looks down, says immediately and without taking a breath) But right now my father is what's important (looks up and away).

This quote comes from fairly near the beginning of the hour. They had just been discussing Bob's fear that his father would run him over, which led to Bob's statement that he wants to be diplomatic with his father. This in turn lead to a discussion about Bob's diplomatic behavior and the fact that the whole group is angry with him because of this behavior. (The group was angry with Bob because of his ''everyday'' diplomatic behavior.) Then the above quote. One sees his split easily here. He is already fairly aware that he needs to be more decisive and more ready to have conflict but he still cannot actually act in this way. The ''fighter'' is associated with his father; Bob wants to be diplomatic with him to avoid a fight. In the above quote Bob is defending himself, saying that he really has been working on the diplomatic behavior - but as one can see from the dialogue - he still has massive resistance to having a fight. When it comes to the point where they could discuss this problem, Bob suddenly switches the subject back to his father.

This jumping from one subject to another is fairly difficult to follow; but when the names of the parts also change, it becomes nearly impossible to follow exactly what is happening in the moment. Within one hour the names by which Bob describes his conflicting sides change nine times:

- Father	Diplomat
- fighter	doing the right thing for everyone
- runner over	the one who is run over
- concrete	in between
- Understanding	Feeling
- ''I don't ever want to go back to my father's firm''	''honest''
- disciplined one	the one lacking discipline
- therapist	patient
- junkie	Daddy's boy

The following passage shows the rapid changing of the parts' names. (Although part of the following passage was quoted earlier in another context, it is the most concise example of this phenomenon and so will be repeated.)

B: What? And then nothing happens on Sunday? (high pitched voice)

T: (laughs) No, nothing, no father comes here, you're not prepared, you haven't yet decided what you want to do.

B: Yeah, but T, now I have to argue. I can't tear myself in two. On the one hand I want to be honest and on the other I want to use my Understanding. It's so difficult.

T: Be the honest side for a while.

B: Honestly, I could say to my father, ''Good, I never want to come back to you,'' and wink at him and point to the psychologist and when you're not looking I'd point to my head.

T: (laughing) I like that! It's a 5 year old's trick, but, you know!

B: No, I don't want to blabber stuff to you that I can't stand behind... Oh shit! The other side, the Understanding side says that I... and I'm scared of the absoluteness when everything is settled and not to be changed when possible.

T: And concrete.

B: (mutters) And concrete... that doesn't sound so good.

Just before this passage they had been working on Bob's double signal and had changed roles, Bob playing the therapist who is angry with him. Here they have just switched back again and T has quoted Bob's therapist figure back to him, saying that Bob's father cannot come because he is not prepared for the visit. T had polarized the process in order to bring out Bob's inner therapist more strongly. Although Bob, in the therapist role, had said exactly the same thing that T has now said, Bob is surprised and wants to argue. The conflicting parts now receive new names, ''honest'' and ''Understanding.'' The term ''Understanding'' (not expressed clearly in this section of the dialogue) was often used in the clinic to denote the part of oneself which is more distanced from drugs and which comprehends intellectually the clinic philosophy that there are

reasons to avoid situations and people who had been connected with drug use. Therefore, Bob was strongly encouraged and confronted by staff and patients not to go back to his father's company - because he had used drugs there and because his relationship with his father and working for him was believed to put Bob in danger of using drugs again. ''Feeling'' was used in this connection to express the side of oneself which was not in agreement with the clinic's philosophy - which still wanted contact with old friends and places and, most probably, with drugs. ''Honest'' means here that Bob would act in front of T, as if he would never go back to work for his father, but then let his father know that he was lying because T was there. ''I never want to come back to you'' is a statement which means that he is complying with the social pressure from the clinic, and/or that he has an intellectual understanding that it would not be good for him. The fact that T helps Bob polarize the ''honest'' side makes things a little bit clearer. He is very much on an edge here. It seems that he would like to be more concrete and definite but is terrified of the consequences.

In the following passage one sees how the ''hard'' therapist figure becomes what Bob now calls self-discipline.

> T: You're a good therapist. You do a good job of therapy with Bob.
>
> B: No, I can't do that.
>
> T: Yes, you can. You'd just have to be a bit stronger with yourself and then you could do a good job on Bob.
>
> B: I'm not at all convinced; I have no self discipline.
>
> T: You have to learn it.
>
> B: I have the beginnings of it... But it falls apart again so quickly...
>
> T: Ummm... If you were very self-disciplined, imagine... You're a very self-disciplined person... what would you tell Bob he has to do?
>
> B: (laughs really hard) I'd know something (laughs some more) I'm afraid, I'm afraid to say... Then you'll slap me with (crosses arms over chest) an Obligation* right away [meaning T will give him an Obligation].
>
> T: Yeah? So what kind of Obligation do you need?
>
> B: (laughing) No, no, no, no! Not like that!

Bob does not believe that he can be (or does not want to be) self-disciplined and becomes afraid that T will make him do something before the community, such as an exercise or speech about how he plans to work on his self-discipline. He actually knows exactly what he would need to do in order to work on this, but he does not want to be concrete and say what it is. He is afraid that T will hold him to it.

* Expression in the clinic for a clearly declared duty which the patient must fulfill publicly.

Session Two Years after Clinic

Background

Bob successfully completed the clinic program 6 months after the author (T) had stopped working there, and was able to find a job in his profession (not in his father's company). He decided not to live in the half-way house of the clinic, but found an apartment of his own. He also decided not to continue with any kind of therapy. Shortly after leaving the clinic he met his present girl friend. T and Bob had no contact until a month before this therapeutic hour, when they met for dinner. T again asked Bob's permission to use him as a case in this dissertation. He consented readily and inquired if it would be possible to read what had been written about him. T agreed but asked that he wait until it was finished. Then T asked him if he would come for another hour (with video), with the goal of reaccessing the drug state. He said he would come, as a favor to T, but that he was not interested in doing any more therapy.

The Session

This hour involved certain complications. First of all, Bob was coming as a favor to T , so she was not comfortable about being too hard on him. She had also gotten a clear message from Bob that he was not interested in therapy anymore. Nevertheless, it is an interesting session to study.

During the small talk at the beginning of the hour Bob says that he is doing well, with slight exceptions. He likes his relationship with his girl friend and they are planning to take a 9 month trip to Africa, starting in a few months. Bob is busy repairing his Land Rover and otherwise getting ready for the journey, although he is still fully employed, even working overtime. He is under a lot of stress, but enjoys it a lot. He says that he is tired now; it was a long day and besides that he was at the police station in the morning. He then tells the story of how one of his friends had gotten a parking ticket and in trying to avoid paying it, had said that he was picking up something from Bob's apartment. He talked about his shock that it was a very offical police meeting (complete with typed minutes), the stress of having to talk his way out of the situation and the fact that he could get 6 years in jail if caught lying. With a deep sigh he says that he is always getting into trouble because of little things. He made a vigorous, energetic impression during this exchange.

T begins explaining that she wants to reaccess a drug state with him. She is quietly astonished to notice that Bob does not know what she is talking about (she had explained in detail what she was planning to do and the theory behind it, when she had met Bob the last time). After this she becomes slightly hesitant as she tells Bob what she would like to do with him. After her explanation, Bob drops his head a bit and raises his hands to cover his face quickly, looks away and then back at T , says he did not understand and could T please explain again. At this point T becomes even more hesitant (she is picking up his resistance but does not realize it consciously) and wants to know which drug Bob misses the most. Cocaine gives him the most problems. T then says he should tell her if he has difficulty talking about drugs or for any reason wants to stop the session. He replies that, of course, he will tell her. Then she collects information about what the cocaine state was like for Bob.

> B: It's a self-made stress. (starts to move a lot) It fascinated me. My heart would almost stop and there was the feeling that physically I came to an edge with the vibrations. And that fascinated me totally.
>
> T: Everything vibrated.
>
> B: Especially with the coke flash it was extreme. That really turned me on.
>
> T: The vibrations.
>
> B: Yeah, and to feel the limits.
>
> T: To feel your limits.
>
> B: Yeah, and then also the self-confidence which came with it.
>
> T: How would you describe that?
>
> B: When I got to touch the limits I was an absolute individual, untouchable somehow because I have my private boundary with the flash. It's hard to say. Because I could have that experience with coke and stuff, I could close myself off against the masses. I felt I experienced more than they did. I almost felt pity for them because they didn't know that experience.

T then asks about heroin. He explains that heroin was something very different and he does not miss it. He adds that the whole thing was a long time ago and he was not prepared to reaccess it like this. This last statement was spoken with little energy, his voice lowered and his body became motionless.

> T: How is it to talk about these drugs?
>
> B: To be honest, it's a bit difficult and then comes the whole outer mess [his situation at work, the police visit that morning and getting ready to go to Africa]; from every side so much to do (starts to move a lot) and this is like dead for me (makes a movement as though crossing something out with his hands).

Bob is giving T a double signal. Primarily, he does not understand what T is saying about reaccessing and says that drugs are dead for him. Secondarily, he gets very excited when talking about cocaine. The excitement is apparent in his tone of voice, tempo of speech, and raised physical activity. T decides to continue with the cocaine experience. Bob can not imagine that he could get there without chemicals. He will try but is very skeptical. He says cocaine is

a specific state and only that is what he misses - it is very real, with strongly beating heart and ringing ears. He has already tried to find something else that comes near to the cocaine state, like driving fast and extreme physical activities. He does not believe it is possible to get the body feeling and the particular taste in his mouth that he enjoyed so much.

They agree to try anyway. T tears a piece of paper out of her notebook, folds it and offers it to Bob, saying, ''Here's the coke. What do we do with it?'' Bob's body stiffens and his voice momentarily nearly disappears; this looks very much like fear. Then he really gets involved, asking if they should take it all and answering himself that they should, but that T needs less than he does, because she is a woman. He minutely goes through the motions, making sure everything is out of the paper, preparing and filling the hypodermic needle, even filtering it through a cigarette filter. ''Now we shoot it.'' He laughs and then freezes as T offers him her bare arm. The tension had been building since T folded the paper representing the cocaine. By the time Bob froze, staring at T's arm, the tension was extreme; the expression ''hair raising'' could easily be used to describe this moment.

T: (with a kindly tone in her voice) You're scared, you don't want to do it.

B: Na ha.

T: It's too heavy for you that way. We could do it like this (pulls down sleeve, makes the motions of shooting up into her covered arm).

Bob does the same, then holds his elbow joint. He is moving in a very stiff way. He looks as if he is in shock.

T: What's too heavy?

B: It's like a sound barrier, even like this (looks down and away, gives the impression of being sad, his movements stop).

T: (puts hand on his knee) What's happening to you now?

B: It's completely foreign. It's everything I've pushed away for the last 3 years. It's just what I imagine when I get the urge. I don't want to get into the state because then I'll just want it again. If I could just do it once it would be super, but I'd want it the next day.

Bob seems scared to death. The tension is still high at this point. There had been a feeling of gaiety - almost childlike enjoyment - in Bob's preparations of the hypodermic syringe. Then suddenly this ''game'' became deadly earnest. The contrast between one moment and the next was very strong. His facial expression had gone from relaxed smiling, with twinkling eyes to mouth hanging open with eyes wide and staring. His body movements, which had been energetic, but relaxed and flowing, changed to stiff movements - almost like a robot. This is an excellent example of what behavior at the edge can look like. At the same time, Bob seemed totally unaware of what certainly seemed like extreme fear. He speaks about the moment in which they played out the shot, as being everything he has pushed away for the last 3 years. His use of ''pushed away'' to describe how he deals with his former addiction to cocaine, the fact that he needs to push it away now and his almost unconscious fear reaction to even playing out the ''shot'' in the present, indicate that he is still very fascinated by the drug - much more than he admits to himself or T. He is repressing his fascination and when it comes up, his response is fear. Fear of what? The fear that his primary process might be destroyed. He seems convinced, at least for the present, that the use of cocaine is out of the question for him. Cocaine, and whatever it represents unconsciously for Bob, is now part of his secondary process. He probably should be frightened about the possibility of actually beginning to use cocaine again, but there is still the unprocessed fascination of the drug, which continues to bother Bob. This should be dealt with. There is still something about the drug which, when he is not repressing it, seems to be needed in his life. This becomes more apparent as the session progresses.

T notices his fear and decides not to press him. If she had felt she had a willing and interested client or perhaps had more experience, she would have been able to help him over this tense moment and the edge described above (see Comments, this chapter).

Now she becomes interested in what exactly Bob was feeling when he froze. She asks Bob if he did not trust her or if he felt that what they were trying to do was dangerous for him. He replies that he trusts T, does not feel that he is in danger of starting to use cocaine again, but that the idea of drugs disgusts him. He had worked to build up a strong revulsion against needles, hypodermic syringes and little envelopes and could not get over that now. T says she thinks reaccessing is not for everyone and wonders aloud why he does not just say, ''Let's stop.'' To be thorough, she checks out other channels, for instance, could he see himself shooting up? This does not work either. She did this to make sure that the kinesthetic channel was the correct one for Bob to be working in, or if he had another channel which would be more accessible to him. Movement was the indicated channel for Bob, because it is unoccupied; he was simply too frightened to go on without more help from T (see Comments, this chapter).

Bob states that he feels curious about what T wanted to do with him, but at the same time it is a closed subject for him. He had built up a wall and did not want to break it down. He then goes on to say that he is convinced that he can live without knowing why he took drugs - that partly he is curious, but it also goes against his will. Then he says that he is worried that T is disappointed. T says he should not worry, that it was just as interesting for her that it did not work. Bob seems relieved at this.

Bob gets excited again talking about the extreme war he won with himself. He tells stories about running into drug situations in which he had to resist the

urge and was successful - once he was offered a large bag of cocaine for free and was able to leave it; and once he found a box of amphetamines and flushed them down the toilet. As he speaks of these experiences, he again becomes physically very active, making many gestures and movements. He said that in these moments he had his situation before his eyes; he was afraid of jail and the people he would lose if he went back on drugs. This is great, he is lucky to have this attitude, but one could wonder why he constantly runs into situations like this. Why is he being unremittingly tempted? From a process-oriented viewpoint, one would say that there is still something about cocaine which Bob needs to integrate and therefore he keeps ''running into it''.

He changes subjects once more and becomes quiet physically. His voice lowers as he says that he has a lot of trouble getting excited about things. He feels he lacks the ability to feel enthusiastic.

> B: When I get excited I have tons of power [energy] because I have a goal. I can do it. But with pills and coke I could have it all the time. At work, when there is a new project I have power in the beginning but when something goes wrong ... there's no power left.

He changes again and becomes active and excited as he talks about how he gets high by doing things with his body which push him to the limit, like diving down really deep in the water, so deep that he almost cannot reach the surface again before his breath runs out.

After the hour was over, Bob comments that he thinks he could have an alcohol problem later in his life. T offers to work with him then and Bob agrees. He seems fairly relaxed and invites T to go with him to meet his girlfriend. She accepts the invitation.

Comments on Session Two Years after Clinic

Bob did a good job of acting as though he was cooperating. Perhaps he felt he was in a situation similar to that in the clinic. He is interested in the fact that T is writing her dissertation about him, because he wants to be special. He asks several times to read the dissertation, at least the parts about him.

In the background there is a wish for impossible situations or extreme challenge. His power, the state he could reach while on cocaine, is split off from his everyday life. He can have it through physical experience but cannot bring it completely into his normal life, for instance, at work. His power (energy) does come out in his present job to some extent; Bob spoke about what a mess he has at work, how disorganized he is there, and that he does not get all of his work done. He is planning to leave that job and when he gets back from Africa, will go back to work at his father's firm. When he spoke about that his voice lowered, as did his shoulders and general physical activity.

The author thinks that Bob is an example of the ''no problem, yet'' type, described in detail in the reaccessing section. He says, ''I could, in the future, have an alcohol problem but it's not a problem yet.'' Apparently, he notices that he has a problem now, but does not want to deal with it (several people who know both Bob and T have said that Bob drinks a lot now). Therefore, he will avoid it until the problem is so bad that he cannot evade it any longer. One could speculate as to whether he might also have a similar problem with cocaine. He said he wishes to shoot up occasionally, but did not say how often he has this urge. There is no problem ''yet'', because his present job is exciting and stressful and he has stimulating plans for the immediate future. What will happen to Bob's ''not yet'' problem if he goes back to his father's firm, which is not particularly exciting for Bob?

It was interesting to watch the changes in energy levels, both physically and verbally. He became active when speaking about the police, drugs and extreme physical activities. Otherwise he gave the impression of being slightly depressed and hopeless.

T's reaction to Bob was mixed: he is an interesting person as long as he speaks of the above things which excite him, but otherwise he is slightly boring. He cannot be truly individual, for instance by really bringing his whole self into the hour with T. He does tend a bit in this direction; he enjoys his job, where he to some extent has to go toward his limits, but he plans to go back to his father's firm. He has not yet completely picked up his secondary process of being an individual, which could be one reason why he occasionally has the urge to use cocaine.

Behind Bob's cocaine state is the experience of being an individual. That would mean that Bob is ''there'' in the moment with all of his reactions and feelings. This would be almost a death-like experience for his primary process, his identity of being nice, controlled and collective. At the moment this is beyond Bob's possibilities. He can cross this edge in physical channels as he could with drugs, but in relationship, in the world (his job) and in relation to himself he is stuck at present in the primary process. If Bob were interested in continuing therapy, the process would be to teach him and help him to be present in the moment with his whole being, including the frightening unconventional sides, which he presently finds unacceptable. To be able to feel all his limits and be alert enough to notice everything which is happening to him, is something very few people (and no one who is on heroin or cocaine) ever experience.

One might wonder at this point whether Bob is in danger of going back to cocaine through reaccessing the state. Experience so far shows that there is much less chance of a client going back on drugs once he has reaccessed the drug state. The client usually experiences this as relieving and as an encounter with a broader aspect of life (Mindell, personal communication).

In this hour, the most significant moment is where they reenact the drug shot. Not going on with the shot was right for Bob, because he had stated that he was not there for therapy but to do T a favor. Had Bob been an interested and willing client, T could have dealt with this key point differently. One possible way of helping the client over the moment of paralytic fear would be to take his hand (the one with the imaginary needle) and very slowly guide it toward the therapist's arm, saying, ''I want you to go very slowly and I want you to notice everything. You don't have to put it in, but I want to hold you right there.''

Whether a therapist can do something like this (while remaining alert to the client's feedback) depends also on the therapist's process. If the therapist is working on being more sensitive, the above suggestion would be wrong for him or her. Going through such a strong scene with someone, pressing them in the way they would have to be pressed, must be done congruently or it will not work.

If one works with a drug user and can process the moment that the needle goes in, one has accomplished a great deal. This is a very important moment which can contain the meaning of a whole life-time. It embraces the difference between the present state and the altered state, being alive and the potential of killing oneself, having a boring life and having wild experiences. The importance of this moment can be seen in Bob's excitement and increased activity when telling about the cocaine experience and approaching the enactment of shooting up. It can be extremely important for the client to have a chance to cross this edge and integrate some of the material now locked in the altered state.

In a conversation with Dr. Mindell, he gave an example from his practice of working with the moment when the needle goes in:

> This is an example of a young man who was more excited about buying the drug. He acted out mixing a cocktail with heroin and other stuff and then came to the moment that the needle goes in and I held him there. He said, ''Don't make me do it. Don't make me do it. I don't want to kill her.'' He then feltfaint and lay down. Afterward he claimed that he hadn't said anything. Then the story came out that as a child, he had tried to kill his mother with a knife and his father had caught him. His mother was an awful person and he's been angry with himself for acting like her. That's the psychology of what came out of the work. He's trying to kill himself daily and didn't know it. Fixing for him seems to mean constantly trying to kill his inner mother - and he didn't know it. He had forgotten this early childhood scene with his mother. Enacting shooting up seems to bring out the important information and you can go on and work on that (Mindell, Control Case Seminar, 1987).

Process Structure

In the clinic session one sees that Bob primarily identifies himself as a diplomatic person, someone who tries to do everything right for everyone. The reason for this is that he does not want to have any fights or be offensive to anyone. He wants to be thought of as a ''nice guy''. Unfortunately, this does not work; Bob also has a secondary process which disturbs him. His secondary process is personified as someone who is decisive, concrete, fights to get his way; someone to be noticed and respected. In his outer life this figure is represented by his father, who is a powerful business man. Bob feels very weak and inadequate compared to his father and is afraid of being run over by him. During this hour Bob's process leads in the direction of needing to become more like his father - concrete, decisive and self-disciplined. This is nearly impossible for him at that time. It is apparent that he needs to become a person in his own right, independent of his father.

Two years later, at the time of the second session, Bob has attained this independence to some degree. He is successful in his job, working in his former profession at a firm unattached to his father's company. He is planning to quit that job and go to Africa for 9 months. Afterward he intends to go back and work for his father.

He no longer uses ''hard'' drugs, such as heroin or cocaine, but smokes hashish periodically and drinks alcohol regularly, but not so often excessively. He sometimes (perhaps often - the author does not know this) has the urge to take cocaine now. He says he has no further desire to use heroin.

Bob is not interested in therapy, he comes as a favor to T, because she is writing her dissertation about him and needs to see him again. Bob has integrated some of the characteristics of his father and inner father figure - he is more decisive and self-disciplined - but still acts rather diplomatically toward T.

One thing which is very noticeable in this session is the way in which Bob's energy level changes as he speaks of drugs and extreme physical experiences or when he speaks of his father and plans for later working at his father's company. These changes are apparent in the tone in which he speaks and in his body movements and body tension. In this way one sees that there is still a conflict about the use of drugs and his feelings about his own power, opposed to that of his father. Bob has made tremendous progress since his clinic days, but some of the problems he had then still remain or have been more or less successfully repressed.

There is also a difference in the way Bob talks about working for his father. In the clinic session, when Bob speaks about going back to work for his father, he sounds like he is talking about a drug, similar to how alcoholics talk about alcohol. The job with his father has the quality of being a drug, as a matter

of fact, in the clinic it was handled nearly as a drug. He was confronted many, many times about wanting to go back to work for his father. Now he sounds slightly depressed, his tone of voice lowers, the tension goes out of his body and his movements lessen, when he talks about the job in his father's firm.

It seems that in Bob's mind his father is so strong that Bob cannot be strong around him. It is as if Bob's strength gets occupied by his father, so Bob cannot consciously have it. He is somehow strong and courageous, but this side rarely comes out in a constructive way, instead it is turned against himself. He once told T about not having any drugs to shoot up, so he shot up Kirsch. ''Straight alcohol in my veins - I could have killed myself! I could have gotten alcohol poisoning! I was crazy!'' This was said with a smile, he enjoyed the danger. It is possible to call that some kind of brutal courage, although not in a very useful form. He needs to make an identity change, to that of someone who is strong and competent in a constructive way.

It will be interesting to examine Bob's childhood dream and see if there are any connections to be found with his life-history.To ease reading it will be repeated here. This was actually a series of dreams, this is how he told it:

> I would be flying completely relaxed, looking down at the earth. I had to stay relaxed or the vibrations would come. When they'd come I'd go out of control and then I'd crash. Otherwise I could fly well. I had to try to find out how to fly so the vibrations wouldn't come. Sometimes I could get back into the quiet flying after the vibrations started. I felt like the goal of the dream was to get the vibrations under control.

This is an interesting dream because there are three layers in it, 1) the ground, which he looks down at or crashes into; 2) flying quietly and 3) vibrating while flying. The dream has an almost moral idea that flying should be done in a relaxed manner.

He gives no reason for flying, neither is there a transition from being on the ground to flying. He is simply flying and looking around, downward. He has an overview. Behind this could be a hurt feeling or some kind of difficulty - he does not want to be on the earth. Given the history of his troubled relationship to his father, this seems plausible. He cannot be as big as his father on the ground, so he has to fly away. It could point to a rivalry with his father - he thought his father was the best on earth, so in order to be able to also be the best, he had to take to the air. He is also above the others, looking down on them. If he could have this state in real life, it would be something like having an overview of a given situation and then being able to make a strategy. He could use this capacity in his work.

Then comes something which disturbs this idyll. Vibrations, which to judge from his physical movements while telling the dream, begin in his chest. What they do is to shake him up; they bother the state of flying happily. One could speculate that they are saying, ''Hey, do something!'' They force him to have control of himself by making him get them under control. They might have something to do with the earth, because if he cannot get them under control, he ends up on earth - although in a crash.

The vibrations have the quality of an ally, to be feared when unknown and a helper when accepted. This is a power which shakes him up. He should get in touch with this power. The ally needs to be confronted and asked what it wants.

In the second session, when Bob described the effects of cocaine, he spoke about ''the vibrations'' as one of the things he especially liked. He has a different attitude to them now than he had as a child. Now he seeks this state. He can no longer get it through cocaine, so he tries to get it by physically extreme undertakings. He also said that he nearly looks down on people who have never experienced a state like cocaine, because they have never gone to their limits. He needs this state, but unfortunately has little possibility to have it now. The vibrating state in his childhood dream can be associated to the cocaine state.

Flying smoothly also has drug states associated to it, namely heroin, methadone and alcohol. His descriptions of these states sound very much like how he characterizes the relaxed flying state. Alcohol is like a vacation: nice weather, cool and refreshing. Heroin and methadone are comfortable security, everything goes relatively well and no one can touch you.

One nearly sees the drug states in this dream. Probably if one heard the dream, but did not know which drugs he had taken, one could guess them.

Now he has brought the two sides of his process closer together. He is still diplomatic, at least in his behavior toward T, but is also more able to do what he wants. He now has a job which needs a lot of self-discipline, but in some ways he is still Daddy's boy. He still wants to go back and work for his father. He has not yet managed to become an extreme individual. Perhaps he will become an alcoholic. This is a possibility even Bob admits. Behind many cases of alcoholism is an attempt to relieve the pain of being an individual (Mindell, personal communication).

SARAH

Anamnesis

Sarah was born in 1965, in one of the larger Swiss cities. (Her age at the time of the first video was 18.) She spent most of her childhood in a nearby town where her family owned a large house. She has one sister who is 2 years younger and a half sister 15 years younger.

Her father was a salesman for a large international cosmetic company during Sarah's early years and was often not at home. Later, he started his own company. He was originally German. Her mother, of French origin, is presently an executive secretary.

Sarah did not get along with her sister very well, because she felt her sister was given more advantage and freedom. Her sister quiet but sly, while Sarah was provoking and coercive. For this reason, Sarah was often physically punished and, in her jealousy and defenselessness, began to hit her sister, who got back at Sarah through other means.

In her early years, Sarah idolized her father. He made lots of money, owned their large house, loved fast cars, and always smelled nicely of perfume. He was cool, unemotional and very strict in dealing with Sarah and her sister. When he took care of them alone, he would often lock them in the house so they would not go out. Early on Sarah started to dress like a ''lady'', a behavior her father strongly supported; he encouraged her to act like a ''lady'' too. If she was childish, he would not have anything to do with her. As long as Sarah can remember her parents fought over money. Her father was stingy about paying expenses for the family. Later on, Sarah found out that her father had had a girl friend for many years on the side.

Sarah's mother was extremely good natured and protective of the children. Sarah maintains that her mother could never defend herself against her husband. He would often scream and hit her and she would only break down and cry. Sarah felt she was totally helpless. Typically she would try to comfort Sarah after fights with her husband. Sarah is not sure but suspects that her mother drinks heavily. After their divorce, Sarah's mother lived alone and had very few social contacts; she watches TV every evening.

Her parents divorced when Sarah was 12. She tried to prevent being separated from her father. At this time she saw her father cry for the first time. She says that she was shocked to realize that her father had emotions. Afterward she did not idolize him as much as before.

After the divorce, Sarah lived with her mother and sister. She did more or less what she wanted, enjoying her freedom. She began skipping school and hanging around with a ''cool'' group of classmates. Eventually, she missed so much school that her parents and teachers decided to put her in a boarding school. She liked it there and did well under the direction of the strict nuns. She began to orient herself again and this gave her a sense of security. After a year at the boarding school Sarah returned to live with her mother and attended secondary school. Afterward, she began an apprenticeship, staying one year before being fired for stealing money from the cash register.

Education

Sarah had a normal Swiss school career. In her early years she did very well and was often the favorite of her teachers. She had trouble with math and would often study in the evening with her father. He had no patience with her slowness in this subject and would tell her how stupid she was. She slowly developed a sense of panic whenever she had to do math. The family moved several times during her early school years. For this reason Sarah did not have many close friendships; whenever she had made a friend, the family would move and she would have to start all over again.

Addiction History

After the year in boarding school, Sarah attended a secondary school in the neighboring large city. She began to hang out in a ''drug cafe'', where she was fascinated by the cool, above-it-all, outsider-types. She enjoyed the attention which she got there.

At her school were two girls whom Sarah especially respected and admired. She began to try to act like them and dressed as they did, namely ''cool''. She began smoking hash with them and soon was smoking daily. Then she began taking codeine pills regularly and occasionally took trips. She was more and more fascinated by the heroin users and felt comfortable when she was around them. On her 16th birthday she had someone shoot her up for the first time. She decided to become a junkie and 4 days later prostituted herself for the first time to get money for heroin. (This was also her first intimate sexual contact.)

Her parents quickly found out about her heroin use. Her father took her to live with him in Zurich where she also began her apprenticeship. She did not get along well with her father's girlfriend. For a short time, she only shot up heroin on weekends when she was visiting her mother. Then she began stealing money from the cash box at work, which she would return when she had enough left over from prostitution after buying her dose of heroin. She soon had a regular group of customers on the strip and for a while was able to maintain the punctuality demanded by her job and her father.

After her father found out she was taking heroin again, he would sometimes appear on the ''scene'', grab her by the hair, drag her away, and lock her in the cellar for a withdrawal. He even bought handcuffs. She did 5 withdrawals in this way.

In the spring of 1983, her parents, with help of the youth socialservice, placed her with a foster family. She stayed there for a month before running away to the ''scene'' in Zurich. This time she experienced it negatively, being threatened by several pimps and raped by a man she vaguely knew.

Under pressure from the youth social service from her home city, Sarah decided to enter a mental hospital for withdrawal and then entered the clinic in July 1983.

Legal Problems

Sarah was tried in Juvenile Court for consumption of illegal drugs and theft in November, 1983. No sentence was imposed under the condition that she remain in the Clinic and finish the program there.

Childhood Dream

At age eight: I had to give a piano concert. I was seated at the piano which was floating above the audience. I tried to play as well as I could but I was still not a professional. I tried really hard! The people in the audience started to boo and yell at me. Then they threw rotten eggs and tomatoes at me. It was terrible. It was a real horror dream!

Drug Feelings

There were no conflicts when I was high; I was cool, unemotional and above-it-all. I felt like a woman, could be a good prostitute, had control over my life and men, but maintained a child's body. I was like my father.

Sensory Grounded Information

1) tone of voice:
She often spoke in a rather whiny, childish tone. This would change to a rather loud voice, with a slightly cold undertone. These changing tones would mostly occur during a crisis. In her ''junkie'' state, she spoke in a typically slurred, indistinct, and slow manner.

2) clothes and looks:
She is a pretty young woman with dark blond hair, which she wore short, as did T. She said she had the same haircut, but did not say that she cut it like that to be like T, although many patients and staff made jokes about it. She has blue eyes and a rather broad face which she usually described as ''fat''. She wore make-up when she went out, but otherwise not. (There was some pressure from male patients not to wear make-up, so this might have been because of social pressure.) She is short and at the beginning of her clinic stay had a very slender, childlike body. She then gained several pounds and became more womanly looking, both of which troubled her. She usually wore fairly normal clothes for her age group, except for her pants which she wore tight. In a difficult phase she would wear her ''junkie'' clothes, black T-shirt or sweatshirt and black jeans (very tight). She wore her fingernails extremely long and was often told by T and others in the clinic that she should cut them.

3) posture and facial expressions:
She has a very mobile face, which when she is feeling well is very expressive. When in crisis, her face gets stiff but still has a rather wide range of expression. She could show how she feels with her expressions much more than the average patient. She has two basic postures during therapy hours, which were conducted sitting on the floor: 1) sitting up, leaning slightly forward with her legs crossed and hands in her lap or on the floor (her fingers often playing with the rug) or 2) leaning back with legs outstretched, arms crossed over chest. This leaning back position occurs often in the beginning of an hour. She says she is trying to be cool and above having problems. After she becomes involved in the hour, she sits up.

4) movements:
She is much more kinesthetic than the average patient. She uses her hands when she is talking.

5) relationship characteristics:
She has two main ways of acting with people, which alternate with each other: 1) childish, nearly babyish, asking for help and asking lots of questions about what she should do and how she should act; 2) ''grown up'', which means aloof and slightly cold. She has some trouble in the clinic because she likes to ''snuggle'' a lot and the men get turned on and accuse her of taking them in. At other times, she tries very hard to turn someone on and enjoys flirting and the feeling of power it gives her. She says she likes being with people until they start to get too close; if they try to get to know her more deeply, she backs off. She had a very close, dependent relationship with T, often seeking contact outside the therapy hours. In the beginning of her clinic stay she was in a child's role, which gradually changed to a more mature relationship, after going through phases of aloof distance-making.

6) synchronicities and accidents which happen around her:
Once Sarah wanted to leave the clinic. She packed a plastic bag and started walking down the road away from the clinic. Just then, T arrived at work late (usually she would have been in a staff meeting at that time of day), saw Sarah leaving and more or less dragged her back to the clinic.

7) body symptoms:
She has frequent colds, dry lips, sore throats and bulimia nervosa (bingeing on food and then vomiting it out, which she called anorexia).

Clinic Session

At the time of this hour, Sarah had been in the clinic for nine months and was in a crisis. Sarah was the youngest patient in the clinic and was at the stage in the program where it was expected that she had to start taking over a leadership role among the patients. This was difficult for her not only because of her youth but also because of her sex. The male/female ratio was 3 (sometimes 4 or more) to 1. These two factors led to a lot of extra problems for her, in that she would often be attacked by other patients (especially older male patients) under the guise of ''helpful confrontation''.

The therapist (T) and Sarah had a very close relationship, also outside of the therapy hours. T liked her very much and was warm and supportive. T had a lot of sympathy for Sarah's situation, especially for being female in a very male world (clinic staff ratio was 3.5 men to 1 woman). During the therapy, Sarah had become dependent on T; this dependency had recently become a theme in the therapy hours with discussions of Sarah's feelings of fear and dislike of being dependent.

This hour has several phases in which the same motive comes up in different ways and channels. Sarah's basic conflict was that she was feeling weak and defenseless and wanted (and needed) to change to become stronger and more aggressive.

S: (enters room, talks in loud, high-pitched voice) Hey, I don't like this! I want to hide! (walks over to normal place, then to camera and back) Is it running?

T: Yes, it's running.

S: The sound gets recorded too?

T: Yes, but the picture's not so good. Oh! You brought me a coffee.

S: (sits, with legs crossed, leaning slightly forward, her lower back against the cushion and studies the camera from her seat) It's cold in here. (sips coffee) Did Andy [her former boyfriend who had the hour before] have a good hour? You said, ''goodbye'' so funny.

T: (laughs) You'd have to ask him.

S: I did, he said, ''It was okay.''

T: (sits in the middle of the room, leaning slightly forward, legs in diamond - stretched forward with heels and toes together) Oh, did you just ask him?

S: Yes, our relationship goes up and down, it goes well for a while, then we fight, then it goes well, and then we fight. (takes out a cigarette)

T: If you want to smoke with the video on you have to hold it away, because the glow can damage the camera.

S: (leans toward camera and begins making faces at it) Then you don't see me?

T: No, but it can burn the camera. The smoke doesn't matter, just the burning tip.

S: But then you don't see me?

T: Hu uh [no]. (gets camera and viewer and brings them closer) Do you see yourself?

S: Hey! Why do you do that?

T: So you can see yourself better. Do you see yourself better?

S: Yeah.

T: You can see what you look like with a cigarette in your mouth.

S: (makes faces, then a noise and lifts chin) Uhh! (quickly lights the cigarette, facing full into camera)

T: (puts camera back) That's exactly what you're not supposed to do!

S: Ah ha! Because of the glow?

T: Yes.

S: Are you recording this now?

T: Yeah, it's running.

S: Already! The whole time? For heavens sake!

T: The whole time.

At the beginning one sees how Sarah deals with her fear. She states that she wants to hide, but instead walks directly to the camera. This short scene around the camera is interesting. She is afraid of the camera and then tries unconsciously to destroy it. Her aggression is just under the threshhold of being open. As we shall see as the hour progresses, she needs to integrate this aggression, which is also her strength. At the moment, it can only come out in double signals and unconscious acts of aggression. One sees her strength in her double signals; she pushes out her chin, speaks in a loud voice, and lights her cigarette directly into the camera.

When T brings the camera closer, she asks, ''Why do you do that?'' She feels threatened and indignant, but cannot say so directly. Instead she whines and does exactly the opposite of what T was asking her to do. (T had asked her permission to video this session the week before. She had given it freely then.) She leans back and her voice is whiny, which points to fear, but at the same time her chin is shoved forward and her voice is loud, indicating aggression and strength; these are more secondary for her.

Her stated fear of the camera and questions about it show that her visual channel is unoccupied, as is her auditory channel, since she asks whether the sound also gets recorded. There is a dream figure in the

camera, which she would like to destroy. One could have asked, ''Who's observing?'' As will become apparent, Sarah needs this observer because she has trouble observing and controlling her own behavior and therefore dreams up people to do it for her. She needs to be able to look more at what she is doing, to have an inner awareness.

A transition follows, when she says she wants to begin work. Her power lasts through a very strong statement and then disappears as she begins to identify with the helpless victim. She is dissatisfied with this identification and is fighting against it but cannot quite change it (yet).

S: Well, T! Shall we start? (pause, leans over, looking down, touches foot) I don't even know where to begin. I decided this morning that I want to be completely open. (gestures with hand) And what I'd like is for you to be harder with me. (hands on knees)

T: Okay.

S: Somehow you are too sweet. (big exhale then laughs and makes beating motions with her hand to her heart, her voice is much lower than before, whiny, almost subdued) UMMM. I have, (pause) I have a complete feeling mess. On the one hand I'm... first of all, I'll start like this ... (hand to chin and down again) I'm anorectic again. [The correct term for Sarah's ''anorexia'' is bulimia nervosa.] Did you think that?

T: No, I read about it in the journal book*, that you'd had a relapse.

S: I'm completely anorectic. It's just like before. The stuff has to come out somehow, I don't feel well when I have something in me. It doesn't matter what I eat, it's the same.

T: I have to say, you look pretty bad today too.

S: I have a fat face.

T: No, you're very dark under the eyes.

S: Yeah? (fluffs up hair, pulls down bangs, her hand quickly covers her face)

T: Yes, when you said I should be harder with you, I wanted to say that, but I held myself back.

S: I said that because I have the feeling that you're too sweet with me.

T: How am I too sweet? (moves to cross legs, sips coffee)

S: I think... I think that I can cheat you in the same way in the therapy hour, as I otherwise cheat... umm ... cheat myself, too. You say... (T props chin on hand) You should push me more. (gestures with hand, up from leg and down again)

*This was the clinic's record of events - for staff only - kept in the locked staff room.

T: Um hum.

S: It seems so quiet in therapy. I find out things, but... I think it wouldn't be bad if I were challenged more. I think recently that... you know, so I'd have to really open up, so it's more uncomfortable for me. (rolling motion with her hand in front of stomach) It's just happening here. (points to head)

Sarah accusingly reproaches T for being too nice. T has difficulty being hard on her, while Sarah cannot look at herself and take over the hardness she demands from T for herself. Actually one sees in this passage that Sarah has two edges. The first is to her primary process, that of being the victim, and saying that she is hurt when T tells her she looks bad. Instead she gives a somatic answer, fluffing up her hair and pulling down her bangs, quickly hiding her face. Sarah looks like a completely different person than the one who walked into the therapist's office a short while ago. When she is even slightly hurt, she flops out completely and becomes depressed. The bigger edge is to taking over the secondary process and becoming the attacker, or the carrier of her strength.

This is a point where the therapist can get into trouble. The client is projecting her strength onto the therapist and asking to be treated more toughly. This is something the client needs for herself, so the therapist is now in danger of stealing the client's process. Different therapists will tend to deal with this situation in various ways. One possibility is for the therapist to go on being ''nice'' or perhaps to be nicer, thus forcing the client to be strong. There is a good chance that the client's show of strength will come out in her simply leaving therapy, because the two processes are not brought together. Another possibility would be for the therapist to really take over the projection and be strong and directive. Unfortunately, this intervention will leave the client in the victim role. The author thinks the best choice in this situation is to take over the strong side, while at the same time metacommunicating about it. This means explaining what is happening and asking for directions and feedback from the client. ''Am I doing this right?'' ''How could I do it better?'' ''Is this the way you imagine me being harder with you?'' Gradually, in this way, the therapist can help and support the client to take over the role herself, thus integrating her strength.

The hour goes on with Sarah making the comparison between being a junkie and her ''anorexia''.

S: I'm just a complete junkie at the moment. I'm always dressed in black, I eat an incredible amount of sweets, I'm just up. (gestures upward with arm, then back to picking at rug) I'm standing on a high horse. Somehow I look at everything from up above - ''So what do you want from me?'' I push everything away.

Sarah complains that she is constantly under attack and is not able to reach out for some warmth and support. She says that she would like to just cry with someone, but cannot. She is completely hopeless at this moment. T then brings in her own process

instead of staying with Sarah's hopelessness.

T: (pause) I think you said you were on a high horse. That reminds me so much of that dream you had when you first came here. (both are leaning forward) I just thought of that. I can't remember it exactly, but I think I saved you in that dream. I'd like to help you now, so maybe we could work on the dream.

S: I'll never forget that dream. You were as big (points up with hand) as a skyscraper and I was so small, (shows size between thumb and forefinger) normal, like a person, and you were a giant. You brought me down off the skyscraper. There was no other way down.

T: But how?

S: I don't remember exactly, I just know you were standing there and took me down. (props right elbow on knee, head on hand) You were so big because of me. I was lying there and you could get me down because you were so big. And that was because of me.

T: I was so big because of you?

S: You wanted to help me, I knew that in the dream. I was lying there and you were standing there. (makes motions with head as if she was lying on her side and then looks and points upward, sighs deeply) And... then I guess you just... or is the dream not even finished? I don't know. I just know you wanted to help me get down. And I was able to come down, too.

Sarah's response is enthusiastic. Her voice immediately lightens; the hopelessness is gone for the time being. As they work on the dream together the energy level goes up. Both are involved and congruent in what they say and do. Sarah plays T's role in the dream using a small figure, while T talks for the figure. They take the dream further and Sarah (as the dream-T) puts the dream-Sarah into the desert.

S: (pointing to the rug, while playing T) It reminds me of the desert. I'll put her here - just to test her. She should go on by herself. (talking to the figure) You have to become independent. (Loud voice, looking straight at T) BUT I'm allowed to come back again and ask what I should do!!

T: Okay, ask.

S: (takes figure and holds it up to T) T, what's the matter with me? (looks directly at T, pleading tone of voice)

T: I don't know.

S: Somehow something is wrong. (looks at figure then at T)

T: Can I be Sarah?

S: Um hum.

T: In the desert. (takes figure, puts it in the desert, trots it back to Sarah's knee) T, what's the matter with me? Something's not right... I need help!

S: Ah! (very quiet, looking down, moves her hand to forehead and down again) You have to decide! What you want... (nearly crying) T, I don't know! That's too embarrassing! (pushing away gesture with hand) It bothers me! (laughs in a high pitched tone, which does not fit with the quiet tone before, head down)

Sarah is on a big edge here; she does not like feeling weak. Then she says that she is in conflict about staying in the clinic or leaving. Sarah gives a description of the side who wants to leave.

S: The one who wants out, that's the one who doesn't want to be small, the side that wants to be strong, who wants to have power over men again, the one who wants to be someone again, ''zue'' (which means ''closed'' in German and is slang for ''high''), cool. It wants some peace and quiet again.

Then T asks why she was so embarrassed.

T: Why was that so embarrassing? ''T, I need help. Something is the matter with me.'' (touches Sarah's knee with the figure) ''I need help!''

S: I'm so uncomfortable, really! (leans back and away, left hand makes pushing away gesture, scratches head with right hand and as she lowers the hand, makes a pushing away gesture)

T: Um hum. ''I need help!''

S: (loud) No! I don't need help! I don't want help!

T: I'm Sarah, the little one... I need help!

S: What should I do?

T: You have to decide! You have to tell her...

S: But you know... how long I've needed help? I've needed help for so long and it doesn't do any good! I'm becoming only as small as this! (gestures with hand almost to floor) Because I need help all the time! (talks fast with no pause between sentences)

T: And then?

S: This is how it is, I don't want it like this and that's the decision. I want to stay here, but I don't have the energy to be open, I don't feel like doing anything!

This again illustrates how difficult it is for Sarah to show that she feels weak and needy. Being only in the primary process does not solve the problem. She really does need to stop being so needy and learn to help herself. She is making an attempt to change something, but it will not work because she still has not integrated her strength. Her solution is to do nothing instead of getting strong and/or aggressive.

She then attempts several times to change the subject, but T has taken over the hard side and suggests that they stay with the uncomfortable theme. After T helps Sarah to amplify a double signal (she was leaning back in a very relaxed ''cool'' position, while talking about a problem in a whiny voice - the position and verbal message were incongruent), they decide to role-play Sarah's two sides with T as the one who wants to leave and be a junkie and Sarah as the weak, sweet one, who wants to stay in the clinic. (Sarah felt closer to this side in the moment.)

S: (laughing a bit) Really I'd like to sit like this. (bending over, head to knees, with arms covering head)

T: Go ahead.

S: (she does) Like this. (comes up suddenly, looks directly at T) Okay, I'd like to be the sweet side.

T: Ah! Good. Down there? (Sarah bends over again) And I'm the junkie?

S: Yeah.

T: I'm the one who wants to go on the street again and be cool.

S: I don't know why the sweet side has to be down here.

T: (as the junkie) Oh come on, I want to leave this place, it's for shit. (out of role) Is the voice okay? Is it cool enough?

S: (turning head up) No, a bit cooler.

T/Junkie: (with singsong voice and slightly slurred words) So... Do you think I want to stay here? It pisses me off to be here.

S: (very quietly) I want to stay here. (really whiny tone) I have to stay here.

T/Junkie: Tsk! What for? You're just a dependent little thing and I don't want to have anything to do with you! I want to go back on the street.

S: I want to live (quickly) I want to learn to live like the others... I want to be able to be open. I want to be able to be Sarah!

T/Junkie: Yeah, well, I want to be Sarah, too. But I want to be on the street and I want to be cool and I want to control men and I want to shoot up when I want.

S: Yeah, and then sometime we'll both have to start again.

T/Junkie: Start what again?

S: Back there, where we're stopping now.

T/Junkie: What? What kind of shit are you talking?

S: If we go then we'll both have to start all over again where we're stopping now.

T/Junkie: I don't understand that!

S: Sometime we'll start again.

T/Junkie: Start what?

S: Start stopping shooting up!

T/Junkie: What? But I don't want to quit shooting up! Are you crazy? Shooting up is much better than...

S: I don't want to die!

T/Junkie: Blah! We won't die!

S: Sometime we will, if you don't want to stop!

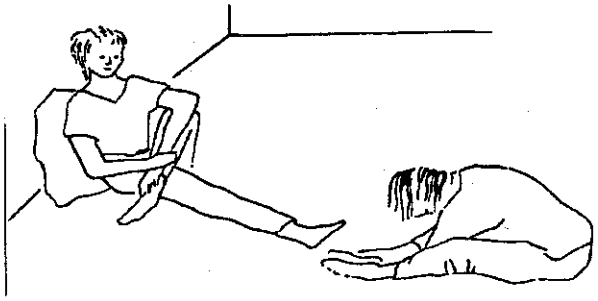
T/Junkie: That's ridiculous!

S: Believe me or not, but I don't want to give up! Somehow I have to be different with myself.

T: (moving leg, holding foot) Something strange just happened to me, I got a cramp in my foot.

S: (looking up) Why? (sits up)

T: I don't know, I have to... I didn't want to be her anymore. Shall we change? Can you be cool?



Sarah is ''cool'', T (right) plays the weak side.

S: Ah ha! (moves to lie back on cushion, really cool!)

T: Oh wow! And how shall I be? Like this? (leans forward like Sarah was)

S: Um hum. Come on, let's go. I'm pissed off here.

T: No, I want to stay here!

S: (muttering, slurring, slow voice) Yeah, but then they'll all start to mess your head around again. And they'll attack you and you'll have to show them, without being cool.

T: No, I need to be here and don't forget, I don't want to die.

S: Oh, we won't die. And anyway, it doesn't matter if we do. It's all the same. I've already noticed that we won't make it here, so we might as well go shoot up.

T: No, I want to keep trying.

S: Oh, don't be so weak, screw you! (throws a wool fuzz from the rug which she'd been playing with)

T: I feel weak!

S: I want to be out again, I want to be able to do what I want again. I want to lead that life I led earlier... They'll leave me alone then, I'd like that.

T: Yeah, but then sometime we'll have to start to stop shooting up again. Then we'll be back again where we are now!

S: Well, maybe sometime, somehow we'll be in agreement and then we can try again. Right now I, for one, don't want to.

T: But I don't want to go on the street!

S: What keeps you here anyway?

Here one sees both sides separated and amplified and the hopelessness which comes up in both of them.

As soon as Sarah is able to take over the cool side she does not want to leave it again, even though she realizes that in this form it is not very helpful. T pushes her to go back again.

S: Ach! Okay. (leans forward, head down as before as the weak side)

T/Junkie: What's holding you here anyway? It's so stupid to stay here... People attack you all the time... they just tear you apart.

S: (now supporting head with hands elbows on floor) But at least some of the people here care about me!

T/Junkie: Nobody likes you, Sarah.

S: I think so.

T/Junkie: Pfft!

S: It's my fault, I think they'd start liking me again quickly... also, I'm in a protected place here, I'd be afraid to go out.

T/Junkie: Not me, I know what I'd do!

S: I wouldn't want to go out in that cold. (moves around a bit, picks at rug)

T/Junkie: Hum! I'd just shoot up a little and then I wouldn't notice the cold. (sees her movements, speaks in normal voice) What is it? What's happening to you?

Suddenly the role play is over with Sarah claiming that she knows the two sides of herself by heart and asking what good the whole thing is doing. They begin to metacommunicate about the two sides, Sarah saying that she likes the cool side better but would also like to let people get close to her again. What Sarah needs is to be less emotional - a bit more cool - while at the same time being open. At the moment she can only be one or the other, which is not satisfying. She also says that she hates many of the people in the clinic. T says she must hate her, too.

S: Because you pry into me? No, I want to be normal again, finally.

Then there is another change.

S: But why am I so uncomfortable? Holy shit! I have a stomach ache, too. (whiny voice)

T: Hum.

S: I have the feeling that I've gotten so cool because I have to constantly defend myself. Mia (a staff person) said she had noticed on Friday, how I got hurt a lot of times and didn't even defend myself.

T: And then you get cool because you can't say anything?

S: Um hum. And more and more people are coming and trying to get at me. Even people who I don't have anything to do with.

T: Umm. Yeah, we can do whatever we want with you.

S: Yeah.

T: And then you just turn on the cool one and you want to leave.

S: (very quietly) Yeah.

T: And what happens with that one here? (leans over and puts head down)

S: She gave up. (takes coffee cup and talks behind the cup) She noticed that she can't get by. It also pisses me off that in this house (the clinic) it's just one big fight. That's no kind of life, hey, are you kidding! And I also thought, the night before last, that since I could notice things, since I could think, there has always been someone in my life who was attacking me, when I was in school earlier, I was always the garbage can for a lot of people. And here it's the same shit all over again. (leaning back, head back)

The last part seems to describe a life myth. She talks about herself as being the victim her whole life. She goes on complaining, getting more and more hopeless, and at the same time leaning back in a cool way. T finally asks her what is going on with her. She says she almost has to cry and does not want to. She also complains of a pressure in her chest and burps as she describes it. T decides to work with this, because she sees a connection with Sarah's vomiting. She begins to amplify the pressure by pressing on Sarah's chest and asking for feedback. Sarah asks if she is supposed to cry now. T, respecting Sarah's desire not to cry says that she does not want her to cry if she does not want to. T notices that Sarah returns the pressure by leaning into T's hand with her chest (this is positive feedback) and remarks on her own inner feelings, which were that she was feeling a strong desire to really push Sarah hard. She is dreamed up to be the

victimizer now, the inner part who torments Sarah. After a few moments of resisting following this feeling, T lets herself be consciously dreamt up and applies more pressure to Sarah's chest. Sarah laughs and giggles and roles to lie on her side on the floor. T suddenly raises Sarah's head to look her in the eyes. Sarah takes T's hands away and says in a strong, clear voice, ''Don't do that, I'm serious.'' T stops immediately and congratulates Sarah for defending herself so well.

This leads to a discussion of the violent way in which Sarah's father treated her and how she hated him for it. Then they speak about Sarah's edge against crying because she thinks it would not do any good anyway. T tries to have Sarah take over the victimizer (pressurer) but this does not work. Sarah is still very identified with the victim.

Then they begin to metacommunicate about what went on in the hour. Sarah has the awareness that she wants to leave the clinic because she is being attacked so much and cannot defend herself. She gives an example in which she defended herself against one of the male patients and he stopped attacking her and got friendly, but she is not able to see that that really is the solution to her present situation.

T is very strong and gets positive feedback but Sarah remains slightly hopeless because she cannot go over her edge to being strong herself.

> S: It won't do any good if I say tomorrow that they should stop attacking me.
>
> T: No, you have to say it many times, over and over, and attack them back.

T attempted to get Sarah to say she would stop vomiting in the toilet and would begin to ''vomit'' with the individuals who were troubling her. She did not say she would stop but seemed lighter and more hopeful when she left the hour.

Comments on the Clinic Session

Sarah's bulimia relapses had come up often as a theme in the therapy. Several months before this hour, both had agreed that Sarah's next vomiting relapse should be treated in the same way as a drug relapse would be handled in the clinic, namely that Sarah would spend a month in the 1st level with loss of all privileges of her present level (3rd). T found this to be counterproductive at the moment, and so gave Sarah an ''obligation'' to make a play ''toilet'' and bring it to the next community meeting and ''vomit'' to each person. In other words, to give each member of the community feedback as to how she felt about them and how they were hurting her or disturbing her. After this the crisis disappeared and Sarah was able to continue in the clinic without being under constant attack. Recently she told T that this was one of the strongest, best and most helpful interventions she had experienced at the clinic.

This was a forceful intervention on T's part. Sarah was pressed into going over her edge to her secondary process. T's feeling was that unless she integrated her secondary process in a hurry, she would be unable to stand the tension she was under in the clinic and would have to leave.

It is important to say that this is not a permanent transformation. The point is not to flip into the secondary process and stay there, but to bring both processes closer together. In Sarah's case this means that she be able to be weak and sweet when she needs to be, while also capable of accessing her strength and aggressiveness when that is called for.

Session Three Years after Clinic

Background

In the three years since the first video, Sarah had completed the clinic program, lived 6 months in the clinic's half-way house, and then shared an apartment with a girl friend, who had also been in the clinic. She has recently moved into a ''living collective'' with 6 other former clinic graduates. She had searched for an apartment of her own, but was unable to find anything cheap enough. She had also been uncertain about living alone.

After leaving the clinic, Sarah began a 2 year private schooling program, which she completed in the spring of 1987 (she had to repeat one semester). She now has to work for one year in a large company, plus take evening classes, to be eligible to take the Swiss Maturitäts exams (equal to approximately 1 1/2 years of Bachelor's Degree studies). She had just begun working 2 weeks before this video was made.

In the past 3 years, Sarah had periodic drug relapses (never with heroin). She said she smoked hashish heavily for a short time about one year after leaving the clinic. In the past year, she has occasionally drunk wine or beer.

She has some contact with her family; she visits her mother occasionally and during vacations sometimes works in her father's company to earn extra money. She has not had a longer relationship, but 3 months ago began her first relationship with a woman. She feels shy about this but also thinks it is just what she needs right now.

Sarah has been in therapy since leaving the clinic. She said recently, ''I'm on my 4th therapist since you (the author or T), now.'' She claims to be fairly happy with the psychoanalytic therapist she has seen for the past 1 1/2 years; although she says she is in conflict about coming back to work with T. She would like to do so, but is afraid of becoming dependent on T again. She has attended T's weekly beginner's course in process-oriented psychology, for the past 6 months. She has also attended other process work courses and seminars. Her present therapist is against Sarah's going to these classes because it ''ruins'' (quote Sarah) the therapy. Sarah says she wants to go anyway, so she goes.

Sarah had expressed much interest in T's dissertation, especially when the idea of reaccessing the state came up. She asked T if she would help her to reaccess the heroin state so she could find out what was the meaning for her previous addiction.

Actually Sarah had tried to reaccess the state in T's group a few days before this video, but then decided she did not want to show her junkie-side in front of the group. That work turned into a relationship process with the group and will not be discussed further here.

The Session

Sarah sits on the floor with knees up to her chest, holding her toes and visibly chewing gum. T sits in almost the same position - she is not holding her toes. T asks whether Sarah wants to go through the whole ritual of shooting up or if she had had other ideas since they had seen each other last. Sarah is indecisive and T notices that Sarah is playing with and holding her toes and asks her what she is doing. Sarah replies that actually she is wondering why she is so afraid to go into the state. Her conscious fear is about what will happen afterward; will she feel bad or depressed or will she feel like using heroin again? T asks her how she knows she is afraid; to which Sarah answers that her stomach aches and, besides that, she notices she has an edge. T has her go into the details of her stomach ache. They get to the point where Sarah describes that something is hammering and something is hurting. This still is not enough detail - ''hurting'' is vague; there is no channel connected with it. To the question of what kind of pain is she having, Sarah answers, ''Sad, something is locked in (laughs) in the stomach. It yells a bit and when it yells it hurts.'' T goes for more detail, asking if Sarah hears anything.

> S: I don't know if I hear anything, something is drumming. It's moving, a child. It's moving around, so nervous and crying. It's standing in a big hollow room and crying.

T takes Sarah's hands and pulls her up.

> S: I'm embarrassed, I don't want to play.
>
> T: (makes a crying sound)
>
> S: Yeah, something like that. (she looks at the camera, pulls sweater up in front of her face, very quickly, and down again)
>
> T: Who's looking.
>
> S: No one. (said very coyly)

T then walks to the camera, looks through the view-finder, and says, ''For sure, someone is looking.'' Sarah replies that it is someone who thinks what they are doing is dumb. T notices that Sarah is more closely identified with the figure who thinks it is dumb, so she has Sarah go to the camera. T asks what she should do and then after receiving Sarah's instructions, acts out someone who is trying to get out of a small closed room. Sarah tells her she is acting like a dummy, tells her to pull herself together, and to be quiet. She goes on to say that the figure T is acting out has too much feeling, is disgusting and will never be allowed out. Asked who she is, Sarah replies, ''Mac/Daddy.'' She says Mac controls her, tells her she is too fat, and generally bosses her around. She explains why she said ''Mac/Daddy.'' ''Mac is somehow similar to my father, they have comparable characteristics, they both treat me in the same way and I have similar problems with both of them. They're like the same to me, so I'll say Mac/Daddy when I talk about them.'' (Mac lives in the same ''living collective'' as does Sarah. They are not having an intimate relationship.) Sarah

gets back into her role and tells T that she is shaming herself, ''One just doesn't do that!''

T pushes Sarah over her edge to playing the child. Sarah complains that she cannot do anything if T looks so evil. (T was imitating Sarah's expression as Mac/Daddy.) Then Sarah gets into her role and says that she is so cramped and scared in there. She wants to come out and because she cannot she feels like giving up.

> T playing/Mac/Daddy: I'm glad. Better that you have a stomach ache than that you have feelings!
>
> S: But I'm different than you!
>
> T/M/D: You have to be like me. I'm better than you.
>
> S: I need some room. I can't live like this!

Then she picks up a large cushion and hides behind it, saying that when T looks so evilly at her she feels like a little girl. With real surprise and a glowing expression she says, ''You know how nice that is? You could use some of that - it's so nice!''

> T/M/D: I'm too old for that. I need that? Why?
>
> S: Life gets boring and monotonous if you can't also be a little girl.

T thinks Sarah looks so cute that she cannot play her role anymore and asks her if she would like to trade. Sarah replies with a strong ''no'' so they play little girls together. Sarah says she feels better, more comfortable and soft. She has too little chance to be a little girl in her life.

Sarah: I don't have much chance to be a little girl in my life. (T on right)

T asks if they should be little girls who fix heroin. They then sit down to decide. Sarah says she was just like the critical figure when she was on heroin; she was cool and self-confident - definitely not a little girl. She says she is generally like that today without heroin, except in relation to Mac, her father and men similar to them. Then she feels like a little girl and hates it.

T asks her about the feeling of extreme happiness she had described the last time they met. She had said then that when she was high on heroin she had the feeling of extreme happiness.

> S: That was nice. But isn't it just <u>nice</u> when you aren't so hurtable?
>
> T: Then you don't notice the little girl?
>
> S: Yeah, because the little girl has to constantly protect and defend herself. I could do that with Jenny (the girl she lived with before) but now Daddy/Mac control me more. [Actually she is talking about Mac here.] And I get stomach aches!

She describes the problem she has with both Mac and her father. They are both very charming and if there is any discussion, all they have to do is come out with a good argument and whatever she was thinking, she forgets. She feels hypnotized by them; in the moment either of them is talking she feels convinced, but something inside her also wants her to get her own opinion across, and she feels slightly bitter afterward. T tries to demonstrate someone saying, ''This is what I want!'' She gets no feedback from Sarah; so she stops. Sarah is looking down. T suggests they shoot up now since the problem is insolvable. She is trying to provoke Sarah by acting hopeless, but Sarah's response is to hide quickly under her sweater again. Sarah asks in a flirty way how they should do that. T suggests they fix, to which Sarah says she does not want to. T suggests just being stoned, but gets no feedback.

Sarah is herself very charming. This seems to be her way of taming the environment. She looks very open and dresses in a bright, almost flashy way. At the same time, her voice is not very strong and there are long pauses before she answers T's questions; this is an incongruency. She also has a way of slightly tilting her head to the side and down and so looking a bit upward at the person she is speaking to, which seems almost as if she is flirting or acting like a little girl. The long pauses indicate that she is either already in an altered state or is resisting T. She is not yet in an altered state, so probably she is resisting T on some level. Primarily, she is open, ''here I am,'' but secondarily she is closed and in battle.

If this were a normal therapeutic hour, T could have worked with Sarah's problem with the ''charming men'' by having her enact them and then finding out how she behaves like that herself. T is presently acting like one of these men, in the sense that she is being strong and goal-oriented. Sarah probably feels weak compared to T. This is a feeling which Sarah had expressed to T before. This could be the reason she is resisting. T tries another way of getting around Sarah's resistance, namely to ask her directly how she could get into the state and then to listen to what she answers, besides looking for any physical messages.

> T: How do you get into the state that I could act like Mac does and you could stand up for your opinion against me -even if mine is also good? That's the goal, that would be taking over [the] heroin [state consciously and integrating it].
>
> S: I'm afraid to be open with either of them. I'm always closed and cramped.

T: And if you were on heroin?

S: Then I'd be however I am. I like them both so much. I want to please them.

T: Would that be important on heroin?

S: No, I'd be more important. Yeah, well, I'd still like them to like me, but if they didn't I'd just go to someone else.

Then she puts her sweater over her mouth and blows into it. She stays like that, blowing into the sweater. This a somatic answer to T's question about how to get into the heroin state. This means that instead of giving a verbal, conscious answer, the body answers. This kind of body response is usually unconscious and needs to be amplified and worked with until it comes into consciousness. T proceeds to do so by telling Sarah that what she is doing is great and asking her to do it even more. After a few minutes Sarah exclaims, ''I'm getting stoned! For heavens sake! It also hurts my lungs!'' T asks her to keep doing it just a few more seconds, and adds, ''Go all the way with what you are doing, take it to its conclusion!''

S: Something wants to explode, in a fun way. Before, when I was breathing like that, it was like not having any blood in my head (makes ''peeping'' sounds and shows her head growing larger with her hands) and everywhere it was cold in my veins and also warm. (makes blowing up motions with hands and cheeks) Like a balloon! My lungs hurt (coughs), I feel like I'm suffocating.

T asks her what was the strongest feeling she had. She answers: the feeling in my head; the feeling of it blowing up, the buzzing sound and the feeling of cold and warm. T suggests that she blow just a bit more and concentrate on the feelings in her head and then when she is ready, she should make a picture out of the feelings - of a person (not herself) or a fairy tale person. (It is easier to work with a figure in a vision if it is 1) something living and 2) not the person himself.) Sarah starts to blow again. T says, ''Feel it.'' Sarah keeps blowing; her face is quite red. Then T says, ''Now make a picture.'' There is a pause, while Sarah is involved with herself, then she says:

Three times the same thing. It's a huge fire - like an explosion, the fire has all kinds of colors and lots of black, too. Bright and intense colors. Then I saw myself with a sword, ready to attack. Then I thought, ''Fairy tale figure'': it was a knight (giggles) with a white horse. Just like you'd imagine it! They go together, the knight and the fire. At first [I saw them] alone and then together. I could see them together.

T picks up on the story and takes a part in it. ''He rides away from the fire and then...''

S: He goes out to protect the helpless. He's warm, sort of, and very consistent and sticks up for himself. He supports the ones who aren't treated right. He's strong, but has feelings.

T helps her to go on with the story by adding the next part; that he was out riding around one day and then... Sarah adds that she sees him riding up to a young girl who is having trouble because she cannot protect herself. She is being treated badly. T goes on and says, ''And he chops off her head!'' (T was just having some fun; besides, deliberately guessing wrong can be an effective way of eliciting more information.) Sarah says ''NO! The knight gets angry with the man who was being mean.'' She goes on to say that the girl cannot handle the situation because the man is much too strong and she is nearly giving up on herself. The knight comes up to them and does not kill the guy because the girl has to learn how to handle him. He stands between them and helps them resolve their differences.

T: He's a psychologist!

S: He goes for the goal, straight, Zack! With lots of courage - he goes into it. He doesn't hurt the man because both of them have made mistakes. They have to do it differently, but they don't know how.

T: What's his tip for the girl?

S: To tell him (the man) what's so awful. At least tell him clearly what she wants and how difficult it is for her. To try and assert herself. But I can't do that with Mac!

Sarah suddenly takes the story into her own life and exclaims about her biggest edge at the moment. They begin to talk about how to bring the knight into Sarah's life. She cannot imagine actually talking as openly with Mac as the knight suggested the girl talk to the man. Then she says she was aware when she moved into the house that Mac was a lot like her father and she knew it would be difficult, but she also wanted that. She wants to learn to deal with men who are like her father. T says the fire and the knight are what is behind heroin for Sarah. That would mean being goal-oriented and direct and also say what she is feeling. To that Sarah replies, ''I feel I had to shoot up to separate from my father.''

They then talk about how to deal with Mac. T suggests she be direct and clear and tell him how she feels. Sarah replies that then he would either continue to argue or he would be considerate of her. T wonders what would be wrong if he were considerate. That would mean that she had manipulated him and Sarah thinks that would be bad! When T says that no one wins in a relationship issue, Sarah is impressed. This is a new idea for her. ''The knight would recommend a compromise. But what is important for me right now is that I notice what is paralyzing me, so I don't give up on myself.'' T asks what she means when she says she gives up on herself.

S: Well, when he brings an argument - it's like with my father - I just feel they know better than me.''

Sarah cannot quite go over her edge, even when she is imagining talking to Mac. She says that she is glad to know what the situation is - that at

least she is aware of how she behaves now. She can easily imagine acting as the knight suggested with a girl friend - she can already do it and gets positive feedback. Mac or her father are another story.

Sarah says she thinks the knight is cool. He is like being on heroin - self-assured and goal-oriented. The body feeling is similar also - her blood feels warm and at the same time, cold. It is like the fire as well. Fire is lively and that is also one of the body feelings she had when on heroin. T makes a last try at helping her in her conflict with Mac. She suggests that Sarah try to feel herself more when she is with him. Sarah says she feels good now. She has no more stomach ache and feels soft, like when she first gets up in the morning.

Comments on Session Three Years after Clinic

A similar problem to that which Sarah had in the first video hour comes up here, namely that she feels weak and incapable. It has changed in degree; she no longer generally feels this way, but feels specifically weak and incapable in relation to her father and Mac. She has made a lot of progress since the first video-taped hour.

She has a tendency to behave in the same way as before when she is in conflict - by closing. She describes herself as closed, which is interesting since the German slang word for being ''stoned'' is ''zu'' or closed. This is the same thing she did while taking heroin - she dropped out of her conflicts.

In this hour, Sarah has started to consciously integrate heroin, although it is more an intellectual insight and awareness than a full behavioral integration. By using heroin, she could get as far as dropping out; when the state is completed, one finds an explosive fire and a knight. This would mean that the process behind Sarah's use of heroin is the knight, i.e. the ability to defend herself and to stand up for who she is; a person with lots of feelings, including sometimes being angry (the explosive fire).

The main feelings Sarah has trouble with are anger and aggression. When she first began to talk about her visualization, Sarah saw herself holding a sword - ready to attack. As the story of the knight developed, he lost this aggressive quality, except for T's idea that he do an aggressive act, ''chops off her head,'' which Sarah did not accept into her story. At this point, T was the carrier of Sarah's ability to be aggressive. The knight in her story is a pretty agreeable character. He does not actually use his sword. A short way into Sarah's story, the knight even begins to take on attributes which seem more like Sarah's primary identity; although he still carries the unsheathed sword, the knight has a discussion with the man and the girl. Sarah used a term from her clinic days here, which was used to depict a conflict-solving intervention, whose goal was to soothe away relationship difficulties. The term does not fit with the idea of a bared sword.

It is possible that the knight was as far as Sarah could go into her secondary process at this time. She was not able to follow his suggestion to the girl in the story to express her feelings about how difficult the situation is for her. Sarah says she could not do this with Mac because she does not want to manipulate him. At the stage of development she presently is in, Sarah should learn to consciously use her flirty type of femininity to get her way more. Her primary identity's attitude toward manipulation is negative, although she does it secondarily - with her flashy clothes and open manner (and previously as a prostitute). The process-oriented assumption is that there is something right for her in what she does secondarily; it should be carried through with awareness and integrated. This would be a step toward accessing her background strength, by consciously realizing that she can assert herself. If she were a bit older, the author would suggest that she learn to be more direct, but this is not possible yet. Right now, Sarah needs to have more a feeling of being in control of her life.

The knight is not too bad, although at this stage, as he first comes into consciousness, he does seem a bit too adapted. Once it has been integrated, aggression can become persistent goal-orientation, as well as self-assertion. Still, Sarah could use some of his qualities: he is strong, but has feelings. Sarah is either coldly strong or a weak ''feeling-muddle''.

In order to bring up deeper secondary material, T could possibly have tried to bring the fire into the story. Another possibility would have been to drop the story, go back and work on Sarah's associations to fire. This might have been more successful than the knight in bringing out her secondary process. As a symbol, fire, especially a fire with lots of black in it, suggests emotionality and aggression even more than the knight symbolically does. The author thinks a good part of her unwillingness to tell Mac that she does not like the way he is treating her, is because she would then also have to show him that she is angry with him.

This hour is a beginning. The further integration of Sarah's heroin use would be to encourage her to be more direct. She is a strong personality who has the ability to become very aware. She needs to learn to say ''No.'' At the moment, she still often behaves like a sofa, one can sit on her.

Process Structure

In the clinic session Sarah claims that she has been the garbage can for everyone her whole life long. This is a strong statement; she has an almost mythological identification with being the victim of other people. One way that she tried to get out of this role was by acting and appearing as a woman, while at the same time trying to remain a little girl. She acted and dressed like a ''lady'' to please her father, while at the same time she kept a thin, childlike body with the help of her bulimia and later with heroin. Another attempt to deal with this identification was her use of heroin. On heroin she did not notice the constant attacks from other people, which she felt (real or imagined) she was under.

From very early in her life Sarah suffered by having a strong, unemotional and uninvolved father, who had very specific ideas of how his daughter should be and act. If these expectations were not fulfilled, he withdrew even more. In her family, she lacked an example of a woman who could stand up to and deal with such a man; her mother was no more capable of dealing with her husband than was Sarah. In other words, Sarah had no pattern for doing anything but adapting to her father's wishes.

Here we have a case of an individual who identifies herself as a victim. What is unconscious and needs to come into life is ''the one who victimizes.'' If Sarah could integrate the contents of this figure (what it represents to her), she would no longer feel victimized, she would then have more of the feeling of having her life under control. Her earliest representation of this figure was her father. He victimized her in the sense that he did not accept her as she was, but instead, tried to make Sarah over to fit his idea of how his daughter should be: she should not act as a child, but as a lady. Since she wanted to be accepted by him, she had to conform to his wishes. She said that at age 13, she accompanied her father to a business dinner in Germany and both she and her father were flattered that the people there thought she was her father's girlfriend, not his daughter.

In order to get out of the role of the victim, she will - to some extent - have to integrate the figure of her father. She describes him as strong, cool, unemotional and above-it-all. While the point is not that she should become just like her father, she does need some of his qualities. She needs to combine having her feelings with the ability to be distanced and look consciously at them. This would be an integration of her father figure.

Let us now look at some of the ways this conflict expresses itself in Sarah's life. In the section on sensory-grounded information, one sees again and again child-like behavior set against cool, above-it-all deportment: in her tone of voice, clothes and looks, relationship characteristics and to some extent in her posture. At the time she was in the clinic these behaviors flipped back and forth in a very extreme way. Three years later (at the time of this writing) the changing behaviors are less obvious and more fluid. She presents herself to the world, through her clothes and actions, as a young adult woman, but in most situations can also drop this persona and have a good time - sometimes giggling and playing like a child. This is a more balanced, creative integration of the parts of her personality. The situation in which she cannot do this is when she is together with her father or a man to whom she associates her father (Mac).

The relationship to T was an important one for Sarah. Through this relationship Sarah was able to gain a pattern for dealing with the type of father she has. T has many of the characteristics of a female integration of Sarah's father figure: strong, goal-oriented, can be cool when necessary, but stands up for her feelings. Sarah had the dream about T (see Clinic Session) in the second week of her clinic stay. Unconsciously, she must have noticed that being more like T would save her. Incidentally, this dream also had positive effects on T. She was dreamt up to be more of a ''giant,'' which helped her to develop in this direction, something which she also needed. It often happens that a client's positive transference evokes the therapist's healing ability and other good qualities. T was able to come up to Sarah's level and so, could bring her down to the ground.

Sarah's life myth is also apparent in her childhood dream. To ease reading it will be repeated here:

> At age eight: I had to give a piano concert. I was seated at the piano which was floating above the audience. I tried to play as well as I could but I was still not a professional. I tried really hard! The people in the audience started to boo and yell at me. Then they threw rotten eggs and tomatoes at me. It was terrible. It was a real nightmare!

The two main symbols in this dream are the piano and the audience. The piano represents her primary process (she is identified with it), while the audience represents the secondary process. She is the victim in this dream also, the audience is booing and attacking her. It will be interesting to find out is why she is the victim.

Sarah had no feeling reaction to floating with the piano. She said that her father made the women in his family learn to play the piano, because ''women should be able to play the piano.'' It is interesting, and also rather strange, that Sarah says she was not a professional. It is not so common that an 8 year old notices the idea of professionalism. Sarah did. By saying that she is not a professional she is criticizing herself and identifying with what her father wants her to be. In a way, she attacks herself for playing like a child. She had to identify and live up to her father's expectations in order to survive. The piano is not on the ground. This would point to a poisoned attitude toward feelings in general, because a musical instrument usually has to do with one's feelings. Her feelings cannot live on the ground, that is, in ordinary everyday life. Not playing as a child, but professionally, would be being like the father.

The audience represents another part of Sarah which is attacking the part which identifies with her father's expectations and the groundless approach to feelings. She does have a feeling reaction to this: she hates it. They boo her and throw rotten eggs and tomatoes at this attitude. The audience seems to be trying to ''bring her down'' to a more grounded attitude toward her feeling life. That she hates their reaction could indicate that she will have difficulty integrating their dislike for her attitude.

What is missing from this dream is an account of how she and/or the piano got up there and how she gets down. It would be a good dream to ''dream on'', to fantasize further, so that the dream can come to some kind of conclusion.

The two main symbols in this dream, the booing audience and the floating piano, can be compared respectively to her constant inner criticism and Sarah's way of dropping out of conflict, formerly by using heroin and today by getting cramped and closed (see Comments on the second session with Sarah).

While, in reality, Sarah tried to do what her father wanted her to do so that he would accept her, she was unsuccessful in the dream. To stop the attacks from her inner father she really does need to do something competently and professionally in her life. This is the dream of someone who is pushed by her unconscious to develop. With her life experience and a dream like this, she would be an ideal personality to deal with difficult situations. If she can overcome the attitudinal problem toward feelings, which she seems to be attempting to do, she would be someone who could help others with strong emotional situations, for instance, as a therapist or social worker.

Sarah has a process of needing to develop her own inner awareness and inner judgment. In this way she could become free of her dependency on the father. She also needs to learn to express what she thinks, as could be seen in the first session, when she talked about why she vomits - the stuff has to come out somehow. It is interesting to note that she spoke of the junkie side of herself as being ''just up''. The author speculates a connection here to the floating piano of her childhood dream.

In the second session, one sees a spontaneous reaccessing of the drug state. She says that she feels she had to shoot up to get away from her father. This is true in a sense, actually she became more like him when high. Now she needs to go back and collect her feeling side into her new identity. In her work on her stomach ache, one can see how the feelings have now become secondary. This is a change from the first session where she was over-flooded with feeling.

Before the clinic and to a great extent during that time, Sarah was over-sensitive, troubled by attacks from other people and feeling hurt all the time. She was the victim of others. She tried to be like her father and behave in the way he wanted her to - unemotional and in control - but was unsuccessful until she discovered heroin. Then she reached the goal, at least superficially, in that she no longer felt like such a victim. Heroin is a dangerous and illegal drug; besides which, when its effects wear off, so do the behavioral changes. Sarah needed to integrate heroin, in other words, learn to be less emotional and more distanced from her feelings, which overwhelmed her.

Now she is capable of being essentially unemotional and competent in most areas - except in relation to her father and men like him (Mac). When she consciously takes on this figure (as in the work on her stomach ache) she finds him too distant - she has attained the ability to stand up to this inner figure and defend having feelings - saying that life is boring and monotonous without them. With her outer father and Mac she is presently at an edge, i.e. to defend having feelings with these two unemotional characters. After integrating heroin - being able to act like she was when on the drug - she needs to go back and work on being able to have feelings again. She is now in this process.

CHAPTER 5

Conclusion

The first working hypothesis (see Chapter 1) postulated that heroin serves a purpose and has an intrapsychic function for the individuals taking it. They temporarily find themselves in a state in which they feel they obtain qualities (such as: being unemotional, being distanced) otherwise missing. The drug protects them by warding off dysphoric feelings (their normal everyday feeling about themselves: feeling weak, incompetent, too emotional), caused by constant attacks from inner negative dream figures. Instead of being the victim of these attacks, on heroin they become identified with the attacker.

This study has shown that the dysphoric feelings are elicited by an inner negative figure. Heroin ''helps'' the individual in the sense that he temporarily becomes identified with this figure. Astonishingly, in each case study presented here, the description of the state experienced on heroin was almost exactly a portrayal of how each client experienced his father. The real, outer father - mirrored in the individual's psyche as a strongly critical inner figure - is the originator of the dysphoric feelings.

By taking the drug, the client experienced a certain relief from the attacks of this figure. Sarah's statement about the feeling of extreme happiness she had on heroin - that it came simply because there was no need to protect herself and that she felt respite from the constant inner attacks - is a good example of this phenomenon. Confirmation is found in Chein's writing (1964). He is often criticized by other psychoanalytic authors for accenting the heroin addict's nirvana-like experience on heroin. However, the current study seems to support his views to some extent. Freedom from negativity is often experienced as a ''high''. Sarah feels ''high'' because nothing can touch her which could hurt her.

At first glance, this seems like a flight away from the critical figure, an attempt to simply escape from its negativity. When the strategy is examined in detail, it becomes apparent that the abuser does this by becoming what he was trying to get away from, by identifying with the aggressor. Both of the individuals studied here actually began to behave similarly to how the inner critic said they should, but could not behave. (Example: Bob's inner critic attacked him for being undisciplined and insufficiently concrete. While he was taking heroin he had to be concrete to get what he wanted (heroin) and it took a certain amount of self-discipline to be able to keep up his double life, that of being a junkie and of being a ''good son'', working in his father's company.) Unfortunately, these apparently beneficial effects do not hold, nor do they take very constructive forms. It is, as Stanton (1979) said, a form of ''pseudo-individuation''.

In the terms of process-oriented psychology, taking heroin flips the individual into his secondary process, making it primary. The old primary process disappears, while the new secondary process becomes ''cleaning up'' and the police.

The second working hypothesis stated that by taking drugs, the individual tries to get into a certain state, which does not quite happen, but nearly, so they take the drug again, thinking: this time it will work. Because the state cannot come to its conclusion, this behavior perseverates in the form of an addiction. By discovering the background pattern, its information content becomes clear. This information is unconsciously being sought when using heroin, which in itself contains only the raw, primitive form of the complete pattern. If this pattern is not processed (brought to consciousness and integrated), it remains autonomous - not under the individual's control - and will continuously repeat itself. It can take different forms, such as, switching the addiction to another drug or repression of the drug taking behavior with a continuing fascination for the drug's effects - using up much of the individual's energy.

It has been illustrated in this dissertation that the use of heroin is a protection against dysphoric states, as Krystal and Raskin (1970) and Khantzian (1978) state. In the author's opinion however, to leave it at that, recommending the legal addiction methadone, as Khantzian does, seems too simple, besides being a great loss to the addicted person. In the individuals studied here, the use of heroin was the first step on the way to dealing with the dysphoric state caused by a negative father complex, but only the first step. There is no integration and resolution of this complex in the use of heroin, therefore the dysphoric state will only be temporarily relieved. One finds the seeds for helping the individual work through and integrate this negative inner figure in their ideas about what heroin does for them. This means that what is needed, if the addiction is to be overcome, is the integration of this figure.

The effect on the individual of having a father complex which appears negative, is that his ability to father himself is weak or missing. These people need support from the outside to learn how to father themselves. The problem with Sarah is not that she lacks strength, but that she is not in touch with her strength. She needs help (symbolized, for example, by the father-like figure of the knight in her vision) to redress the wrong that is done to her, for instance, that Mac and her father do not take her as seriously as she wants to be taken. Without further integration of the inner figure, she will go on feeling that she is their victim. She is presently still too easily affected, she needs the coolness of the knight and the explosive quality of the fire, a kind of distanced anger or the ability to express her feelings (especially negative ones) in such a way that she does not become possessed by them; then she would have no trouble getting her ideas across to either Mac or her father. Her strength simply needs to be accessed.

In Bob's case, his negative father complex is telling him he should achieve more and do more. He feels weak and inadequate compared to his father, but the actual fact is that Bob has the capacity to do and achieve much more than he presently thinks he can. Underneath the negativity of this figure is a force which pushes him to be stronger and more effective.

Acting out the negative figure is not the answer. The critical figure needs to be brought together with the primary identity and both must change, creating a new identity containing aspects of both parts. Bob wants to be an individual, not just ''his father's good son''. He does also want his father to accept and approve of him, but at the same time, does not want his father to plan his whole life for him. Sarah needs to be able to have her feelings, ''otherwise life becomes boring and monotonous'', but she needs to be able to have distance from them and not just be taken over by them. Both sides are right in some ways - a discussion and coming together, integration, needs to occur.

What is important about studying the addictive process in this way, is that the details of how dysphoric feelings are warded off, and how the individual needs help, becomes clear. Other, more constructive ways to protect oneself from the dysphoric state can then be developed.

One can speculate that Bob is in the process of developing (or perhaps has already developed) an alcohol addiction because the ideals of the inner critical figure - such as that he should be an extreme individual and that he should fight for what he wants - are still far away from his conscious personality.

The third working hypothesis postulated that reaccessing the drug state is a useful method for treating drug addiction. Reaccessing is done by using process-oriented techniques to help the client into and through the drug state, in other words, to complete the process which is trying to happen in the use of drugs. Reaccessing also indicates that the effects of drugs are not purely a chemical phenomenon.

The information gathered in this work was not clear enough to prove this hypothesis conclusively. There are indications, though, which point to the usefulness of reaccessing in the gathering of detailed, concrete information about the individual's background process. Sarah's spontaneous reaccessing produced more detailed information about the state than did the session from the clinic. By helping her go into her unoccupied proprioceptive channel and amplifying the experience which was waiting there, and then bringing it into her occupied visual channel, she was able to bring an unconscious occurrence closer to her conscious life. Through this she can gain a clearer picture of what was trying to develop and now has some idea of how to go on working with herself. The visualizations of the knight and the fire are closer to her consciousness than was the author's intervention after the clinic session (where she helped Sarah express her feelings by first having her act like she was vomiting, and then saying how she felt). She now has a new representation of the heroin state, besides having a conscious overview of her situation. She could use the figure of the knight in problematical interactions by asking herself, ''How would the knight behave?'' or ''What would the knight do in this situation?'' This would be helpful guidance and, eventually, when he and the fire are finally integrated, she will be able to react in a way which satisfies her.

In Dr. Mindell's example of reaccessing the state (see Comments on the second session with Bob), his client was able to bring up information which had been totally repressed from his conscious life - the fact that he was trying to kill himself with the injections because he was acting like his mother, whom he hated. Reaccessing the drug state makes a process which wants to happen conscious, but bringing it truly to life, so that the client can fully integrate this process, takes much hard and creative work on the part of both client and therapist.

Reaccessing is an indication that the effects of drugs are not merely a chemical phenomenon. Remarks by addicts that one does not always notice the effects of certain drugs the first few times they are used (the author has heard these remarks specifically about hashish, heroin and cocaine), hints that these effects are not purely chemical in nature. There seems to be a quality of learning which goes along with them. Drug states are fairly easy to reaccess: 1) it happens spontaneously (a client will suddenly start to talk and act like they are high), 2) when an ex-addict suddenly gets the urge to use drugs again, and, 3) it can also be purposefully brought about again (as nearly happened in the second session with Bob). The biochemical explanation does not address the actual state. As was shown in Sarah's spontaneous reaccessing, a drug state can be attained without the use of drugs, as can a sober state be accessed by someone who has taken a large dose of drugs:

> A colleague took a heavily medicated psychotic client for a walk. He commented about the way the client was walking, that he was stumbling and staggering and generally having trouble walking. The client replied that it was because he had been given so many drugs. The colleague decided to take over and amplify his client's manner of walking; he started to stagger and stumble even more than his client. His client suddenly started to walk normally, saying, ''Stop that, people are looking at you funny!'' In that same hour the therapist challenged his client to a race; the client won (Dr. J. Goodbread, personal communication).

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