Measurement of levels of narcissistic rage in methadone patients and the relationship between narcissistic rage and extracurricular drug use: a study of the psychodynamics of compulsive drug use

Michelle Ava Epstein

University of Wollongong

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MEASUREMENT OF LEVELS OF NARCISSISTIC RAGE IN METHADONE PATIENTS AND THE RELATIONSHIP BETWEEN NARCISSISTIC RAGE AND EXTRACURRICULAR DRUG USE:

A STUDY OF THE PSYCHODYNAMICS OF COMPULSIVE DRUG USE

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ABSTRACT

Leon Wurmser's (1974) formulation of the psychodynamics of compulsive drug use focuses on individuals with a core narcissistic disturbance, who are prone to suffering narcissistic crises, leading to narcissistic rage. If normal defense mechanisms prove ineffective, this rage may be expressed as hostility and aggression in order to force a change in the external situation. If these attempts also fail, individuals will be compelled to use mood-altering drugs as a means of regaining control over their internal state, thereby satisfying infantile needs for omnipotence.

Wurmser’s formulation of the psychodynamics of pathological narcissism in compulsive drug users may account for common problematic interactions between patients and staff in methadone clinics, as described in the literature on transference phenomena those environments. Research indicates that the presence of severe concomitant psychopathology in methadone patients is common and greatly reduces treatment outcome. However, narcissistic disturbance, a core structure of psychopathology often discussed in the psychoanalytic literature, is rarely the subject of empirical research.

Two studies were designed to investigate a possible link between narcissistic rage and extracurricular drug use in methadone patients. In Study 1, the Narcissistic Rage Scale, an observer instrument for measuring the level of narcissistic rage displayed by an individual,
was constructed from a review of the literature, then validated, based on the conceptualization of narcissistic rage by experienced psychoanalysts and psychotherapists. This general scale was later translated into the Narcissistic Rage Scale for Methadone Patients, a nineteen item scale based on observable behaviour, suitable for use by general staff in a methadone clinic.

In Study 2, the theoretical relationship between narcissistic rage and compulsive drug use, as postulated by Wurmser, was investigated among methadone patients. It was hypothesized that patients with higher levels of narcissistic rage would show more extracurricular drug use than patients with lower levels of narcissistic rage.

The Narcissistic Rage Scale for Methadone Patients showed good inter-rater reliability and retest reliability. Scores on the scale indicated that over 70% of patients on the methadone programme used in this study had high levels of narcissistic rage. The clinical significance of this finding is discussed, including implications for staff training and supervision on transference and countertransference issues. Implications for patients needs are also discussed, and the need for adjunct psychotherapy for patients, focusing on resolution of narcissistic transference, is recommended.

Level of narcissistic rage was shown to be a modest predictor of extracurricular drug use. Since extracurricular drug use is a major indicator of response to treatment, methadone treatment efficacy may be enhanced if patients with high levels of narcissistic
rage are identified and treated, or perhaps referred to drug-free interventions.

Study 1 demonstrates that a complex psychodynamic concept can be translated into an instrument utilizing observable behaviour that can be reliably rated by general staff in a methadone clinic. Study 2 demonstrates that a theory of the psychodynamics of drug use can be tested empirically and the findings lend support to psychodynamic formulations of addiction.
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Heroin addiction represents a large and growing problem in contemporary society. Mattick and Hall (1993) reviewed projects attempting to estimate the number of heroin-dependent people in Australia. An estimate based on opiate-related deaths in 1986 (249) produced numbers of between 25,000 - 50,000 regular users. Other estimates based on number of people in treatment for opioid/polydrug dependence produced estimates of 50,000 - 80,000. Another study in 1986 estimated 10,00 users in NSW and 30,000 dependent opiate users in Australia. Between 1986 and 1990 the population prevalence of dependent heroin users increased from 4.5 to 7.2 per 100,000 (Hall, 1995). Generally the number of heroin-dependent people in Australia in 1993 was estimated to be between 30,000 - 50,000. With regard to the most cost-effective form of treatment for this population, data from the Treatment Outcome Prospective Study (TOPS) which compared the long-term outcome of patients in therapeutic communities, methadone maintenance and out-patient drug-free programmes across fourteen treatment centres, indicate that methadone maintenance out-performs
detoxification and therapeutic communities (Hubbard, Marsden, Rachal, Harwood, Cavanaugh & Ginzburg, 1989).

Methadone maintenance treatment was introduced in the USA in the early 1960's and since then has been the opioid replacement treatment of choice and the most extensively researched treatment for opiate dependence. Dole and Nyswander (1965, 1967) first proposed that opiate dependence was a physiological disease due to a metabolic deficiency which the addict self-medicates. Based on this theory, they concluded that heroin addicts need to be supplied with methadone indefinitely.

As reviewed by Mattick and Hall (1993), the history of methadone treatment in Australia began with the introduction of methadone maintenance treatment by Dr Stella Dalton in 1970. Until 1985 there were two methadone clinics in Sydney, New South Wales providing indefinite blockade doses which, according to Dole and Nyswynder (1980), would block the effects of any extracurricular narcotics, thereby eliminating the patient's motivation to use heroin whilst in methadone treatment. With the increase in methadone programmes and the consequent entrance into the field of non-medical staff who generally favoured a more psychological and "curative" approach, this model was eventually abandoned and replaced with a time-limited low dose model. Government policy also favoured time-limited treatment to reduce costs and push more people through the treatment system, especially as demand for methadone treatment increased. In 1984 in Australia, the NSW Government
Department of Health introduced an expansionist policy for the provision of methadone maintenance treatment (MMT), with a parallel introduction of MMT programmes in the private sector. At the 1985 Premiers conference methadone maintenance was endorsed as the favoured treatment for opioid dependence, resulting in a dramatic increase in the number of patients participating in methadone treatment: in NSW in 1984, 783 patients, in 1987, 3,200 patients, and in 1989 a total of 3,800 patients. By 1995 the number of people in methadone maintenance treatment in NSW rose almost 300% to 9,479 (NSW Department of Health, 1996). Across Australia the numbers rose from 2,203 patients in 1985 to over 10,000 in 1991. The proportion of heroin users in methadone maintenance treatment has risen from 17% in 1987 to 30% in 1992 (Hall, 1995). In a monograph funded by the Federal and State Drug Offensive, Mattick and Hall (1993) conclude that "methadone maintenance is currently a central and very important approach to the management of opiate dependence that must be widely available ...to meet the needs of those who are dependent on opioids" (p.92). The authors also note that while provision of methadone is on the increase, provision of ancillary services, particularly adjunct counselling, is decreasing and there are no government stipulations concerning the availability of counsellors for methadone patients. This gap in policy has meant that the provision of counselling largely depends on the philosophy of individual clinic managers. At the time of the writing (of this thesis),
the Australian Federal and NSW State Governments' commitment to and expansion of methadone programmes continues.

1.2 Literature on Methadone Treatment: Empirical Research and Psychodynamic Case Reports and Theory

Given the enormous investment in MMT and the long-term nature of the commitment, MMT must be regarded as an important area for evaluation and research. Currently there are two very separate bodies of literature examining patient outcomes in MMT; empirical research papers and theoretical / descriptive papers.

Mattick and Hall (1993) reviewed the empirical research literature on treatment effectiveness and found five randomised controlled trials. These studies indicate that when compared to no treatment, MMT has a substantial impact in reducing drug use, criminal behaviour and mortality. The authors conclude that methadone treatment is generally regarded as effective in reducing heroin use but results have been mixed and some programmes have achieved only minimal reduction in heroin use.

Quasi-experimental studies such as that of Bale, Van Stone, Kuldau, Engelsing, Elashoff and Zarcone (1980) compared methadone, a residential period in a therapeutic community, detoxification and no treatment. At 12 months, patients in a long-term therapeutic community and those in methadone treatment were more likely to be employed or attending school and were less likely to be in jail, to
be using heroin or to be convicted of a serious crime than those in the no treatment group.

DARP (Drug Abuse Reporting Programme) (Simpson & Sells, 1982) studied 52 agencies in the USA and Puerto Rico on 44,000 applications for treatment from 1969 to 1973, with a 12 year follow-up. The results indicated that methadone and other treatments for opiate addiction were all effective to some degree. Outcome was influenced by length of time in treatment with a minimum programme duration of 12 months necessary before there is a positive effect.

TOPS (Treatment Outcome Prospective Study, Hubbard et al. 1989) examined over 11,000 applicants for treatment in the USA from 1979 to 1981. The results indicated that methadone maintenance produced significant reduction in heroin use and other drug use. Again, one year of treatment was necessary before treatment gains were maintained at follow-up.

The Three Cities Study examined methadone clinics between 1985-1987 (Ball & Ross, 1991). Each clinic had different results; 4 reduced drug use by between 75-90% and 2 reduced drug use by 44%. The more successful clinics had higher doses, commitment to maintenance versus abstinence, quality counselling, a good record of retaining patients, medical services, good staff-patient relations, low staff turnover. The findings indicated that patients who left treatment had high rates of relapse.
Empirical studies have provided important information about methadone treatment. However, in their quest for rigour and quantitative data, complex phenomena are often reduced to simplistic, inadequate explanations (Kaplan, 1977; Wurmser, 1978). For example, current research investigating outcome in MMT largely ignores the psychodynamics of drug use. Pharmacological and treatment-related variables have received much attention, while patient-centred variables have been limited mostly to demographic and diagnostic considerations (Wurmser, 1974, 1978, 1985b). Policy and practice is often based on the recommendations arising from such research. This has often resulted in an over-emphasis on an approach which is not patient-centred in that it relies on modification of administrative details rather than responding to the psychological needs of the patients (Ausubel, 1983; Wurmser, 1974, 1978). Wurmser (1974) concludes:

When the values of power, expediency, public success, and cost efficiency are uppermost, and the required strategies of manipulation and control become so intermingled with therapeutic considerations, then the value of insight, inner change and control, and with them the methods of introspection and empathy, must take a backseat (p.4).

He argues that severe psychopathology is the fabric of drug addiction but "psychophobia", the fear of looking inside and the tendency to attribute problems to external
things, has fuelled the anti-psychodynamic movement. He goes on to argue:

I have been impressed and distressed by the ignorance and outright denial of the problem of severe psychopathology as the core problem in many, if not all, compulsive drug users. On the one side there is an impressive sophistication devoted to pharmacological studies, to animal studies, to sociological and epidemiological inquiries, .... to refinements in the discovery of yet other traces in urine or other body fluids of some toxic substance, to broad gauged accounts of results with this or that modality alone or in combination... there are exceptions... However, they are still scant, funded only peripherally or not at all, not carried out in a nationally organised, systematic way - and they are pitifully out of proportion, both as to the severity of the problems faced and to the efforts devoted to what I am convinced are less central aims (Wurmser, 1974, p.383-384).

Ausubel (1983) argues that official evaluation studies grossly exaggerate the effectiveness of MMT, masking the fact that methadone is creating more opiate addicts than it is curing.

Clinical literature on the addictions, and specifically on MMT, on the other hand, is often criticised for the anecdotal and qualitative nature of the material, so that the vast body of case reports and theoretical papers arguing for a more psychological
approach to methadone patients is often ignored. The conclusions drawn from single case studies can be quite extravagant and can seem to arise more from conjecture than from the data (Kaplan, 1977). In response to such criticism, there has been a growing movement within the psychoanalytic community towards emphasising the need for empirical research into psychodynamic theory. However, clinicians remain divided and there is still strong opposition in many quarters to any change from the traditional methodology of psychoanalytic investigation. This pervasive opposition has been the topic of a series of editorials over recent years in the Journal of the American Psychoanalytic Association, reflecting general concern about the future of the status of psychoanalysis. Increasingly, research panels are having to confront the issue of the place of conventional research methods in psychoanalytic research (Wilson, 1994). Holzman and Aronson (1992) describe two schools of opposition: the strong clinical position, which holds that if a proposition can be demonstrated clinically, then its validity has been proven and the nihilistic position, which holds that it is impossible to confirm or disconfirm psychoanalytic hypotheses. They conclude "that psychoanalysis has presented us with a rich array of hypotheses about human behaviour which, for the most part, have neither been tested for their validity, nor, more importantly, probed for their generality" (p. 74). As a result, psychoanalysis is falling from grace. Kernberg (1993) refers to this as "the sense of crisis", and
points to the animosity shown towards psychoanalysis by American department of psychiatry heads and universities, which has resulted in, for example, the DSMIII [and subsequent editions] rejecting the psychoanalytic perspective in their classification of disorders. Increasingly, the wider clinical community has limited access to, interest in, and acceptance of the psychodynamic model. Consequently, fewer medical graduates are being attracted into psychodynamic training (Kernberg, 1993).

Generally, current scientific methodology is not viewed as being relevant or sophisticated enough for investigating psychodynamic concepts. This is a widely held view in the psychodynamic community, and poses a serious impediment to the testing of psychodynamic theory and the scientific evaluation of psychodynamic therapy. Also, the development of new research paradigms specifically designed to test psychodynamic theories and outcomes, has not been seen as a priority. Kernberg (1993) goes so far as to suggest that psychoanalysis as a science is "chafing under limitations to scientific inquiry posed by the structure of psychoanalytic institutions" (p. 47-48). Resistance to opening the field up to clinicians outside the medical profession is cited as a misguided attempt to protect the integrity of the field. He recommends that psychologists, for example, with strong research backgrounds, be welcomed by psychoanalytic institutes. "The prestige psychoanalysis enjoys in the medical profession... depends more on the
strength of the scientific contributions made... than on whether the contributor is a physician, psychologist, neurochemist or sociologist" (Kernberg, 1993, pp. 49-50). Alternatively, Kernberg suggests that psychoanalytic candidates could be trained in research methods, although, as Wallerstein (1988) points out, usually the majority of people in the helping professions want to work clinically, while a minority tend to be attracted to research.

An extension of the view that current scientific methodology is unsuitable or irrelevant to psychoanalysis, is the view that psychoanalysis is and always has been a science with its own methodology. Wallace (1989) refers to the compelling force of existing clinical data, and suggests that studying material from case conferences, supervision sessions, verbatim transcripts or tapes of sessions, provides a wealth of evidence to support psychoanalytic theory and practice. He argues that the predictive and retrodictive force of the analytic method is compelling evidence of its validity. However, Wallerstein (1988) reminds us that our tradition of the case study method originated with Freud who took the study of neurosis out of the world of science and into the world of the humanities when he discovered that the symptom had meaning and that meaning is not the product of causes but the creation of an individual. He argues that this tradition has led to a lack of interest in scientific activity, justified through powerful intellectualizations.
Leaders in the philosophy of science, such as Nagel, Hook and Popper who dismiss psychoanalysis as pseudo science and mythology, have been ignored by psychoanalysts. Grunbaum's (1984) book *The Foundations of Psychoanalysis*, makes a cogent argument for viewing psychoanalysis as being unvalidated and unscientific; this proposition has been criticised by Wallace (1989) as arising from a one-sided view of science and ignorance of psychoanalytic methodology. In reply to those who argue that psychoanalysis is a science, Kernberg (1993) maintains that lively discussions about whether or not psychoanalysis is a science, are not a substitute for active research, and that the question must be answered empirically and not philosophically. Wallerstein concludes that the traditional hermeneutic stance is "a massive abdication of our scientific responsibilities as a discipline" (p.13).

Ideally, our understanding of the course and outcome of patients in MMT would be greatly enhanced if the two repositories of information and methodology - empirical research and psychoanalytic theory - were combined to provide a reliable detailed account. Further, our understanding of addiction and compulsive drug use in general is thwarted by the traditional separation of psychodynamic theory and empirical methodology. This study is an attempt at research which represents a collaboration of these two approaches, specifically, to test empirically a psychodynamic theory of addiction and extra-curriculum drug use in methadone patients, proposed
by Leon Wurmser. The study is divided into two parts: first, the development of a new instrument to operationalize and measure the psychoanalytic concept of Narcissistic rage and second, the use of this instrument to investigate the relationship between level of narcissistic rage and extracurricular drug use in methadone patients.
2.1 Addictive Disorders

Substance dependence, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, “is a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that usually results in tolerance, withdrawal, and compulsive drug-taking behaviour” (American Psychiatric Association, 1995, p176).

Opioid dependence is an increasing problem in lower and middle-class individuals and in those professions with ready access to the drug. Increased prevalence is also associated with increasing levels of drug-related crime. Dependence appears to often remit after the age of 40, however many addicts may remain dependent for 50 years or more. There is an increased incidence of psychopathology and other substance-related disorders among family members of opioid addicts (American Psychiatric Association, 1995).
2.2 Prevalence of Concomitant Psychopathology in Addictive Disorders

Studies of the prevalence of psychiatric disorders among opiate addicts have consistently found high rates of some concurrent disorders, most commonly depression, followed by antisocial personality disorder and alcohol abuse (Strain, Brooner & Bigelow, 1991; Khantzian & Treece, 1985; Kleber, Weissman & Rounsaville 1983; Regier, Farmer, Rae, Locke, Keith, Judd & Goodwin, 1990; Rounsaville, Weissman, Kleber & Wilbur, 1982a; Strain, Limbeek, Wouters, Kaplan, Geerlings & Alem, 1992; Woody, Luborsky, McLellan, O'Brien, Beck, Blaine, Herman & Hole, 1983). Women were found to be more likely to be diagnosed with an anxiety disorder (Rounsaville, Weissman, Kleber & Wilbur, 1982) or depression (Khantzian & Treece, 1985; Rounsaville, Weissman, Wilber, Crits-Cristophh, & Kleber, 1982b; Strain, Brooner & Bigelow, 1991), while men were more likely to be diagnosed with antisocial personality disorder (Khantzian & Treece, 1985; Rounsaville et al, 1982a). Mattick and Hall (1993) cite two Australian studies that found approximately 60% of opiate users and methadone patients had significant comorbid non-psychotic psychiatric disorders.

Most addicts have a diagnosable personality disorder, with consistently high rates of personality disorder in addicts reported at between 68% to 90% in the literature (Khantzian & Treece, 1985; Kosten, Kosten & Rounsaville, 1989; Rounsaville & Kleber, 1986). The study of the relationship between addiction and personality
disorder has evolved from early formulations which classified drug addiction as a type of personality disorder in the Diagnostic and Statistical Manual of Mental diseases (DSM) (American Psychiatric Association 1952), to a later development in the DSM III (1980) when drug addiction was categorised separately and not viewed as a permanent condition. In the 1970's many investigators searched to identify an "addictive personality" but later studies concluded that "personality disorders were common but heterogeneous among substance abusers" (Kosten, Kosten & Rounsaville, 1989). In the Kosten, Kosten and Rounsaville study, the most frequent diagnosis was Antisocial Personality Disorder, followed by a group they called Borderline type (borderline, schizotypal, schizoid and paranoid), then a group called Narcissistic type (dependent, narcissistic and histrionic) followed by a final group including passive-aggressive, avoidant and unspecified or mixed personality disorder. It was also noted that many patients met the diagnostic criteria for more than one personality disorder. The DSM IV also cautions that the clustering system for personality disorders "has serious limitations and has not been consistently validated. Moreover, individuals frequently present with co-occuring Personality Disorders from different clusters" (p.630). This issue will be addressed further in section 8.1 when methodological considerations concerning the identification of narcissistic pathology in the present study are discussed.
2.3 The Relationship Between Addictive Disorders and Concomitant Psychopathology

The relationship between addictive disorders and concomitant psychopathology is complex. Traditionally, psychopathology has been identified as a risk factor for Addictive Disorders, with drug and alcohol abuse viewed as a means of self-medicating the psychological pain arising from these disorders (Allen & Frances, 1986). Substance abuse is listed in The Diagnostic and Statistical Manual of Psychiatry (Fourth Edition) as being commonly associated with the following mental disorders: Conduct Disorder, Antisocial Personality Disorder, Borderline Personality Disorder, Schizophrenia, Major Depressive Disorder, Dysthymic Disorder, Cyclothymic Disorder, Panic Disorder, Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Generalized Anxiety Disorder, Anorexia Nervosa and Bulimia Nervosa (American Psychiatric Association, 1994). In addition to mental disorders where substance abuse is often part of the clinical picture, some mental disorders, such as Mood Disorders, Anxiety Disorders and Psychotic Disorders, can be substance-induced. Also, intoxication and withdrawal syndromes can mimic primary mental disorders. Further, there is evidence to suggest that life for an individual with an addictive disorder, entailing problems such as isolation from family, loss of employment etc, can lead to depression and anxiety disorders (Meyer, 1986). In the case of depression,
researchers have attempted to differentiate between the prevalence rates for primary depression; depression that existed prior to a history of substance abuse, and secondary depression, with onset subsequent to substance abuse. Some researchers have also suggested that the course of an addictive disorder is so traumatic, individuals can suffer symptoms similar to those seen in Posttraumatic Stress Disorder (Meyer, 1986).

While depression and anxiety disorders may be factors in the aetiology of an addictive disorder, symptoms of an intoxication or withdrawal syndrome, or the result of the traumatic lifestyle of an addicted individual, personality disorders are generally viewed as being primary to the addictive disorder. A Personality Disorder is defined in the Diagnostic and Statistical Manual of Psychiatry (Fourth Edition) as:

an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (p.629).

Substance abuse may cause long-term "personality change" (Meyer, 1986) but not a recognized symptom constellation that would attract the diagnosis of personality disorder. For example, amphetamine abuse or cannabis abuse may lead to paranoid delusions, but not to the particular pattern of features that constitute Paranoid Personality Disorder. Also, following cessation of the drug, these
drug-induced psychiatric symptoms in secondary mental disorders will disappear, whereas primary mental disorders will persist. Alcoholics Anonymous use the term "dry drunk" to denote an individual who is abstinent from alcohol but still leads a dysfunctional life, emphasising that abstinence will modify personality changes and behavioural problems arising from repeated intoxication, but will not have an impact on other areas of dysfunction often seen in association with alcoholism. Generally, the histories of addicted individuals reveal personality dysfunction prior to or simultaneous with substance abuse, both beginning in adolescence (Meyer, 1986). For example, the diagnosis of Antisocial Personality Disorder, the disorder most commonly found in alcoholics and heroin addicts, requires that the individual had Conduct Disorder as a child, indicating a clinical picture of primary personality disturbance.

and interact within socially accepted boundaries, are all functions of a healthy integrated personality. In the Personality Disorders, these functions are impaired and there is a pervasive pattern of dysfunction in the individual's ability to perceive reality accurately and to interact successfully with others. Psychodynamic theories point to impairment in core personality structures, particularly in the narcissistic realm which determines one's identity and sense of self, as the source of conflict and disturbance in the areas of dependence, attachment, power and autonomy in later life. According to this view these core personality structures form the vital part of the psychological development of the infant, and disturbance at this stage can lead to the dependence on substances rather than people in later life.

Wurmser (1978) observed and surveyed 200 patients in a methadone programme and noted the high prevalence of serious psychopathology which became particularly obvious once the chaos of the addict lifestyle was replaced with a stable environment. Wurmser identified three groups of patients. The first appear to function well despite serious psychopathology because they are maintained on high tranquillizing doses of methadone and lean heavily on support services. This group return to dysfunctional patterns of behaviour once methadone and support are withdrawn. The second group oscillate between periods of reasonable functioning (again relying heavily on support services) and periods of pathological functioning
characterized by interpersonal strife, job loss and depression or uncontrolled anger. A return to better functioning is only possible with intensive help from professionals. The last group are chronically and severely dysfunctional and are likely to die or go to prison.

Studies of psychopathology among heroin addicts confirm the high rate of serious psychopathology found in substance abusing populations in general. Studies have found improvement with treatment of antidepressants (Woody, O'Brien & Rickels, 1979) and significant rates of Major Depression, Alcoholism and Antisocial Personality Disorder (Dorus & Senay, 1980; McLellan, Woody & O'Brien, 1979; Rounsaville, Weissman, Wilber, Crits-Cristoph & Kleber, 1982; Weissman, Slobetz & Prusoff, 1976), Depression and Personality Disorder (Khantzian & Treece, 1985; Treece & Nicholson, 1980), and deficits in interpersonal relationships and affect modulation (Blatt, Berman, Bloom & Feshback, 1984). Studies with methadone patients yield similar results (Rutherford, Cacciola, Alterman & Mc Kay 1996). Given the high rate of psychopathology in methadone patients, some studies have investigated the efficacy of treating specific symptoms with drug therapy (Woody, O'Brien & Rickels, 1975) and treating overall functioning with psychotherapy (Rounsaville, Glazer, Wilber, Weissman & Kleber, 1983; Woody, et al. 1983). Kosten, Kosten and Rounsaville (1989) conclude:
The challenge for clinical research and practice... is to develop comprehensive treatment programs that provide the structure and limit setting needed to control the substance abuse as well as properly arranged support to modify interpersonal limitations in patients with comorbid personality disorders (p. 168).

2.4 Psychopathology As A Moderator Of Outcome In Methadone Maintenance Treatment

In addition to cause and effect relationships of different kinds, addictive disorders and primary mental disorders may interact in other ways. A co-existing mental disorder may alter the course of an addictive disorder in terms of increased rapidity with which the disorder progresses, prognosis and response to treatment (Meyer, 1986). Opioid addicts with Personality Disorders have an increased risk of psychiatric problems such as depression and other problems such as alcoholism, legal problems and medical problems (Kosten et al. 1989).

"Psychopathology" has been identified as an important moderator of treatment outcome in methadone treatment with patients exhibiting high levels of psychopathology achieving poorer outcomes than those with low levels of psychopathology (McLellan 1986; Prescott 1990; Treece & Nicholson 1980). Psychotherapy as an adjunct to methadone treatment has been found to be beneficial to patients with severe psychiatric problems,
who would otherwise be expected to achieve very poor treatment outcomes (Kuncel 1981) although Rounsaville, et al. (1983) found that psychotherapy was not beneficial. Woody, Luborsky, McLellan & O’Brien, (1986) found that co-existing depressive disorders were most amenable to psychotherapy, while methadone patients with Antisocial Personality Disorder may not derive much benefit from adjunct treatment. Rounsaville and Kleber, (1985) conclude that psychotherapy may only improve outcomes for methadone patients with severe levels of psychiatric symptoms. In general, the presence of comorbid psychopathology leads to poorer outcomes in methadone treatment when these problems are not addressed (Mattick & Hall, 1993). Patients who are older, are not polydrug abusers, have good work skills, more stable home lives and less psychopathology at admission tend to have better outcomes (Prescott 1990). It could be argued that a high level of psychopathology would generally be associated with less interpersonal and vocational stability and increased drug abuse. Craig (1979a, 1979b, 1982) found that traits such as poor impulse control, low frustration tolerance, need for immediate gratification, and demanding of attention did not respond to methadone treatment. Prescott concludes that:

...investigations of the relationship between treatment outcome and personality variables are at an early stage. There is a need to relate personality factors to treatment outcomes...

Interventions could also be developed which focus on
the psychopathic traits of addicts... One other area of personal characteristics which appears to have been poorly researched is the nature of the expectations and motivations that opioid users bring with them into MM, and how these are related to outcome variables. (1990, p.18).

This latter issue is the focus of the present study, with particular reference to pathological anger associated with unrealistic expectations in methadone patients.
3.1 Pathological Anger In Methadone Patients

For those who have worked in methadone units, including the candidate, it is not surprising to learn that methadone patients have higher rates of comorbid psychopathology than the general population. Nor is it surprising to learn that research indicates that patients with serious psychopathology do not do well in MMT. Trying to deal with pathological behaviour and treatment failure in a large percentage of patients is commonly accepted by staff as being an inevitable part of the job. While the literature has focused on the high levels of psychopathology in terms of consequences for treatment outcome, there is little recognition of the consequences for staff and their functioning in the clinic. Anyone who has worked in a methadone clinic will describe the daily stress of treating and being subjected to patients' pathological behaviour, as well as the frustration and disillusionment that comes after multiple failed attempts to achieve treatment success for these patients. In the candidate's experience as a psychologist in a methadone clinic, the type of psychopathology in patients that is regarded as producing the most difficult and most frequent problems for staff, is that of pathological
anger. Psychopathology in methadone patients has traditionally been studied by identifying patients with particular psychiatric diagnoses such as Antisocial Personality Disorder and depression. The pathological anger observed in methadone patients has not been the subject of research because it is generally viewed as a problem behaviour involved in various psychiatric disorders, particularly the personality disorders, and has not been singled out as an important feature in and of itself. Also, pathological anger in methadone patients is often accepted as typical in patients who obviously have difficulty with impulse control.

Pathological anger in methadone patients is the focus of the present study. This is an important area for investigation because, as discussed previously, psychopathology in methadone patients is the most important moderator of treatment outcome, and pathological anger in methadone patients appears to be very prevalent, resulting in high levels of distress for both patients and staff (Davidson, 1977; Khantzian, 1977; Mandelberg, 1988; Wurmser, 1978). However, there has been little empirical research to support anecdotal reports. In this chapter, descriptions from the psychodynamic literature on pathological anger in methadone patients will be provided, illustrating that there is wide recognition of this phenomenon. This will be discussed utilizing the psychodynamic concepts of transference and countertransference. Psychodynamic formulations of pathological anger, focusing on the concepts of
narcissistic character pathology and narcissistic rage as
manifested in the transference and countertransference,
will be outlined, followed by a discussion of
psychodynamic theories of the aetiology and development
of narcissistic pathology. Finally, psychodynamic
formulations of the central role of narcissistic
pathology in addiction and compulsive drug use will be
discussed, with particular reference to Wurmser's
formulation on which the present study is based. Based on
Wurmser's theory, the study investigates the possible
link between the level of a patient's narcissistic
pathology (and pathological anger manifested as
narcissistic rage) and methadone treatment outcome.

3.2 Descriptions Of Pathological Anger In Methadone
Patients

The psychodynamic literature is rich with case
reports and anecdotal evidence of the high prevalence and
pathological nature of angry behaviour in methadone
patients (Blatt et al. 1984; Curet et al 1985; Davidson,
1977; Dodes, 1990; Frosch, 1970; Greenspan 1977; Kaufman,
Mandelberg (1988) suggests that "therapeutic effort must
address this element of aggression, firstly, by
acknowledging that it exists, then by understanding
the quality of it and finally by working out how to
deal with it" (p.214) and highlights "the traumatic
the effects of uncontained aggression on all concerned— the individual patient, the other patients, the staff and the wider community” (p.214). Khantzian (1974) observed over 200 heroin addicts seeking treatment and noted that most were frequently verbally angry and often used violent language. When they encountered frustrations, they usually responded with paranoid outbursts, culminating in personal attacks on staff. Although somewhat subdued while maintained on methadone, upon withdrawal from methadone, there was a re-emergence of aggressive impulsive outbursts, projections and paranoia. Khantzian also noted that there seemed to be a significant group of patients who remained angry and aggressive throughout their stay at the methadone clinic.

During the candidate's years working in a methadone clinic and talking to staff in other methadone clinics, there was always evidence to suggest that much time, energy and money was spent in the management of intensely angry patients. While the physical environment of the clinics was designed to ensure the security of methadone supplies, staff security always became the greater concern, with equipment and fixtures, originally installed for anti-theft purposes, being utilised for the physical protection of staff. Clinical meetings often focused on the management of severe "acting out" behaviour of angry patients. In addition to the daily exposure to hostile and aggressive behaviour, most staff were also affected by episodic incidents of serious violence against themselves, others or clinic property.
This kind of constant overt aggression has been described by Davidson (1977) and Khantzian (1974). Other more subtle forms of aggression were also common. During assessment, clients may demand to be placed on MMT even when they do not meet the necessary criteria. Patients' belief in a "god-given right" to receive methadone is often reported by staff conducting assessments. Refusal to accept clinical recommendations can take the form of intimidation, overt threats, violence against staff/property or clinical appeal hearings. When accepted for MMT, patients are informed about government regulations regarding the way MMT is administered, as well as any other programme regulations required by the clinic. Nevertheless, many patients behave as if these rules and requirements do not or should not exist and can become intensely angry when rules are enforced. This anger may only take the form of verbal abuse of staff but some cases progress to intimidation, threat or actual violence. For example, patients may refuse to provide a compulsory urine specimen but still demand methadone. Others will insist that the results of their urinalysis, indicating the presence of extracurricular drugs, are wrong, and will challenge the loss of privileges incurred as a consequence of the alleged drug use. Patients may refuse to attend appointments for prescription renewal yet still demand methadone. Some patients generally display intense rage and aggression when expected to comply with programme rules.
While some patients behave in a very confrontational manner, many patients use deception to override rules. When this deception is discovered by staff and the patient is confronted, patients will often angrily protest their innocence, sometimes escalating into enraged verbal attacks or physical violence. The following are typical examples of deception. Patients may divert their methadone (for example, trick the dispenser into thinking the methadone has been swallowed when actually it has been removed from the premises via elaborate devices hidden in clothing, bags etc.) This methadone is sold on the black market or injected. Another common form of deception practised is urine substitution, when patients hand in urines that have been saved at home during periods of abstinence, or urine that has been purchased. Or, a person's normal dose of methadone may be supplemented with extra black market methadone (which cannot be detected by urinanalysis), giving the false impression of cessation of extracurricular drug use.

Apart from anger in response to programme rules and monitoring, some patients may display intense anger when they become frustrated by the day to day "inconvenience" of MMT, and may blame staff for unavoidable or foreseeable problems. For example, patients arriving for methadone outside opening hours may demand to be let in, using threats or manipulation. Having to wait in a queue in the methadone dispensary or having to wait to see the doctor may move some people to
violence. In general, when some patients feel thwarted or frustrated, either by rules or circumstances, they view the staff involved as hostile, persecuting and sadistic, or merely inept and hopeless. In addition to this unprovoked blaming of staff, patients are often inappropriately intolerant and unforgiving of any genuine mistakes made by staff.

This high level of anger also has serious implications for the patients, with intense rage against staff or the programme often leading to premature expulsion from, or voluntary termination of a patient's programme. Alternatively, patients may be constantly transferred from one methadone clinic to another, as each clinic experiences unacceptable levels of aggression from the patient. These patients' progress in treatment can be undermined by this lack of stability and repeated negative experiences with staff. These observations are echoed throughout the psychodynamic literature (Curet et al. 1985; Davidson, 1977, Khantzian, 1977; Wurmser, 1978). Apart from the more obvious implications for staff and patients, there may also be other outcomes of the intense rage seen in methadone patients which are not so obviously connected. The present study addresses a possible connection between intense rage and increased extracurricular drug use in methadone patients.

While pathologically angry patients remain the greatest management problem for staff, and while they may be the patients most likely to terminate or undermine their own treatment, they are not generally discussed in
the literature, perhaps because they do not conveniently come under one diagnostic category as, for example, depressed patients do (Kohut, 1972). Also, the aggression displayed by many patients may largely be viewed in terms of "problem behaviour" and may not generally be recognized as potentially constituting part of a wider clinical picture. However, a study by Rutherford, Cacciola, Alterman and McKay (1996) examining impairment in object relations in methadone patients did find that methadone patients were much more prone to anger and hostile withdrawal than the normal population.

3.3 Explanations Of Anger In Methadone Patients

The anger typically displayed by many methadone patients may be viewed as a normal reaction or a pathological reaction. Before proceeding to a psychodynamic perspective of pathological anger, which forms the basis of the present study, other perspectives will first be discussed.

One way of viewing the angry behaviour observed in methadone patients is to assume that it is a normal reaction to a treatment that involves many government regulations, rules, restrictions and controls which have to be enforced by clinic staff. In this way, the anger displayed by methadone patients would not be considered to be different from the anger displayed by any group who are subjected to limitations on personal freedom.

At least four problems arise from this view. The
the literature, perhaps because they do not conveniently come under one diagnostic category as, for example, depressed patients do (Kohut, 1972). Also, the aggression displayed by many patients may largely be viewed in terms of "problem behaviour" and may not generally be recognized as potentially constituting part of a wider clinical picture. However, a study by Rutherford, Cacciola, Alterman and McKay (1996) examining impairment in object relations in methadone patients did find that methadone patients were much more prone to anger and hostile withdrawal than the normal population.

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At least four problems arise from this view. The
first problem concerns the quality of the anger displayed by methadone patients. The intensity of the rage observed in some methadone patients, the extreme lengths some go to in order to override limitations, and the "out of control" behaviour that patients may display in the expression of their rage, would suggest that we are not observing instances of "normal" reactive anger. Further, the anger is rarely expressed in conventional ways, for example, through petitions, discussion, requests etc. Its form appears to be more akin to an impulsive, almost unbearable and unstoppable "explosion" of anger, or, in other instances, a devious and calculated act of revenge, as described by Davidson (1977). An example from the candidate's experience illustrating the latter type of expression of anger, was a patient attending the clinic used in the present study, who, when angry with her counsellor, systematically sought out and befriended many of the counsellor's patients and then attempted to turn them against their counsellor. As in Davidson's accounts, once the explosion is over, or the revenge is complete, there is often no remorse or insight: the person continues to believe that they are being slighted and there is no acknowledgement that the staff member is simply enforcing the known rules. In terms of psychiatric diagnosis, this kind of anger is generally viewed as being pathological in nature, and may be related to phenomena such as delusions of grandeur, paranoia or persecution, or impulse control disorders. Personality disorders such as Antisocial, Narcissistic, Paranoid, and
Histrionic types are also associated with pathological levels and qualities of anger (American Psychiatric Association, 1994).

The second problem, arising from an environmental perspective, concerns the context within which the anger occurs. Although being in methadone treatment does entail a significant loss of personal freedom, many clinics work hard to minimize the impact this will have on the patient's life. While some methadone programmes may be more aversive than others, in the candidate's experience, extreme and frequent outbursts of anger are observed in patients across all clinics, irrespective of how therapeutic versus correctional the approach is. The literature reports trends across many clinics and locations (Blatt et al. 1984; Curet et al. 1985; Davidson, 1977; Dodes, 1990; Frosch, 1970; Greenspan, 1977; Kernberg, 1970, 1974, 1975; Kaufman, 1974; Khantzian, 1974, 1977, 1985, 1989; Krystal & Raskin, 1970; Wurmser 1977, 1978). For example, in the clinic used in the present study, regular clinical supervision of staff was provided to minimize the chances that staff members would give inconsistent messages to clients. This uniformity meant that rules and expectations were clear, and specifically addressed the risk that patients could not become victims of a "dysfunctional clinic family".

Relevant to the idea that methadone treatment represents intolerable limitations on personal freedom, is the fact that participation in MMT is voluntary: a
person commences MMT at his or her request and treatment may be terminated or phased out at his or her request. Therefore, to suggest that the anger displayed by people in MMT is the same as the anger displayed by people in prisons, in response to limitations on personal freedom, is not an accurate comparison. Also, methadone is not the only form of treatment available for heroin addiction: if patients feel that the limitations to personal freedom inherent in MMT are unacceptable, they can choose another form of treatment. For many people, methadone is their treatment of choice because it entails fewer limitations to personal freedom than do other forms of treatment such as detoxification and residential rehabilitation. In fact, by offering addicts the freedom to continue to use opiates, methadone maintenance is far less restrictive in this regard, than all the abstinence-based treatments and self-help groups. Indeed, patients who angrily complain about methadone maintenance most often, frequently do not choose another form of treatment. Many stay in MMT and continue to be outraged, perhaps compelled by their particular psychodynamics or pathology to behave in this way. Perhaps being "forced" to pursue a treatment different from the one the person wanted, is also experienced as an unacceptable situation. It is as if these patients are saying "I want methadone and I must have it, even if it is not at all what I expected. I will not change my mind. I am not wrong."

A fourth related problem arising from the view that anger in methadone patients is a normal response to
limitations on personal freedom, involves the unrealistic nature of patients' expectations of methadone treatment (Davidson, 1977; Mandelberg, 1988; Summerhill, 1990; Wurmser, 1977, 1978). This is linked to the role of expectations and fantasies in the perception of methadone clinic rules and procedures. Patients often display idealized or denigratory attitudes to methadone treatment and staff; both attitudes represent extremes based on a distortion of reality. Methadone may be viewed alternately as a miracle or a demon: staff may be viewed alternately as saviours or persecutors. During assessments, when they are asked to outline their expectations about MMT, some patients will report expectations of an almost magical cure to their drug addiction and instant cessation of all personal problems. Attempts by staff to correct these "misconceptions" often fall on deaf ears. Many of these patients will go on to be outraged when MMT does not fulfil their expectations: methadone will be denigrated and/or the staff will be blamed for any treatment failure. It would seem, then, that when an idealized fantasy of methadone cannot be realized, the patient's disappointment in methadone leads to repeated anger and confusion. Often these patients are frustrated that the drug (methadone) they desire comes "with strings attached", unlike heroin, which can be accessed at will as long as the person has the money.

One case in the candidate's experience, illustrating this pattern of unrealistic expectations, is offered, not as proof of the phenomena being discussed, but to
illustrate that case material constitutes a rich source of potential information that is largely untapped, because research is often conducted in a vacuum, isolated from the clinical experiences on which theories are based. Mr A, unhappy and confused with the results he was achieving in methadone treatment, came to believe that his failure was due to the way the staff were conducting his treatment. He knew that he was "right for methadone", and methadone was "right for him": the staff and the programme were getting in his way. His solution was to request a completely self-administered programme. He firmly believed that the only way he would benefit from MMT was if, on a daily basis, he was allowed to decide on his dose, the time he received the dose, and even whether he should have methadone on any given day (as opposed to having heroin or alcohol that day). He also felt that on some days he should have a split dose: half in the morning and half in the evening, if he anticipated he would have a stressful evening or was having an easy morning. He asserted that the dispensary should be open 24 hours a day so that he did not have the stress of getting to the clinic within restricted opening hours. The content of this patient's requests and fantasies indicate an expectation of total control: the absence of any kind of limitation. He believed that he should have freedom to come and go as he pleased because anything less than this created unfair stress for him. He explained that a methadone programme run to his specifications would be a closer approximation of a
normal lifestyle! This patient always blamed the failure of MMT in his case on the fact that staff refused to run the programme according to his specifications. This belief allowed the patient to pursue his drug and alcohol abuse without ever having to question his own role in that failure, including the role of his expectations and fantasies regarding programme rules. It has been mentioned that many patients refuse to accept another form of treatment, even in the face of convincing failure of MMT; in this way, the intense anger seen in methadone patients cannot be accounted for solely on the basis of a normal reaction to oppressive rules and regulations. The case cited here illustrates that an important source of anger is often the frustration and confusion that is experienced when unrealistic expectations concerning autonomy and control, and when idealized expectations of methadone treatment, and are not confirmed. The rapid swing from idealization to denigration in these situations is further indication that the individual is somehow unable to respond to reality in a constructive or integrated way.

A second way of viewing the anger observed in methadone patients is to consider it as a normal response to discrimination. Heroin addicts are seen as a group who suffer constant discrimination and humiliation. There are a number of problems also with this explanation. Firstly, heroin addicts are not born into a specific socio-economic, religious or ethnic group; addiction problems span the socio-cultural spectrum. For
example, the majority of patients participating in the methadone programme used in this study, came from the North Shore of Sydney, an affluent area in a major capital city of Australia, not an area associated with deprivation, discrimination or poverty. Secondly, other drug treatment populations such as schizophrenics, for example, may suffer social discrimination and the limitations imposed by medication, but dispensers of largactil do not report the same difficulties as dispensers of methadone, as noted by Davidson (1977).

"The behaviour of methadone patients... is remarkable in several respects, when compared with the behaviour of other groups of psychiatric patients whose treatment utilizes the outpatient format" (Davidson, 1977, p.121). She describes extreme affective states which appear to be inappropriate to the reality of the situation: "...usually characterised by extreme rage,... expression of strong hostility, anger and blamefulness" (p. 121).

Given that the intense rage observed in some patients in MMT cannot be explained solely in terms of a normal reaction to the infringement of personal rights, or in terms of sociocultural background, it becomes necessary to take into account aspects of the patient's psychological functioning in formulating an explanation of the phenomenon. All psychological models of disproportionate anger, irrespective of their theoretical orientation, are based on internal processes within the person rather than situational factors. For example, even
behavioural theorists such as Beck (1976) emphasise the role of the individual's cognitions, their beliefs and expectations about a situation, rather than the situation itself, in the genesis of maladaptive anger. They have identified certain cognitive styles that predispose an individual to respond in extreme, maladaptive ways to certain kinds of situations. While cognitive theory is based on an understanding of conscious mental processes which are accessible to the individual through self-monitoring, psychodynamic theorists conceptualize disproportionate rage as also arising from unconscious conflict and unconscious processes such as defence mechanisms (Khantzian & Schneider, 1986). In a psychodynamic formulation of addiction, Khantzian (1974) acknowledges that sociological factors are present, given the increase during the past decade in the use of narcotics and the greater incidence of drug use among black people from certain socioeconomic backgrounds. However, he suggests that factors such as war, violence, social upheaval and lifelong oppression are relevant because all these conditions lead to impairments in the psychological functioning of the person, particularly in regard to the development of the ego (or psychological self) and related difficulties in the management of rage. He concludes that "wherever and in whomever there is oppression, developmental impairment, psychic turmoil, rage and depression, there is a correspondingly ready market for narcotic drugs...because they all share in
common, problems with aggression...” (Khantzian, 1974, p.69).

Psychodynamic theory explains enduring, pervasive patterns of pathological responses as involving distortions in one's perception of reality, effected by, not just conscious thoughts and beliefs, but by unconscious defence mechanisms. Defence mechanisms are defined in the DSM IV as "automatic psychological processes that protect the individual against anxiety and from awareness of internal or external stressors or dangers. Defence mechanisms mediate the individual's reaction to emotional conflicts and to external stressors" (American Psychiatric Association, 1994, p.765). Healthy psychological functioning involves higher level, or more mature defence mechanisms such as humour, anticipation, affiliation and sublimation, which rely on redirecting or adaptively dealing with emotional pain, rather than distorting reality in order to avoid emotional pain (American Psychiatric Association, 1994). Psychodynamic theory provides an account of the development, operation and interaction of defence mechanisms and other unconscious processes and core personality structures. In the next section, the psychodynamic concepts of transference and countertransference are applied to explain some of the dynamics observed between patients and staff in the methadone unit, as described previously.
3.4 Psychodynamic Approach To Pathological Anger in Methadone Patients: Transference and Countertransference Issues

The psychodynamic concepts of transference and countertransference can be used to explain the possible dynamics at play between methadone patients and staff when patients display anger that is so extreme or disproportionate that it is considered to be pathological. Broadly speaking, the term transference refers to the emotional reactions of the patient towards the staff, and the term countertransference refers to those of the staff towards the patient, both fostered by unconscious anxieties and wishes.

Transference, derived from Freud's work and elaborated upon by subsequent authors, is seen as:
the experience of feelings, drives, attitudes, fantasies and defences toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant persons of early childhood... For a reaction to be considered transference, it must have two characteristics - it must be a repetition of the past, and it must be inappropriate to the present (Curet et al. 1985, p.436).

The term transference will be used here when "the patient's behaviour at a given moment in treatment is determined more by his very early experiences with significant others than by the reality stimulus of the
The psychodynamic concepts of transference and countertransference can be used to explain the possible dynamics at play between methadone patients and staff when patients display anger that is so extreme or disproportionate that it is considered to be pathological. Broadly speaking, the term transference refers to the emotional reactions of the patient towards the staff, and the term countertransference refers to those of the staff towards the patient, both fostered by unconscious anxieties and wishes.

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The term transference will be used here when "the patient's behaviour at a given moment in treatment is determined more by his very early experiences with significant others than by the reality stimulus of the
transference refers to "the totality of the therapist's response to the patient. It includes reality factors such as the setting and the working alliance with the patient, plus the internal response of the therapist to the patient" (Davidson 1977, p. 121).

Schwartzman, Bokos, and Lipscombe (1982) studied a methadone clinic within the context of family dynamics and concluded that:

the study...reveals a number of pervasive conflicts and covert coalitions. In the clinic, clients and paraprofessionals combine to undercut professionals and limit the effects of any meaningful treatment. Nontherapeutic alliances, first experienced in the family of the addict, are replicated not only in the clinic but in the treatment system as a whole. The effects of these pathogenic relationships... are to inhibit the maturation of the addict (p. 271).

They argued that the family structure re-enacted in the methadone unit replicated long-standing conflict between the parents one of whom is extremely overprotective and intrusive with the child, while the other is distant and hostile towards the child. This results in a chronic situation where the addict is unable to take responsibility for their behaviour and the parents are ineffectual in constraining them. The parents set "pseudolimits" - limits that are not enforced or are undermined by one or both parents. The addict's inability to control himself is inadvertently rewarded. In the
methadone clinic studied by Schwartzman and his colleagues, key staff unwittingly assumed the roles of the over-involved and peripheral parent, resulting in the setting of pseudolimits. No treatment plan was ever really feasible. While the authors conceptualized their data from a structural systems theory perspective, their descriptions illustrate transference and countertransference phenomena, where the patient's behaviour is determined by unresolved conflicts from the past, and has the potential to arouse particular reactions from staff which, if acted out, may mirror the pathological responses of the addict's parents (actual or internally represented).

Interactional patterns between adolescents or young adults and their parents, in the present or recent past, are readily reported or observed, and the parallels between familial and methadone clinic dynamics are often obvious. However, interactional dynamics in the methadone clinic that are a repetition of the past when the addict was an infant or an enactment of the addict's internal world of object relationships are not so obvious and will be more insidious in that, arising from very early times, they will involve behaviours and defences that originated in a more primitive stage of psychological development. The behaviour of the addicts in Schwartzman's account might be seen as a reflection of present family dynamics, just as infantile, angry, demanding behaviour in the addict can be viewed as a revival of intrapsychic and interpersonal dynamics from the past. The methadone
clinic, with its controlling and supervisory role, has parallels with the infant's experience of controlling, supervisory parents constantly watching over the infant, as described by Freud and subsequent authors (Curet et al. 1985). In the case of the normal infant, this overseeing function will later be taken on by the child's superego or conscience. Freud (1914) suggested that in schizophrenia, there is a revival of the experience of constantly being watched and told what to do, now experienced as paranoid delusions and auditory hallucinations. Later theorists, such as Rosenfeld (1987) and Bion (1988), have elaborated on the nature of these psychotic processes. According to Kohut (1971, 1977), in some psychologically disturbed patients, early experiences are revived, not in the form of psychotic experiences, but as unbearable blows to the image of self. The controls and rules of the methadone clinic can precipitate a psychic crisis in vulnerable individuals, shattering their fantasies of omnipotence. The staff, in their efforts to monitor, help, motivate and treat the patient are experienced not as care-givers but as harsh, authoritarian parental figures: a revival of the addict's infantile anger towards their parents at a time when they thought themselves to be omnipotent (Curet, 1985). Thus, the individual's pathology, in combination with the environment of the methadone clinic, provides fertile ground for psychic injury and the associated rage against the perceived offenders to be expressed.
In his description of observable patterns of behaviour in patients' transactions with methadone clinic staff and the clinic itself, Davidson (1977) suggests that "whenever there are rapid shifts...strong affective states...powerful projection of hostile, aggressive impulses...it is safe to say that transference phenomena are present" (p. 120).

Davidson cites examples to illustrate the way patients may deny any form of dependence. Dependence represents a special problem for those with psychological disturbance dating back to early times because dependence revives unresolved conflict over power and autonomy from early childhood and adolescence. One would predict from this view that the transference of methadone patients with this kind of unresolved conflict would have certain characteristics. Patients employ many behavioural and psychological strategies to deny their dependence on heroin, methadone, the clinic staff and the clinic itself. Deception in all its forms can allow the patient to keep their dependence on drugs a secret from the staff. Primitive defence mechanisms, such as denial, splitting and projection, as well as more mature defences such as rationalisation ("I only need methadone for my body. I am not psychologically addicted"), can allow the patient to keep their dependence on drugs a secret from themselves. The patient's need for the staff can also be defended against through idealization ("I need not have any anxiety over my dependence on the staff because they will perfectly fulfil all my needs"), or when this
expectation is not lived up to, through denigration ("I don't need these stupid, useless people"). Omnipotence and grandiosity, in the form of disregarding behaviour (being late, being demanding, being contemptuous) also ward off feelings of neediness towards the staff. Patients may refuse to see the doctor for a renewal of their prescription, complaining that such appointments are a waste of time, thus denying dependence on the doctor.

Based on these defences, patients can develop rigid fantasies about their independence and superiority. For example, some patients who respond well to MMT believe that they have gained total control over their heroin addiction, completely denying that methadone is the agent. They will often leave treatment prematurely and be devastated when they "suddenly" find that they are still dependent on opiates. While some patients achieve enough stability and control in their lives to warrant the convenience and greater freedom of receiving their methadone from a local chemist, close monitoring of other patients via their daily attendance at the clinic will continue to be essential. Sometimes this will be experienced as victimization, or blatant sadism, when their lack of control and progress has to be denied. Clinical evidence from Wurmser (1978) and Davidson (1977) supports the view that denial of whole segments of reality represents desperate attempts to avoid the psychic pain of dependence.
Curet et al (1985) explored the impact that enforcement of regulations and limit-setting activities have on the development of transference in the methadone treatment relationship. Their recommendations include employing clinical supervisors specifically for helping staff to deal with transference and countertransference issues. This is firstly in recognition that patients in MMT bring with them their distorted ways of dealing with people; and second, there is recognition that transference and countertransference issues will be exacerbated in the clinic setting due to the intrinsic nature of methadone treatment. Many patients will find MMT demeaning with all its rules and regulations. Staff may initially be perceived as being just like uncaring, authoritarian and judgemental parents. If these perceptions persist in the face of real evidence to the contrary, and if they result in extreme behaviour which is inappropriate to the present situation, then transference phenomena are likely to be involved. An example from the candidate's experience was as follows. A patient stabbed another with a knife when the second man accused the first of pushing in front of him in the queue at the methadone dispensary. As he produced the knife, the patient said "no-one shames me". While being confronted about pushing into a queue might be a humiliating experience for anyone, strong forces must be at play inside the person to drive him to murder, and one might hypothesize that these forces could be related to transference phenomena, possibly involving the infant's
experience of being humiliated by his mother, for example. It was not surprising to find out that the attacker had just been released from prison for a similar crime, the repetitive nature of the behaviour also suggesting transference phenomena.

Curet et al. (1985) describe MMT as involving a system of accountability that fosters infantile and regressive behaviour. Curet and colleagues discuss the case of Mr F to demonstrate how the patient's unrealistic wish for exclusive possession of the therapist represented a revival of his infantile wish for exclusive possession of his mother. Mr F's angry accusation that his therapist never supported him (arising out of the therapist's genuine inability to "magically protect" Mr F from the programme rules) was a revival of feelings of abandonment and rage when Mr F's mother failed to protect him from the wrath of his strict, authoritarian father. Another striking example of a possible re-enactment of family dynamics is the case of Miss K seen in therapy by the candidate. From the moment Miss K commenced MMT, she believed that all the staff were victimizing her even when staff actions were based on very clear grounds and involved very caring behaviour. For example, when a dispenser would make an effort to chat with Miss K's child, to make both mother and daughter feel welcome, Miss K would experience this as an accusation of being an inadequate mother. Miss K would constantly appeal to the author to intervene and have staff reprimanded or even sacked for their misconduct. The situation was such that
Miss K would weep with rage and hurl abuse at the candidate, when, in her eyes, I challenged her belief that she was being mistreated. Eventually, she viewed the candidate as having totally betrayed her trust and demanded to be allocated another therapist. Miss K reports being the only daughter in a family where males were valued and females were not, even to the extent that only the males (her father and brother) could eat meat because meat was expensive. Miss K left home in her teens when her brother raped her and her mother refused to believe her or support her in any way, despite Miss K having sustained obvious injuries during the assault. One can only guess at the injustices that were suffered by Miss K from early childhood, if by her teens such abuse went unnoticed and unchallenged. Her outraged demands for justice in the methadone clinic may be understood as a defence against overwhelming feelings of helplessness and worthlessness or as a legitimate bid for potency (Alvarez, 1992). Again, this case is presented, not as proof but illustrative of the phenomena being discussed. Such examples might be identified and perhaps researched further in a different kind of study.

Dodes (1990) provides vignettes of psychotherapy with addicts to illustrate how the patient's feelings towards the therapist can precipitate a relapse. In the case of Mr S, a renewed craving for cigarettes occurred when he started to acknowledge that he felt dependent on the therapist, and felt that this was like a feeling of surrendering. Dodes interpreted the patient's request to
change his appointment time, as an effort to take control in the analysis. In the case of Mr C, the patient's secret devaluing fantasies about his therapists were mirrored by his secret drinking. Both activities represented a rebellious, undetectable depowering of the therapist. Mr G relapsed to alcohol and cocaine use after five months of abstinence since the beginning of therapy, when the therapist had to reschedule two weeks of appointments shortly before an upcoming vacation. Mr G admitted to feeling deprived and angry about these things which were out of his control.

Khantzian (1977) noted that many stabilized addicts in methadone treatment go to great lengths to be co-operative and undemanding, often resulting in passivity, indifference, disavowel and self-sufficiency. Khantzian identified parallels in their personal lives, revealed during sessions when complaints of boredom and dissatisfaction were related to rigid self-denial. This "deadness" was episodically juxtaposed against explosive outbursts of rage when they were thwarted or disappointed in some important way. Similarly, in therapy, these patients displayed aggressive behaviour at times, becoming very demanding and self-righteous in their belief that their demands ought to be met. Khantzian suggests that this oscillation between passivity and aggression represents the alternating success and failure of defences employed against dependency and disappointment. Patients who display sudden intense shifts in attitude may be more stressful for staff to
deal with than those who are known to be consistently aggressive.

The demanding, angry behaviour of patients, as influenced by transference phenomena, will lead to predictable countertransference reactions in the staff. Dodes (1990) suggests that "the most common countertransference responses to addictive behaviour are helplessness, frustration, and rage (or the manifestation of these feelings through defensive manoeuvres designed to avoid them, such as rescue fantasies and withdrawal)" (p. 415). He suggests that such intense countertransference reactions are further evidence of the irrational, unrelenting nature of the aggression directed towards staff. Through the defence of splitting, some staff are experienced by the patient as being all-good while others are hated and persecuted for being all-bad. In particular, staff responsible for enforcing rules will be treated with contempt, creating intense feelings of guilt and confusion in staff who are actually caring and sympathetic.

The interaction between transference and countertransference processes in methadone clinics can become extremely complex. In his paper describing the psychodynamics of the methadone unit-addict relationship, Summerhill (1990) notes that tasks involved in the day to day running of the unit and monitoring of the patients' covert drug use leave the staff with little time to focus on the more meaningful dynamics of the patient, the patient-staff relationship, and the patient-unit
relationship. Summerhill suggests that patients tend to be deeply ambivalent about the opportunity to end their relationship with illicit drugs. It then often becomes inevitable that the methadone unit, in offering free access to a legal drug, will bring powerful defences to the fore, the controlling elements of the programme exacerbating the tendency towards passive aggression and denial. Lying and evasion become the norm and the staff collude with this "reality" because they are fully aware that their enquiries and monitoring rarely yield the truth. The patient-staff relationship can become a repetition of the relationship the patient had with their family, based on a collusion of accepting that more is going on than is being talked about. There is a further implicit collusion that addiction is accepted as a way of life. While addiction to illicit drugs ceases (or in many cases, is merely reduced), lifetime addiction to methadone and to the methadone unit is provided. The drudgery of physical dependency on illicit drugs is replaced by an open-ended, relatively "easy" dependence in which unresolved conflicts around the issue of autonomy/dependency are legitimized. "What should be a battle for real change in the outside world is displaced into the 'battle' with the drug dependence unit" (Summerhill 1990, p.586). Offering methadone treatment may be tantamount to colluding with the patient's denial of the true nature of their drug addiction, that is, denial of the core role of overt psychological disorders and covert pathological dynamics. In this way, methadone
treatment may be facilitating somatization as a defence against emotional distress. What should be addressed in terms of individual psychodynamics, transference relationships and defence mechanisms, is validated and becomes the content of case-management negotiations instead of material for analysis and psychotherapy. Transference material is unwittingly taken out of the transference relationship so that 'acting in', which can be constructively worked through in therapy, becomes destructive 'acting out'. (Here 'acting in' refers to the situation where the individual's dynamics compel them to behave in a destructive or defensive way within the therapy session, where the unconscious motivation for this behaviour can be interpreted, giving the patient an opportunity to understand why they are behaving in this way). When unconscious conflict is acted on outside the therapy session ('acting out'), there is no opportunity for the dynamics behind the behaviour to be thought about; the reaction of the other person will be legitimizing rather than therapeutic. Summerhill (1990) concludes by suggesting that the pressure of meeting public health agendas, largely aimed at reducing crime and preventing the spread of AIDS, further compounds the de-emphasis on treating psychological disturbance. Summerhill's account can be seen as an illustration of both the transference and countertransference issues in the methadone clinic: the behaviour of the patient towards the staff and the reaction of the staff to that behaviour. The psychopathology of the patient evokes
intense affects in the patient and in the staff (countertransference) as they struggle to deal with the patient's transference.

One study by Rutherford et al. (1996) provides confirmatory evidence of the clinical material discussed. The study measured the degree of impairment in object relations in 240 methadone patients, using the Bell Object Relations Reality Testing Inventory. Generally they found that the methadone patients were more mistrusting of others, less empathic, and saw themselves as adept in conning, manipulating and exploiting others. The patients were also more prone to anger and hostile withdrawal than the normative sample.

In summary, when looking for an explanation for the extreme and disproportionate rage displayed by many methadone patients, sociological accounts which view the problem in terms of a natural reaction to restrictions on personal freedom or social stigma are limited and cannot account for the pathological quality of the rage. On the other hand, a psychodynamic perspective utilizes the concept of transference to understand the unconscious processes underlying such pathological behaviour. Given that these transference reactions arise from unresolved conflict from infancy, with its primitive level of psychic development, defences and object relationships, an understanding of the infant's psychic development and conflicts becomes an important aspect of understanding pathological anger in methadone patients.
4.1 Narcissistic Rage

Rather than looking for external causes to explain the intense anger seen in methadone patients, psychodynamic theories deal with the involvement of unconscious processes in pathological anger. The accounts of the kind of aggression typically observed in methadone patients previously described indicate a group of individuals who are disproportionately angry, unreasonably demanding and blaming, with unrealistic expectations and beliefs about themselves and the staff. This anger involves a distorted perception of reality and therefore, as with other psychological perspectives, is viewed by psychodynamic theorists as being a psychological rather than a sociological phenomenon. Also, in contrast to behavioural constructions based on the processes of learning and conditioning, psychodynamic formulations of pathological anger emphasise unconscious processes based on primitive defence mechanisms and associated personality structures.

A psychodynamic perspective of mental life attempts to examine the forces at work within an individual
related to drives, affects and those psychological structures that are responsible for regulating drives and affects. Such a perspective also attempts to take into account an appreciation of how developmental challenges have been handled and managed from the earliest phases of life (Khantzian & Sneider, 1986, p.323.)

The constellation of characteristics in the clinical descriptions cited earlier relates to the psychodynamic concept of narcissistic rage: the intense anger experienced and acted on by individuals with a narcissistic disturbance when they encounter a discrepancy between their distorted view of the world and reality (Dodes, 1990; Kernberg, 1970, 1974, 1975; Kohut, 1971, 1972, 1977; Kohut & Wolf, 1978; Wurmser, 1977, 1978). The concept of narcissistic rage has developed from psychoanalytic studies of pathological narcissism and associated character disorders and pathological behaviours. Narcissistic rage (NR) is most often experienced when the narcissistically vulnerable individual encounters a "no" or is thwarted in some significant way that, given their distorted expectations, comes as a painful shock. This situation embodies a narcissistic crisis: this has been construed as a conflict between reality and the individual's sense of self (Wurmser, 1977, 1978).

In contrast to "normal" or reactive anger, narcissistic rage is intense and disproportionate and is not viewed by others to be a reasonable response to the
situation. The person will have no empathy for the presumed "offender" and there will be no realistic appraisal of the situation. Because the individual's perception of reality is distorted, the rage and associated aggressive behaviour are considered to be pathological. The beliefs and expectations that constitute this distorted view of reality are also considered to be pathological. The origins of this specific type of pathology are discussed in detail later in the introduction.

In defining narcissistic rage (NR), Kohut (1972) emphasized several specific characteristics which highlight the difference between NR and normal reactive anger. Firstly, within the wide range of responses that we recognize as anger, everything from fleeting annoyance to murderous rage and paranoia, the term NR refers only to experiences at the extreme upper end of the spectrum. NR can also be distinguished from other forms of aggression by its unrelenting, compulsive nature and its boundless disregard for limitations. An individual's self-image will lay the foundation for expectations of how they will be treated by others, as well as predictions as to how effectively they will deal with the world. When these expectations and predictions are pathologically narcissistic, that is, based on a grandiose rather than a realistic view of self, they will not be validated by the outside world. Kohut describes the incomprehension with which normal boundaries and limitations are met, as a cry of "How can it be?" "How
can it happen?" The individual believes that their power and abilities should be limitless, and that no limitations or boundaries, be they physical or interpersonal, should be placed on them. Kohut describes this as the outrage of total shock that leads to overwhelming fear and pain. These experiences conflict with the person's core self-image and are, therefore, extremely threatening. He cites the example of the evil step-mother in Snow White who cannot rest until she can eliminate the evidence (the existence of Snow White) which has contradicted her conviction that she is the fairest in the land.

Kohut suggests that the aggression employed in such situations can be understood within the context of a natural response to any situation where a person feels threatened, either physically or emotionally. Kohut describes this kind of preoccupation with power and limitlessness as archaic, alluding to the idea that this perception of self is formed very early in life and corresponds to an infantile rather than adult self-image.

Kohut (1971) also compares NR to the fight component of the flight/fight reaction. The narcissistically vulnerable individual responds to actual or anticipated narcissistic injury with shamefaced withdrawal (flight) or with narcissistic rage (fight). Whether the injury leads to shame or rage, the experience is unbearably painful. Wurmser (1974, 1977, 1978, 1985a, 1985b) suggests that narcissistically vulnerable individuals use mood-altering drugs to gain relief from this psychic pain.
and to restore the feeling of omnipotence. Wurmser's theory forms the basis of the present study and will be discussed in detail later in the thesis.

The second way in which Kohut differentiates NR from other types of "normal adult" aggression is that the opponent we face in mature aggression is experienced as being separate from ourselves, whereas the source of rage in NR is perceived as a flaw in one's own reality. Thus, in Kohut's view, a crisis is experienced, not simply, for example, because the person is being thwarted by another person or a situation, but because this limitation to power and control is incomprehensible. In this way, for a brief instant, the individual is forced to question their own reality, their own image of themselves. This moment of self-doubt will be too unbearable: rage and indignation at being made to feel that one is wrong will take over. Vengeance and aggression will be used to restore one's sense of being right. In Kohut's view of NR, the offender is experienced as a recalcitrant part of the self, whose mere "other-ness" is an offence because it is not the grandiose "true" self. In this way, the crisis is experienced as coming from within the self, presenting an internal and therefore more frightening threat. For narcissistically vulnerable individuals, the demarcation between self and others is blurred, allowing fusion with others. They must defend against any form of empathizing, as this might involve experiencing weakness in the fused other, and therefore weakness in the self.
In Kohut's view of NR, insight remains at an infantile level, just like children who get angry and throw a tantrum with anything that crosses them or causes discomfort. The rage is not logical, and there is no capacity to view the situation utilizing mature concepts such as fairness or consideration for others. NR is viewed by psychodynamic theorists in general as an infantile phenomenon manifested as the extreme, unfounded and disproportionate expression of rage, aggression or hostility, and the experience of extreme psychic pain when any limits are placed on the person (Wurmser 1977, 1978). In a clinical setting this regression to or re-experiencing of earlier experiences is regarded as a 
transference reaction. As described in the previous chapter, this term refers to phenomena belonging to earlier stages of development or experience where unresolved conflict is then superimposed or transferred onto present situations. For example, the behaviour of a methadone patient angrily protesting at having to wait in a queue to be dosed may more closely resemble the angry protests of a baby waiting to be fed by a withholding mother, than a mature response to the frustration of having to wait to be served by an essentially benevolent carer. Another example is the situation that arises when a nurse has to refuse to provide a dose to a methadone patient one day because the patient arrives at the clinic intoxicated and therefore may be at risk of overdose if he/she receives their methadone. The patient's anger, verbal abuse, storming out and refusing subsequently to
talk to the nurse, may again be more reminiscent of an infant having a tantrum when her mother stops her from doing something that is potentially dangerous, than an adult response to being saved from harm. Transference in this context refers to the re-experiencing of the original conflict over power between mother and infant that arises when gratification of the infant's needs or desires is frustrated, delayed or deprived. Later in this introduction when theories of the development of narcissistic disturbances in personality are discussed, this important aspect of the infant's history, and therefore psychological development, is explored in detail.

Kohut (1971) compares NR to two related familiar phenomena. In "catastrophic reaction", a brain damaged person has frenzied anger when confronted with their sudden incapacity. There will be rage over not being able to do a simple task or at not having control over one's thoughts. It is the incomprehension of sudden loss of control over one's basic abilities. Kohut points out that to lose a limb is easier to accept because it is an external part of the self. To lose internal capacities is experienced as 'a loss of self'. Dodes (1990) emphasizes the importance of rage and aggression in feeling powerful, potent and in control. Krystal (1978) suggests that affective storms are a means of defending against the experience of psychic helplessness; Dodes that "...the affective flood of the ego (psychic trauma), which is implied by the notion of intolerable affect, is
a blow to the core of one's sense of mastery of oneself" (1990, p.410).

Kohut's (1971) second parallel to NR involves a child's reaction to a stubbed toe. The child's inconsolable crying is not due merely to the physical pain but more to its wounded narcissism. Normal grandiosity in children makes them feel invincible and unstoppable. To be free and playing one minute and injured the next is utterly unexpected. This is more frightening than the actual pain. Of course in normal development, through such experiences, children can develop a more realistic appraisal of their capacities and life's dangers. In adolescence, there is a phase-appropriate belief in one's invincibility, which may be similar to that of early childhood, which can lead to risk-taking behaviour. Conflict will again arise, just as it did in infancy, when parents and teenagers battle over issues of parental authority and adolescent desire for autonomy and freedom. According to psychoanalytic theory, if the original parallel conflict in infancy was unresolved, the potential for healthy resolution during the next phase will be limited (Kohut, 1971). In the pathologically narcissistic adult, this childhood grandiosity remains unmodified and the person, believing in their own invincibility, may engage in potentially dangerous activities such as drug abuse and drunk driving.

The extreme self-centredness of individuals with NR is not consistent with society's expectations for adult
behaviour and, therefore, is not tolerated by the outside world, adding insult to injury. Again, to experience this rejection as justified would be unbearable: therefore, the world is perceived as persecutory and unfair. The need for revenge becomes compulsive. People who place reasonable demands on the pathologically narcissistic individual will be hated, blamed and punished by that individual (Kohut 1971). Kohut (1972) has identified an associated phenomenon throughout history in terms of the way war has been perpetuated as nations seek revenge for humiliation and defeat suffered after grandiose attempts at conquering other nations have failed. For example, it may be argued that it was the need to erase the humiliation of their defeat in World War I that was one important factor responsible for Germany, under Hitler, launching into World War II, confident in the belief that they were a superior race. The need for revenge, for righting a wrong, for undoing a hurt by whatever means, combined with an unrelenting compulsion in the pursuit of this aim, makes NR different from other forms of aggression.

Again, the study by Rutherford et al (1996) lends empirical support to the theoretical material discussed. In studying impairment in object relations in 240 methadone patients, they found that patients were prone to experiencing feelings of helplessness and used grandiosity and egocentricity to defend themselves against these feelings.
4.2 The Concept Of Narcissism

Having identified the role of NR in the intense anger and aggressive behaviour displayed by many methadone patients, the concept of narcissism and narcissistic character pathology will now be discussed in detail. However, before proceeding onto an account of what pathological narcissism is and how it results in the behaviours associated with NR, the use of the term 'narcissism' will be clarified, given that the concept is complex and polymorphous. Jacoby (1990) points out that narcissism can be conceptualized in three ways: as a developmental stage; as a pathological mode of object-relation; and as a synonym for self-esteem.

The first way of conceptualizing narcissism as a developmental stage involves the notion of primary narcissism. Freud's seminal essay on narcissism in 1914 was the first work to consider the central role of narcissism in normal development and in the development of psychopathology. Freud's 1914 essay is divided into three parts. In Part I, Freud used the term narcissism to denote self love, as opposed to egoism, meaning self-preservation. Freud proposed that a narcissistic phase might be part of normal human development. He used the term autoerotism to describe the first stage he proposed in instinctual development, before differentiation between self and object has occurred. During this stage, the infant's instinctual choice of object is his own body or bodily self. Freud termed this primary narcissism. When adults show a similarly inadequate differentiation
between self and others, it may be assumed that this narcissism later in life is linked to the earlier primary phase narcissism. This kind of narcissism in adults is regarded as being pathological in that it is characteristic of early and therefore primitive psychic development, preventing the development of mature relationships. This refers to the developmental stage when, according to Freud, the infantile ego is sufficient to itself. In this stage, there are no firm boundaries perceived between "I" and "Thou": self-representations (mental images of the self) and object-representations (mental images of significant others) are merged and experienced as one. In this post-uterine phase of primary narcissism, the infant cannot emotionally distinguish its mother from itself. Jacoby (1990) describes this phase in the infant's psychic development as "unitary reality", "dual union" and "symbiosis".

A second way of conceptualizing narcissism is as a mode of object-relation. Freud (1914) in his discussion of love distinguished between two types of object choice. In the "narcissistic type", object choice will be based on what the individual himself is, what he himself was, what he himself would like to be, and someone who was once part of himself. In the "anaclctic type", object choice is based on the woman who feeds him, the man who protects him and the succession of substitutes who take their place. The latter type of object choice reflects a later maturational phase in which the mother is experienced as a separate object, and the need for
attachment becomes conscious. The object relations school represents a further development of Freud's formulation but with some significant departures (Klein, 1952a, 1952b, 1955; Segal, 1975). The emphasis on drives is generally replaced with the concept of self-representations or mental representations of the self. These representations become objects of the drives. From an object relations perspective, narcissism broadly refers to a number of conceptualizations that are based on narcissistic object relations, that is, relations (real and phantasized) that are primarily invested in the self and internal representations of the self rather than with other people. Narcissistically distorted internal objects (phantasy representations) become the focus of relationships rather than external social reality. The discrepancy between the internal world of objects and the external object world is not utilized as a basis for the development of more mature ways of relating.

In his book Impasse and Interpretation, Rosenfeld (1987) details his concept of narcissistic omnipotent object relations to describe relationships which serve purely narcissistic purposes for the individual. These relations are characterized by a need for exploitive fusion with others, in order to project into the other unwanted aspects of the self and to introject into the self desirable aspects of the other. According to this view, painful envy of the object is the basis for narcissistic object relationships.
Kernberg (1970) also develops the concept of narcissism based on relationships which are purely exploitive: "as if he were squeezing a lemon and then dropping the remains, people may appear to him either to have some potential food inside,.... or to be already emptied and therefore valueless" (1970, p. 57). Attitudes toward others are either deprecatory ("I have extracted all I need and can now toss them aside") or fearful ("others may attack, exploit and force me to submit"). Behind this grandiosity is anger at a frustrating and fearful world. According to Kernberg, in pathologically narcissistic individuals, the vicious cycle of self admiration, deprecation of others and elimination of all actual dependency characterizes all attempts at relationships.

The following example from the candidate's experience working with a narcissistic patient in methadone maintenance treatment, illustrates the exploitive nature of the patient's relationship with the therapist. In this instance, the candidate performed the dual role of case manager responsible for overseeing the administrative details of the patient's methadone programme, and counsellor, providing support. Mr F idealized the counsellor and was openly contemptuous of all other staff at the unit, referring to them by indecent, degenerate "nicknames". Mr F would often speak of how grateful he was to have found such a counsellor, how his life had been saved and how he had never before experienced such kindness. All staff at the unit remarked
on how intensely attached Mr F was to the candidate. After some years, the candidate left the methadone unit to work in another part of the service. All patients were informed that, while they would be provided with a new case manager who would attend to their requests in terms of their methadone programme, the candidate would still be available for supportive counselling, if they so wished. From that moment on, Mr F did not make any contact with the candidate; no longer useful to him for practical necessities, the counsellor was dropped. About two years later, Mr F requested an appointment. He arrived dressed in a suit and tie, brandishing a bunch of flowers. He said he came to apologise for not contacting me and to thank me again for saving his life when no-one else cared. The next day, Mr F called, saying that he was not happy with the way the methadone staff were treating him, and asked me to use my influence (as he assumed I had been promoted) to resolve the situation in his favour! The lemon, squeezed and discarded, was rediscovered and thought to have some juice left.

Kernberg (1985) points out that while these individuals appear to be extremely dependent on others, to the point of being parasitic, relationships are purely exploitive and there is no capacity for actual trust or intimacy, and no guilt or genuine regard is experienced towards the other person. Even when others are idealized, it is because they gratify the individual's narcissistic needs, not because they are admired; those who are admired but cannot be exploited will arouse overwhelming
feelings of envy. Pathologically narcissistic people identify themselves with those whom they idealize so that normal dependency on others is replaced with dependence on an ideal reflection of the self. Fear of rejection is denied because the idealized person is experienced as a perfect part of the self. In the absence of true dependency on others, narcissistic personalities do not experience sadness or depression in the face of loss. When abandoned, rejected or disappointed by others there are only feelings of revenge and resentment. Again, their reaction may appear to be one of grief but it is deprecation for the other, not longing.

The normal tension between actual self and ideal self and ideal object is eliminated by an inflated self concept in which the actual and ideal self are confused. Remnants of unacceptable self images are repressed and projected onto external objects which are devalued (Kernberg, 1985, p. 232).

A third way of conceptualizing narcissism is as a synonym for self-esteem. A healthy self-regard may be viewed as a healthy type of narcissism. Appropriate self-esteem enables individuals to develop healthy relationships in which others are also held in high regard, as opposed to low self-esteem which makes individuals self-absorbed. As opposed to healthy self-esteem, some individuals may appear very self-assured, but this may be grounded in an artificial inflation of self-esteem, rather than a true self-regard. Freud (1914) used the term secondary narcissism to describe the phase
where the infant, now able to experience its mother as being separate from itself, may inflate its self-esteem as a defence against the experience of being helplessly at the mercy of a frustrating or aversive parent. Because the mother is experienced as being separate from self, the infant can no longer entertain fantasies of omnipotent control over her (and therefore all objects). Secondary narcissism restores the feeling of omnipotence, defending the infant from the pain of helplessness.

Jacoby (1990) points out that the term narcissism is used in psychoanalysis to designate self-esteem, regardless of whether it reflects a healthy self-image or a defence against feelings of inferiority. He cites Pulver's (1970) distinction between healthy and pathological narcissism: healthy narcissism is based on pleasurable self-affect linkages, and unhealthy narcissism is based on an apparent high regard for oneself utilized as a defence against unpleasurable linkages. Pulver describes the accompanying "narcissistic vulnerability": a tendency to be highly sensitive, and to react with intense distress when reality breaks through the defensive "grandiose self", as described by Kohut, or "pathological narcissism", as described by Kernberg.

In the present study, the term narcissism will be used to denote pathological narcissism, that is, narcissism that represents a disturbance in the maturation of the self, rather than healthy self-esteem.

While various authors differ in their accounts of the specific processes underlying the development of
pathological narcissism in the adult, all theorists agree that narcissistic disturbance represents a very early phase of the psychic development of the infant. For some individuals, the infant's belief in a limitless, omnipotent self, and in limitless, all-giving parents does not evolve during childhood into a more realistic appreciation of life. Deep conflicts about self-esteem and power that are not resolved during infant development will be typically mobilised during the maturational crisis of adolescence, which is said to revive infantile feelings of being abandoned, betrayed and disappointed (Wurmser, 1978). Intense disappointment in self and others will be experienced when reality falls far short of exaggerated, idealized hopes and expectations of self and others. All theorists agree that the experience will be overwhelming only if the original conflict was unresolved, that is, if the person has a narcissistic disturbance (regardless of how the development of this disturbance is conceptualized). "Normal" adolescent conflict will be painful but it will be survived and resolved. However, for those with a narcissistic disturbance, infantile omnipotence is seen as being retained as a quasi-delusional way of life. There is a preoccupation with power, exploitation, manipulation, deceit and denial of overt dependence: all devices by which the delusion can be supported. In this drive for omnipotence, there can be little or no real concern for others if it interferes with the central task. Behind the mask of grandiosity is a hungry lonely infant that the
self must never acknowledge or experience (Wurmser, 1977,1978). However, despite their efforts, these people will experience great pain when their idealized fantasies are not confirmed and they inevitably come up against the many limitations apparent in themselves, others and their environment.

The main way in which this narcissistic disturbance is manifested is firstly through unrealistic beliefs and expectations of self and others, and secondly, by the experience of intense rage or shame, and consequent aggression in response to the discrepancy between fantasy and reality: a "narcissistic crisis". (Wurmser, 1977,1978).

Wurmser's model, adapted from The Hidden Dimension (1978)
In narcissistic personalities, there is a disproportionate emotional investment in the self, beyond a healthy self-esteem or desire for self-preservation. It is a preoccupation with power and control that obviates normal social interaction and a concern and empathy for others. In normal self-esteem, there is a contentment with one’s self, not continual conflict over power and control. The ability to maintain sharing and caring relationships with others can both build self-esteem and be a product of self-esteem. However, in a narcissistic personality, the desire for omnipotence can preclude the development of meaningful relationships, and interactions with others become purely exploitive, pursued for gratification of the need for power rather than the need for love and attachment. Independence is valued over need for others (Kohut, 1971, 1977).

Narcissistic personality structures according to Kernberg (1970, 1974, 1975) are characterized by denial of the individual’s need for dependence and attachment, and therefore any inherent neediness and limitations. Instead, the individual’s perception of self is distorted so that they believe they are powerful, limitless and perfect, obviating the necessity to depend on others for practical or emotional needs.

Individuals with a core personality structure which leaves them vulnerable to narcissistic injury (a crisis of one’s sense of self), will be prone to experiencing intense rage during these crises and will be driven to
express the anger and to use aggression in order to force a change in the situation so that it comes to resemble their view of how things should be. Jacoby (1990) points out that, in the animal world, aggression is released when territory is to be defended, or self-preservation is threatened. Similarly, in narcissistically wounded humans, aggression is unleashed when there is a perceived need to defend the territory of one's psychic reality. Self-preservation means defending one's self image against hostile attack. The need to defend against anything that questions their grandiose self results in dependence on a constant supply of narcissistic gratification from the environment (Jacoby, 1990). Dependence on mood-altering drugs which enable the individual to believe that he/she can maintain omnipotent control over internal states, is often an associated feature. It then becomes necessary to deny any dependence on drugs, so that the myth of the powerful "magical" self can be protected. The normal human need for recognition and confirmation, serving to maintain a feeling of self-worth, becomes an all-encompassing search, reminiscent of the compulsiveness of drug-seeking behaviour in addicts.

Wurmser (1978) defines narcissism as a "pathological phenomenon: an archaic overvaluation of the self or of others, a host of grandiose expectations, and an abysmal sense of frustration and let-down if these hopes are shattered" (p.114). "Narcissistic conflict" refers to:

.. conflict about self-esteem, self-worth, and power.

There will be a wish for massive overvaluation of
the self and other, the inevitable disillusionment, consequent overwhelming affects and primitive defences against these affects. There is always conflict about limits, limitations and boundaries because these three sectors of reality usually "embody a NO" (Wurmser, 1978, p.246).

Wurmser stresses that "...the whole concept of boundaries and limits turns out to become crucial for the study of narcissism" (1978, p.248). Boundaries here refer to the demarcation between inner life and outer reality, outer world boundaries, self and one's inner world of mental representations (the object world). Within the ego there are issues involving ego boundaries, the unity of the self and intrapsychic boundaries between structures. In the interpersonal world there are boundaries in relationships to objects. In the intrapsychic world there are also boundaries between objects. Every area of social functioning involves boundaries such as those between private and public, professional and social, social and sexual. In pathological narcissism these demarcations are blurred, allowing magical merger and omnipotent control. Wurmser points out the connection between the geographical concept of territory and the psychological concept of boundary. Historically, aggression has always been used to expand or defend territory. Wurmser maintains that aggression establishes boundaries, therefore "the history of aggression is the history of boundaries of ourselves and the boundaries limiting and
He views:

the whole process of psychic life as an unending dialectic between the narcissistic drive to expand, to overwhelm or to merge on one level or another, with an object, and the (aggressive) drive to establish limits to defend them, to constrict them, or to enlarge them...(p.270).

These concepts of limits, limitations, boundaries and aggression form the basis of the scale developed in Study 1, described in Chapter 8.

The role of narcissism and narcissistic rage in the psychodynamics of addiction and compulsive drug use will be discussed in detail later in Chapter Six. First, the major theories concerning the genesis and development of narcissistic pathology will be outlined.
5.1 Freud's Theory Of Pathological Narcissism

Freud's seminal essay on narcissism in 1914 was the first work to explore the central role of narcissism in the development of psychopathology. Sandler, Person and Fonagy (1991), emphasizing the importance of Freud's conceptualization of narcissism, point out that in contemporary psychodynamic theory "the concept of narcissism is pivotal in revisions of theory, and the treatment of pathological narcissism central to technical innovations and to the evolving theory of technique..." (p ix). Freud's interest in schizophrenia led him to suggest that schizophrenic megalomania (overvaluation of the self) may have a precedent in normal infantile omnipotent thinking; primary infantile narcissism. Freud noted that in both psychosis and neurosis, there is a withdrawal of interest from people and things. In neurosis, this withdrawal from the external world, due to disappointment and frustration, leads to investment in phantasy objects, largely based on the object relationships of childhood (idealized parental figures). This is still what Freud terms object-cathexis. However, unlike neurotics who maintain erotic relationships with
external objects, even if only in phantasy, Freud proposed that schizophrenics withdraw interest from the external world and do not invest in fantasy objects. When "object libido" is redirected to the self, becoming "ego-libido", the resulting narcissism leads to schizophrenic megalomania. This is no longer object-cathexis but psychotic self-cathexis or secondary narcissism. In neurosis, there is investment in fantasized ideal objects, but in psychosis there is investment in an ideal mental self-representation that consists of the remnants of the primary narcissism. Thus, pathological narcissism was generally discussed by Freud in relation to the distribution of the libido in the ego and its pathological consequences. Freud viewed libido as a fixed quantity and therefore concluded that an increase in ego-libido must cause an equal decrease in object-libido: the object cathexis almost disappears and the ego (self) becomes more invested with libido. In this sense, Freud discusses narcissism in terms of libidinal investment in self rather than others. The resulting grandiosity, involving a belief in the magical power of words and of one's wishes and mental acts, is not a new creation but an augmented state (through the use of defences) of a pre-existing normal stage of child development.

In Part II of the essay, Freud explores the psychodynamics of love and emphasizes that it is adaptive to go beyond the limits of narcissism (self-love) and attach libido to objects (others). In normal development, primary narcissism, where the infant's instinctual choice
is his own body or bodily self, is succeeded by instinctual object choice. In his account of the relationship between narcissism, organic disease and hypochondria, he states "We must love in order not to fall ill, and we are bound to fall ill, if, in consequence of frustration, we are unable to love" (p. 88).

In Part III, Freud explored the fate of primary narcissism, the child's megalomania, in normal development. He proposed that primary narcissism is a stage in the instinctual development of the individual, between early autoerotism and subsequent object choice. In his view, part of the primary narcissism (ego-libido) is eventually redirected to the object (object-libido) and another part is repressed: that is, part of the primary narcissism develops into a more mature structure, while some remains in its infantile state:

Man is not willing to forego the narcissistic perfection of his childhood: and when, as he grows up, he is disturbed by the admonitions of others and by the awakening of his own critical judgement, so that he can no longer retain that perfection, he seeks to recover it in the new form of an ego ideal. What he projects before him as his ideal is the substitute for the lost narcissism of his childhood in which he was his own ideal (p. 94). The "ideal ego" is the remnant of self-love that was enjoyed in childhood by the actual ego. Defence mechanisms are employed to divert libido. Sublimation
diverts object libido towards some aim other than sexual satisfaction. Idealization aggrandizes the libidinal object (which can be self or other). Freud further proposed that the "conscience" is the psychic agency that attempts to guarantee narcissistic fulfilment through gratification of the ego-ideal. This psychic structure is derived from the infant's experience of the supervisory and critical activities of the parents. In this way, infantile megalomania is repressed when it comes into conflict with cultural standards. A person has instinctual wishes he wants to indulge but he measures this against his ego ideal and represses it. According to Freud, in normal development, the task of the conscience is to measure the self (ego) against the ideal, whereas in schizophrenics, this will be experienced as delusions of being watched and hallucinations of being told what to do.

Finally, Freud discussed the issue of self-regard and its close connection with narcissistic libido. Freud described self-regard as arising from three sources; residual primary narcissism, reciprocity of love, and fulfilment of the ideal. In this way, narcissism is viewed as a component of self esteem but not identical with it. Normal ego (self) development is viewed as a departure from the primary narcissism of infancy, leaving us with only the wish to recover that ideal state. According to this view, ego pathology in later life is based on what was normal in early life: pathological
narcissism in the adult looks like primary narcissism in
the infant.

In their discussion of subsequent authors' critiques
that all theorists since Freud agree with some of the
basic tenets of Freud's conceptualization of narcissism,
particularly with regard to the idea that what is
pathological in later life was normal in early life.
However, other ideas contained within Freud's formulation
have subsequently been reviewed or developed beyond their
original limitations.

5.2 Narcissism In Object Relations Theories

The object relations school represents a development
in psychoanalysis in Great Britain which proposed
significant departures from Freud's emphasis on instincts
and internal structures. Object relations theory focuses
on complex internal psychic constructs created in early
childhood development, which are influenced by the
child's biological endowment and the early social
environment. The emphasis on psychic development arising
from interactions with others, rather than from instincts
and drives as in Freudian theory, represents an expansion
of Freud's work that retained but de-emphasized Freud's
core concepts. There is a focus on inner objects and
inner object relationships, based on phantasy
representations of early vicissitudes of the instincts.
Internal objects have been defined as "unconscious
phantasies which people have about what they contain." (Segal, 1975, p.12). In object relations theories Freud's concept of unconscious phantasy is given more weight. In this way, phantasy is viewed as the mental expression of instincts, and "phantasy-forming" is a function of the ego. The nature of an individual's unconscious phantasies and the relationship between these internal phantasies and the real external world will largely determine the psychological make-up of that individual.

This complex phantasy life, involving conflicts between internal objects, is viewed as the key to the development of psychopathology. The infant's early interactions with others, particularly the mother, within the context of libidinal and aggressive drives, will lay the foundations for psychic development and, most importantly, relational development. The infant is always involved in intense loving or aggressive relationships. Conflicts involving internalized objects become more important in object relations theory than Freud's instinctually programmed stages of sexual development. Understanding development and psychopathology rests on an understanding of the objects and the conflicts between them in the infant's early object world and the anxieties and defences mobilized by these inner conflicts.
Melanie Klein's important contribution to the understanding of psychic development was to combine Freud's instinct theory with the theory of internal object relations. Klein disagreed with Freud's suggestion that there is a stage of autoerotism and narcissism preceding object relations. She maintained that there is no mental state that is objectless or conflict-free (Klein, 1952a). According to Klein, from birth the ego is driven by instincts and anxiety to form primitive relationships, not only with real objects but also with phantasy ones. Klein (1952a, 1955) emphasized the importance of dynamic unconscious phantasy in the child's mental life and the reformulation of the concept of unconscious phantasy. According to this view, phantasies that the ego has about itself and the objects it contains determine the structure of the personality. The person's capacity to subject their phantasy life to reality testing is of great importance in the achievement of mental health.

Klein describes a conflict-ridden internal world where the infant must cope with intense anxiety arising from the interplay between the phantasy internal objects and the actual activities of the child's caretakers. Segal (1975) emphasises Klein's concept of phantasy (unconscious fantasy), not just as an escape from reality but as a normal accompaniment to reality. Normal phantasy may then be utilized as a defence against
internal or external distress. In this view, there is confusion at first for the infant as to which experiences are its own internal ones and which experiences come from the external world. In phantasy this confusion can lead to the infant feeling that aggression is coming from the mother rather than from the infant itself. In this way unwanted or difficult feelings are projected out of the infant and onto the external world. Similarly, through introjection, good feelings and capacities can be taken in from the mother. In this way the infant's projections and introjections, through phantasy, have an impact on the internal self and object representations that make up a complex inner world.

In 1936 and later expanded in 1946, Klein proposed two momentous positions of infant development, detailing the object relations, anxieties, and defences characteristic of each position. Position 1, the Paranoid Schizoid Position (Klein, 1952a, 1952b), characterizes the first 4 to 6 months of life and is dominated by paranoid psychotic anxieties. According to Klein, the ego experiences anxiety from birth and uses defences against this. The death instinct as proposed by Freud, is converted to aggression. The defences employed against anxiety over aggression in this phase are splitting of the ego, projective identification, denial and omnipotence.

Splitting allows the infant to cope with its hateful and loving feelings towards the mother. The co-existence of these contradictory feelings towards the one person
upon whom the infant is so utterly dependent creates too much anxiety for the infant, so separating or splitting the feelings, as if they are felt towards two different people, becomes the solution. In an attempt to deal with aggression the immature ego becomes split and projects this unwanted part out, first into the breast. In this way the breast becomes, in phantasy, an aggressive persecuting object. The libido is also projected into the breast and a relationship is formed with the ideal object. In this way, the infant attempts to acquire, keep inside and identify with the ideal object and to keep out and expel those parts of itself arising from aggression and the death instinct. In so far as the mother comes to contain the bad parts of self, she is not felt to be a separate individual but is felt to be the bad self. Much of the hatred towards parts of the self are now directed against the mother. This is the prototype for aggressive object relations.

Klein further suggests that even when good aspects of the self are projected onto the mother, she may be felt to have stolen parts of the infant or to be implicated in aggressive attempts to take him/her over (Klein, 1952a). This position therefore is characterized by anxiety about persecutory objects (paranoid anxiety) and by a schizoid or split ego, defended against by the mechanisms of introjection and projection. Splitting also leads to increasing idealization of the ideal object, so that reality can be avoided through magic omnipotent denial.
Splitting is accompanied by the operation of the mechanism of projective identification. "Parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts" (Segal, 1975, p.27). Through this mechanism, bad parts of self may be expelled, or may be projected as an attack on the object. Good parts are projected to avoid separation, to keep them safe or to improve the external object. When the mother is experienced as a whole object and not just a breast, projective identification may intensify.

Splitting and projective identification represent defences that come into play much earlier than in Freud's conceptualization of defences which postulated repression as one of the earliest defences (Klein, 1952a). Although Freud (1915) did discuss more primitive mechanisms involved in fending off instinctual impulses, Klein's emphasis on splitting and projective identification as defences that pre-date repression, represented an important theoretical development, particularly in explaining psychopathology arising from preoedipal stages of development. These early defences are particularly implicated in the development of pathological narcissism. According to Klein's view, narcissistic object relations characterize this earliest stage of infantile development, where the world is split into good and bad objects. Infants, and later patients, through a process involving projection of unwanted aspects of the self, get
caught up in a world that is full of frightening projections of the self.

To summarise, projective identification as described by Melanie Klein is a defence mechanism involving splitting of the early ego, enabling the infant to expel and project good and bad parts of the self, in the form of love and hate, into external objects. The resulting fusion of the projected parts of self with the external object leads to paranoid anxieties, characterized by fear of persecution. This represents a primitive narcissistic object relationship.

Just as the infant splits its experience with the mother (or other caretaker), it can be seen that the experience of the self is also split into the good self and the bad self, thereby separating the gratifying and frustrating aspects of the self. This split can then become the foundation for defences based on ridding the self of aspects that engender intense anxiety. This fragmentation of the self, an important aspect of normal infantile development (Bion, 1988), if not modified during later phases of development, can become the basis of borderline personality pathology, where integration of the different aspects of the self is not possible.

Klein (1975) emphasizes envy as a primitive and fundamental emotion associated with the aggressive drive. The mother, first as the breast, is envied for some possession or quality. Envy aims at being as good as the object but when that fails, it aims at spoiling the goodness of the object. If the infant experiences
excessive envy and defence mechanisms fail to deal with the anxiety, the ego is invaded by envy. In this case disintegration of the ego may occur as a defensive measure. Strong feelings of envy lead to despair. The spoiling may take the form of devaluation. Idealization together with envy cripples the ego. Normal development of an integrated ego is disrupted. The course of the paranoid-schizoid position is altered and normal movement into a more mature position is precluded, resulting in later pathology. However, in normal development where envy is not overwhelming, gratitude modifies envy.

Segal (1975) points out that although Klein's view may seem to imply an infancy dominated by anxiety, it is important to place these developments within the context of a normal infancy where most experiences are pleasurable. This allows the ideal object to be gradually integrated into the ego. Also, in normal infancy some periods of anxiety and the infant's defences against anxiety lay the foundations for an integrated personality. In normal development the infant emerges from the paranoid-schizoid period with psychic mechanisms which allow it to order its experiences. This capacity is vital for later integration and discrimination. Excessive deprivation or trauma will result in primitive defences being retained rather than modified into more mature mechanisms. However, if there is a predominance of good over bad experiences, the infant can move from paranoid-schizoid to the next phase of psychic development.
The second position of development postulated by Klein (1952b, 1952c), starting from 4 to 6 months of age, is the Depressive Position. Klein believed that this is often experienced at the time when the infant is weaned and has to bear the frustration of a newly experienced "separateness" from mother, so that the confusion between what is self and what is other is no longer readily exploited for the purposes of projection of unwanted aspects of the self. According to Klein, intense anxiety (resulting from intense aggression), may result in splitting being maintained or reverted to as a defence, precluding movement to the Depressive Position. If the defence mechanisms of the Paranoid Schizoid Position persist, and are not modified by the Depressive Position, schizoid illness can develop later in life, or narcissistic object relations may continue to be a feature. In a normal infancy, good experiences outweigh bad experiences and the infant will come to feel that his world contains a predominance of good impulses and objects. This lessens the need for projection of unwanted aspects of the self and strengthens the ego.

In the Depressive Position the infant can now recognize its mother as a whole object, not various part objects which provide exclusively good or bad experiences. This creates painful conflict because the mother is now recognized as the one object who is both loved and hated. Also, as the mother comes to be recognized as a separate object from the self, the infant experiences anxiety about his dependence on her and his
helplessness to stop her from leading a life with others, independent of him. Envy of her independence and jealousy of her relationship with others incite feelings of aggression which are in conflict with love and dependence on the mother. Powerful and uncontrollable aggression leads to phantasies of destroying the needed and loved mother, this filling the infant with intense fear and anxiety. Whereas in the Paranoid Schizoid Position there is anxiety about being attacked from the outside, in the Depressive Position, the fear is of the self as the attacker. The depression experienced by the infant arises out of the awareness that the mother who is loved and needed is the same mother who is hated and destroyed: that the infant, not the mother or the outside world, is the source of the aggression that it fears so much. Mourning and guilt lead to depressive despair and fear of having destroyed the loved mother. The resulting fears of loss and feelings of guilt are defended against by phantasies of reparation and restoration in order to repair the phantasized damage. Integration of conflicting emotions comes from the ability to retain love while remembering hate.

Manic defences may be employed to protect the ego from depression and guilt while it develops its reparative capacities. Through denial of dependence and valued internal objects, these manic defences strengthen omnipotence and contempt. The infant may become caught in a vicious cycle of attack, guilt, and defence against guilt leading to further attack.
Reparation in reality and in omnipotent phantasy enables the infant to become more aware of itself, its impulses and phantasies and to distinguish phantasy from reality. Concern for the object modifies the infant's behaviour both in phantasy and reality. This together with the mother's consistency and reliability alleviates the infant's fear of its omnipotent destructiveness and allows a more realistic view. The ego is strengthened by assimilation of good objects introjected into the ego and now the superego, based on internalization of the parents who lovingly stop the infant from acting on impulse. In this way the infant develops a capacity to love and respect others as separate people. Failure to successfully negotiate the tasks of the depressive position may lead to regression into psychosis. If development is successful defences should progress from more psychotic to more neurotic. Primitive defences such as splitting and projection abate in favour of more mature defences such as inhibition, repression and displacement. However, the anxieties and defences of the depressive position may re-emerge later in life, resulting in depression. Klein's views stress the narcissistic nature of early infant psychic conflict. She points out that schizoid object-relations are narcissistic in nature, because they rely on introjective and projective processes:

When the ego-ideal is projected into another person, this person becomes predominantly loved and admired because he contains the good parts of the self.
Similarly, the relation to another person on the basis of projecting bad parts of the self into him is of a narcissistic nature, because in this case as well the object strongly represents one part of the self" (Klein, 1952a, p.306).

In the later Depressive Position, "...reparation comes from guilt, not only about the object but parts of the self" (Klein, 1952a, p.306). Even if these early phases of development proceed successfully, resulting in a well-integrated personality, primitive anxieties and associated defences continue to exist and may re-emerge during conflict later in life.

5.2.2 Rosenfeld's Theory Of Pathological Narcissism

Rosenfeld disagreed with Freud's suggestion that in narcissistic conditions there is a loss of all object cathexis, resulting in an attitude of indifference to objects. In Rosenfeld's view, narcissistic and schizophrenic patients do form a meaningful relationship with the therapist which differs dramatically from normal healthy object relationships. Rosenfeld's contribution to the field largely comes from his work with psychotics. Unlike Freud, Rosenfeld believes psychotics can form transference relationships. He has developed the concept of narcissistic omnipotent object relations from studying the omnipotent way psychotics relate to objects only for narcissistic purposes:
Psychotic patients seemed typically to show omnipotent attitudes to others and particularly to their therapists. In phantasy they seemed to make insatiable demands on their objects, to confuse self with others, to take others into themselves, and to put themselves into others. To formulate what I have observed about narcissism, I have introduced the term 'narcissistic object relations' to emphasize that it was not generally an objectless state...I had in mind the way psychotic patients use others (objects) as containers into which, feeling all powerful, they project those parts of themselves which are felt to be undesirable or which cause pain and anxiety...In the case of introjection, the object becomes part of the self to such a degree that any separate identity of boundary between self and object is felt not to exist (Rosenfeld, 1987, p.20).

Rosenfeld's theory is largely based on an understanding of the concepts of projection, introjection and projective identification, as described by Klein. Of particular importance, was Klein's theory of projective identification as a primitive narcissistic object relationship. This led to Rosenfeld's awareness of a close link between envy, narcissism and object relationships, in particular, the importance of the process of projective identification in severe narcissistic conditions.
Rosenfeld (1987) suggests that psychotics use others (objects) as containers into which, feeling all powerful, they project those parts of themselves which are felt to be undesirable or which cause pain and anxiety. The object (through introjection) becomes part of the self to such a degree that any separate identity or boundary between self and object is felt not to exist. In projective identification, parts of the self become so much part of the object (the mother), that the patient has the idea that they possesses all the desirable qualities of the object; in fact, that they are the object in these respects. This is the process of identification through the mechanisms of introjection and projection. Rosenfeld points to the central role of overvaluation of the self in narcissism, based on idealization of the self:

Self-idealization is maintained by omnipotent introjective and projective identifications with ideal objects and their qualities. In this way the narcissist feels that everything that is valuable relating to external objects and the outside world is part of him or is omnipotently controlled by him (Rosenfeld, 1987, p.105).

According to this view, infants may develop a narcissistic omnipotent object relationship with the mother as a defence against aggression and ambivalence aroused by frustration by and envy of the mother. It is a defence against experiencing the separateness of self and object. The other cannot be envied if they are
experienced as being one and the same as the self. The greater the infant’s envy or aggression, the more the object relationship will be of a narcissistic omnipotent quality: the greater the envy, the more difficult it is to face separateness and give up narcissistic omnipotence.

As discussed previously, in early infancy, confused feelings and anxiety are projected into the mother, providing an opportunity for the mother to become aware of the infant's feelings and to show the infant that these unbearable feelings can be contained and thought about creatively. The mother's processing of the infant's diffuse experience is the forerunner of the infant developing its own capacity to process and contain feelings, a capacity that will be vital if the infant is to survive as a separate psychic entity from the mother. However, according to Rosenfeld, when there is intense envious aggression in the infant, reliance on primitive projection may be retained so that the aggression and the associated conflict it produces, are expelled. The infant may refuse to give up this early interaction with the mother and this may preclude the development of a more mature object relationship with the mother.

Rosenfeld details the complex difficulties that can arise in the transference and countertransference during analysis of such patients. The narcissistic omnipotent object relationship is revived in the transference when the patient's narcissistic self-idealization diminishes and there is a potential for dependency and need for the
object (the therapist). The primitive object relationship enables the patient to defend against the pain, anxiety and envy that would be aroused by that awareness. This can lead to a negative therapeutic reaction, where the analyst must be attacked. If the patient starts to get better, envy of the therapist's capacity to help, and fear of the associated dependency on the therapist will compel the patient to want the therapist's attributes for themself. The therapist is obliterated as a separate person and is devalued, resulting in both the therapist and patient becoming very frustrated.

To deal with these complex transference and countertransference reactions, the analyst must understand the mechanisms of narcissism and projective identification. Klein's theory of projective identification as a primitive narcissistic object relationship and her work on envy in the transference form the basis of Rosenfeld's ideas about negative therapeutic reactions. Rosenfeld's awareness of the close link between envy, narcissism and object relationships has led to his emphasis on the role of projective and introjective processes of identification that provide the individual with a phantasy of oneness so that all dependence and its associated experiences such as envy and need can be denied. On the positive side, by projecting their confused feelings and anxiety into the analyst, the patient also, as they did in infancy, provides an opportunity for the analyst/mother to become aware of their feelings and to show the infant that these
unbearable feelings can be contained and thought about creatively. Thus Rosenfeld suggests that narcissistic patients with negative therapeutic reactions are utilizing a narcissistic omnipotent object relationship to defend against dependence on the therapist. His work represents an elaboration of the principles described by Freud, Abraham and Klein in their theories concerning chronic resistance in the analysis. Superiority, arising out of feelings of envy and destructiveness are maintained by either devaluing the therapist or by the patient giving himself the entire credit for any progress. Just as in infancy, phantasies of omnipotence come at a time when there are overwhelming feelings of being helpless, small and incapable of coping. This infantile omnipotence may be revived whenever the person feels that way again.

Destructive narcissism will be the patient's way of coping with their loving feelings towards the therapist. When the patient finds that the therapist is loving, understanding, and kind, the patient puts all their energies into remaining sadistically strong, regarding any love in themselves as weakness. This results in prolonged resistance to treatment, with some individuals presenting with a long history of failed attempts at treatment. Rosenfeld emphasises the need to interpret the special ways in which aggression and destructiveness are incorporated into the life of the narcissistic individual. Narcissistic rage arises when the patient reacts to a narcissistic hurt and feels humiliated,
looked down on, and misunderstood. It often improves when
the patient feels well understood in analysis. This
includes the therapist showing, through interpretations,
that he/she understands why the patient is being
aggressive and destructive. Rosenfeld's recommendations
concerning interpreting the patient's aggression as a
defence against narcissistic injury has been elaborated
by Otto Kernberg (discussed below) but is disputed by
Heinz Kohut (discussed in section 5.4).

5.3 Object Relations And Ego Psychology: Kernberg's
Theory Of The Development Of Pathological Narcissism

as a defence system directed against a pathological
development of oral aggression in the infant. This
development may represent a constitutionally determined
strong aggressive drive, interacting perhaps with severe
frustration in early infancy. Constitutional lack of
anxiety tolerance may also play a role. Even if initially
there is good enough mothering, the strong aggressiveness
of the child may take its toll on the mother and she may
be increasingly unable to connect with the child in a
loving, empathic manner, thereby leaving the baby feeling
frustrated; the baby's unusually strong aggression in
response to this frustration will perpetuate the cycle.
If this aggressiveness is in fact constitutional, it
raises questions concerning how such infants can be
helped, how the parents' rejection of the infant can be
prevented, and how far these individuals can go in
treatment as adults.

In addition to identifying a constitutional factor,
Kernberg has also studied the family backgrounds of
pathologically narcissistic patients, and found that the
primary caregiver (usually the mother) provided a good
environment but was often cold, hard and covertly
aggressive. Another feature was that the patients often
had a special talent or trait that might provoke envy in
a narcissistic mother, thereby interfering with her
ability to empathize with the child. The child in turn
may have become absorbed in its own specialness, as an
escape from feeling unloved or hated by their
narcissistic, envying mother. This lays the foundations
of the development of the grandiose self in narcissistic
personalities.

Kernberg describes the pathological grandiose self
as representing a fusion of three aspects of self: the
real self, including real specialness; the ideal self,
representing exaggerated phantasies of specialness; and
the ideal object, representing a phantasied replacement
for the hateful mother. Conflict between the frustrated
real self and the idealized all-powerful self, together
with conflict between the devalued, hateful real mother
and the idealized all-loving mother, form the foundation
of the inner turmoil of the individual. Defending against
these conflicted feelings toward self and mother (the
latter feelings subsequently being transferred onto
others), becomes the raison d'etre of the psyche.
The process by which the defensive grandiosity develops is described by Kernberg (1975) as follows. In normal development, experiences of frustration and gratification with the object world lead to the separation of affects and cognitions into libidinal and aggressive, positive and negative. These become mental self-object representations (in unconscious phantasy) that structure the infant's experience of its interaction with the outside world. However, unmanageable aggression (arising from the factors described previously) overwhelms the ego as it struggles to integrate the increasing differentiation of its representations. This may cause the normal processes of differentiation to collapse, resulting in pathological refusion of actual and idealized self-object representations.

At first, ego boundaries fluctuate. Refusion of self and object representations of a good (and gradually idealized) type can occur as an early defence against bad, frustrating situations. If there is severe frustration, bad self-object representations will predominate. As a defence against the predominant bad self-object, refusion of primitive "all-good" self representations and object representations occurs, interfering with the development of ego boundaries. This leads to a conflict between overwhelming dependency needs and aggression. To cope with this conflict, the infant employs two defences: projection and splitting. The unmanageable aggression is projected onto the outside world. This expulsion further exacerbates the infant's
struggle with "bad external objects". This intensifies splitting in order to preserve the ever-weakening "good objects". The ego becomes more disintegrated and is unable to withstand painful, frustrating experiences with the object world. To shield the ego, grandiosity is utilized as a defence against aggression. This defensive grandiosity represents the final stage of the development of pathological narcissism.

To summarise Kernberg's account, intense aggression due to the interplay between constitutional drive and environmental frustration or deprivation leads to overwhelming dependency needs. The conflict between dependency and aggression is "resolved" through primitive defences anchored in splitting. The all-good, all-powerful self-object split off from the all-bad, devalued object world is the basis of a pathological narcissistic experience of self and others.

Kernberg (1985) emphasizes the distinction between normal narcissism and pathological narcissism. Normal narcissism is defined as "the libidinal investment in the self... The self is an intrapsychic structure consisting of multiple self representations and their related affect dispositions" (1985, p.315). According to Kernberg, the structure of the self in normal development is different from the structure of the self where there is pathological narcissistic development. In the normally developed self, self-representations reflect "the person's perception of himself in real interactions with significant others and in fantasized interactions with
internal representations of significant others, that is, object representations" (pp.315-316). Kernberg asserts: The self is part of the ego, which contains, in addition, the object representations mentioned before, and also ideal self-images and ideal object-images at various stages of depersonification, abstraction and integration. The normal self is integrated, in that its component self-representations are dynamically organized into a comprehensive whole... Therefore, although normal narcissism reflects the libidinal investment of the self, the self actually constitutes a structure that integrates... good and bad self-images into a realistic self-concept that incorporates rather than dissociates the various component self-representations..." (1985, p.316).

In normal narcissism, self-esteem, self-appreciation and self-criticism represent advanced ego and super-ego functioning within an integrated self. "Good" object representations maintain self-esteem in the face of real disappointments.

In pathological narcissism, narcissistic supplies are continually sought externally to compensate for the lack of good internal object representations and the absence of the ego ideal which normally increases self-esteem when the self lives up to its expectations. In normal narcissism, self-esteem is also increased by structures related to the id when instinctual needs are satisfied. Therefore, in normal narcissism, success in
the external world and gratification from external objects constitutes one source of narcissistic supply, whereas in pathological narcissism there is a relentless search and over-dependence on external gratification as the only source of self-esteem. Only in a developmentally mature integrated self can self-esteem be regulated by realistic self-expectations and aspirations.

Kernberg (1985) maintains that narcissistic pathology can exist at various levels, corresponding to more or less severe types of psychopathology. He suggests that narcissistic problems are involved in all neurotic reactions and character pathology, as evidenced by "a pathological vulnerability of the self, defended against by pathological character traits" (p.322). In more severe cases, "the self has developed pathological identificatory processes to such an extent that it is modelled predominantly on a pathogenic internalized object, while important aspects of the self (as relating to such an object) have been projected onto object representations and external objects" (p.323). In the most severe cases there is a massive impairment of object relationships characterized by projection of the grandiose self into objects so that the relation of self to self replaces true object relations.

According to Kernberg (1985), whose personality theory encompasses a formulation of pathological narcissism as a defence mechanism, narcissistic rage is a re-enactment or revival of the individual's original phase-appropriate omnipotence during infancy. Thus the
infantile nature of the rage is viewed as a return to early psychological constructions as a defence against conflicts concerning love and hate, rather than fixation at an early level of psychological development, as in Kohut's formulation (discussed next).

Kernberg (1985) outlines important ways in which pathological narcissism differs from normal infantile narcissism. First, the narcissistic resistance of patients with narcissistic personalities is different from that seen in patients who are fixated at or regress to infantile narcissism. Second, whereas infantile narcissism represents libidinal investment in the self, pathological narcissism involves libidinal investment in a pathological self-structure arising out of conflicts between love and aggression. Third, the structural characteristics of narcissistic personalities reflect pathological differentiation and integration of ego and superego structures, rather than structures seen in normal early psychic development. Consequently, object relationships are pathological rather than primitive. For example, when normal children entertain grandiose fantasies or become enraged in an attempt to control their mother, these efforts are more realistic than the fantasies and rage of patients with narcissistic personalities. In children, exaggerated rage and demandingness go hand in hand with feelings of love and trust, whereas in narcissistic personalities, a genuine attachment is absent. Further, infantile narcissism involves demands for real needs whereas in pathological
narcissism the demandingness is more pervasive and far-reaching, and can never be fulfilled due to deprecation of valuable objects as a defence against envy and dependence. Infants fantasize about being special and perfect so that they will feel sure they will be loved whereas pathologically narcissistic individuals fantasize about being superior so that they will be envied and have power over others. In children, others are idealized in order to protect them as "good objects" but in pathological narcissism others are idealized as a way of owning and controlling them in order to defend against feelings of envy and dependence. In general, Kernberg's account emphasizes the central role of aggression in pathological narcissism which produces a different quality of object relationships from that seen in normal fixated narcissism due to frustration or deprivation.

Kernberg (1970) defined "narcissistic personalities" as those patients who have "specific disturbances in their object relationships, and whom we might consider almost a pure culture of pathological development of narcissism" (p.51). In their phantasies they identify themselves with their own ideal self images in order to deny normal dependency on external objects. "That ideal person and my ideal image of that person and my real self are all one, and better than the ideal person whom I wanted to love me, so that I do not need anybody else anymore" (p.55). Unacceptable self images are repressed and projected onto external objects, which are devalued.
This has important implications for the superego, which normally functions to integrate ideal self images and ideal object images: the tension between actual self images and such integrated ideal ones becomes tension between the ego and superego. In narcissistic patients, the pathological (defensive) fusion between ideal self, ideal object and actual self results in a highly unrealistic structure which cannot be integrated with actual parental demands and actual aggression in the ego. This unintegrated aggressive and primitive kind of superego is easily expelled in the form of paranoid projections. On the other hand, idealized people, on whom the patient seems to depend, are projections of their own aggrandized self concepts.

Kernberg emphasizes that when narcissistic patients enter analysis, the focus of treatment must be on the interpretation of narcissism as a defence. Of course, given that maintaining this defence is vital to the patient's "well-being", the analyst's interpretations will be met with rage and even overt aggression, either in the form of devaluation of the therapist or idealization of the self. If these defences in turn are interpreted, the patient and therapist may become caught up in a spiral of interpretation and counter defence, making therapy with such patients an extremely difficult task.

Kernberg (1985) has detailed a special methodology for the treatment of severely narcissistically disturbed patients, particularly borderline personalities who tend
to act out aggressive drives, creating an environment of chaos, manipulation, exploitation and destruction in the therapy. He stresses the importance of a consistent combination of limit-setting and interpretation of aggressive acting out. Kernberg points to the success of his treatment approach as evidence that interpretation of unconscious aggression leads to insight and change, and is not a self-fulfilling prophecy for the therapist as suggested by Kohut, discussed below.

5.4 Self Psychology: Kohut’s Theory Of The Development Of Pathological Narcissism

Kohut (1971, 1972, 1977, 1984) conceptualizes narcissistic pathology as the ultimate result of the parents' inadequacy in addressing the infant's grandiose and idealizing needs. To relieve feelings of helplessness, the infant requires the parent to serve as a "self-object", that is, an object that can perform psychological tasks such as tension management that the infant is unable to perform for itself. Later, the infant will merge with the self-object and internalize these functions. Through empathic echoing of the infant's normal grandiosity, the parent reinforces the infant's imagined omnipotence. In addition to "mirroring" the infant's grandiosity, the parent must serve as repository for the infant's primitive idealizations of the parent. By confirming both the infant's self-image of being omnipotent, and the infant's idealized image of the parents, the parents can help the infant ward off
feelings of helplessness. In normal development, the infant can gradually internalize the functions performed by the parents. According to Kohut, failure to empathically indulge the infant's omnipotence prevents this necessary merger and therefore undermines development. Failure to provide an idealized object that the infant can merge with will result in deflated self esteem and emptiness. The child's psychological development is blocked by the continued search for idealized objects with whom it can merge. Narcissistic rage will emerge as a reaction to frustration of these basic psychic needs. Kohut maintains that this aggression is the result of, not the cause of (as in Kernberg's theory) the parent's failures in mirroring the child's normal grandiosity. In this way, the presence of a narcissistic grandiose self is explained by Kohut as arising from chronic and traumatic frustration of the normal phase-appropriate need, in the infant, for omnipotent control over the self-object (Kohut, 1977).

Kohut (1971) suggests that under optimal conditions, the early phase grandiose self will be integrated and there will be a more mature perception of reality, where the infant will be able to recognize his limitations. Exhibitionistic needs will be replaced by realistic self-worth and enjoyment of his own actions. However, according to Kohut, when this normal integration is disturbed, the grandiose self will be retained in a quasi-delusional form, split off and repressed, independent from the reality testing function of the ego.
While some frustration of the child's trust in the self-object's "empathic perfection" is necessary, not only in order for the building of structures necessary for the tolerance of delays, but also in order to stimulate the acquisition of responses to real enemies, Kohut maintains that chronic frustration will be traumatic. Alternatively, in cases where there are only minor delays in gratification, the baby may react with violent temper tantrums, straining the mother's ability to respond to the baby's needs. Chronic frustration of the infant's needs will result if the mother withdraws from the infant.

From this conceptualization, Kohut (1972) rebuts the argument that narcissism in the adult is a regressive defence. He maintains that human aggression is not a regression to our animal past and suggests that viewing narcissism in this way has loaded the idea of narcissism with a pejorative connotation that follows the Western hypocrisy of extolling altruism and disparaging egotism. Kohut further suggests that Christianity's main focus is on curbing normal grandiosity through offering merger with the omnipotent self-object, Christ.

Kohut conceptualizes narcissism as an integral, self-contained set of psychic functions. Due to ostracism and suppression, the aspirations of the grandiose self, particularly the wish for merger with the omnipotent self-object, may seem to subside, and therefore, will be denied. However, this suppression does not modify
narcissistic structures, but merely blocks their expression.

The infant's psychic development from the archaic narcissistic cathexis of the child's body-self to more mature attachment and dependency, as described by Freud (1914), is elaborated by Kohut as follows. The increasing selectivity of the mother's admiration and approval of the infant enables the infant to gradually adjust its image of itself and also forego phantasies of perfection. If however, the mother's selective admiration is a feature from the start and continues, rather than something that gradually evolves as her expectations of the infant change according to the age of the infant, the crude and intense narcissistic cathexis of the grandiose body-self remains unaltered and its archaic grandiosity and exhibitionism cannot be integrated with the remainder of the psychic organisation which gradually reaches maturity. The archaic structures then become split off from the reality ego or separated from it through repression. The archaic body-self will from time to time assert its claims, either through by-passing the repression barrier or by breaking through the brittle defences. When the reality ego is suddenly flooded with unneutralized exhibitionistic urges, intense shame and narcissistic rage are experienced.

Kohut summarizes pathological narcissism as the uncompromising insistence on the perfection of the idealized self-object (mental image of an ideal self) and on the limitlessness of the power and knowledge of a
grandiose self, where the maintenance of self-esteem and indeed of the self, depends on the unconditional availability of an admiring self-object, based on an internalized adoring mother or parent. This is the image of a perfect person perfectly admired by oneself; a kind of self-infatuation. For those who do not equally admire this perfection, there will be no empathy, only narcissistic rage.

Kohut (1972) maintains that our narcissism or self-image undergoes an independent line of development within the total personality, a development that leads to the acquisition of mature, adaptive, and culturally valuable attributes in the narcissistic realm. In this way he postulates a separate narcissistic sector of the personality which is modified as a normal part of psychic development.

Kohut (1972) cites the ambitions of Nazi Germany and total surrender to the will of the Fuhrer as an example of what can happen on a national scale when grandiose wishes break through and result in the unrestrained pursuit of grandiose aims and the merger with omnipotent self-objects. Kohut maintains that, instead of denying our ambitions, we should learn to acknowledge the legitimacy of these narcissistic forces. Only then can archaic grandiosity become realistic self-esteem. Through acceptance, we can transform our yearning to be at one with the omnipotent self-object into a socially useful and joyful capacity to be enthusiastic and to admire the great, and to model ourselves on them. Kohut warns that
unless our true nature is mirrored by our social conventions, we will continue to suppress and deny our true selves, until, under enormous pressure and humiliation (such as the Germans suffered after their defeat in World War I), our narcissism breaks out in more pathological forms.

Following on from Freud, Kohut (1972) emphasized that the vicissitudes of the infant's early life and the formation of the self will determine later psychological events which revive the conflict of the earlier phase. For example, just as choosing a marriage partner reactivates a dormant Oedipus Complex, so do certain periods of transition which demand a reshuffling of the self, constitute emotional situations which reactivate the period of the formation of the self. The specific vicissitudes of the early pathology are experienced as specifically repeated by the new situation. Extensive changes to the self must be achieved, e.g., in the transition from early childhood to latency, from latency to puberty, from adolescence to young adulthood. Experiences during the period of the formation of the self become the prototype of the specific forms of our later vulnerability and security in the narcissistic realm: the ups and downs of our self esteem; of our lesser or greater need for praise, for merger into idealized figures, and for other forms of narcissistic sustenance: and of the greater or lesser cohesion of the self during periods of transition.
Kohut (1977) departed from Freud's original formulation and has elaborated the nature of transference relationships in narcissistic patients. He describes two types of transference in working with these patients: the mirror transference and the idealizing transference. The mirror transference refers to the infantile image of the "grandiose self": the patient brings to the therapy the expectation that the therapist will mirror the patient's grandiose image of himself and will therefore treat the patient in accordance with this image. This has parallels with the infant's need to have its grandiosity mirrored by its mother. In the idealizing transference, the patient will view and treat the therapist as an idealized parental image. From studying the mirror and idealizing transference in his patients, Kohut reconstructed infantile and childhood trauma that left the psyche insufficiently structuralized.

According to Kohut (1977), when patients with a narcissistic disturbance enter analysis, the therapist's task involves identifying what traumatic conflict between parent and child (when the child began to construct a grandiose-exhibitionistic self and omnipotent self-object) is now being repeated. This repetition will become the basis of the narcissistic transference in therapy. The therapist's countertransference in turn may cause him to withdraw from the patient and rationalize this by the 'judgement' that the patient is not analysable.
Kohut emphasizes that the main aim of therapy with these patients should be the transformation of narcissistic rage into mature aggression. The patient's sudden attacks of fury must not be censured by the analyst, nor hurriedly interpreted as being infantile. They must be accepted with implicit approval for some time. Kohut emphasises that narcissistic rage must not be confused with mature aggression; narcissistic rage enslaves the ego whereas mature aggression is under the control of the ego. In working through, the ego can gain dominance in this sector of the personality so that the patient can derive self respect from new arenas, such as the satisfaction of knowing about the existence of the unconscious (insight), and from satisfaction in the ability to tolerate unpleasant aspects of reality. By showing empathy towards the patient's narcissistic needs, the therapist provides an opportunity for the patient to learn to understand and accept the demands of the grandiose self and its propensity towards rage. If the patient does not feel he is being treated like a naughty child, fears of another traumatic rejection may be allayed. Kohut (1977) warns that if narcissistic rage is not treated, the ego increasingly surrenders its reasoning capacity to the task of rationalizing.

Kohut disagrees with Kernberg's recommendations concerning therapy with narcissistic patients. Kohut suggests that therapy based on interpreting grandiosity as a defence will create rage in the patient, not because the interpretation is right, but because the patient,
longing for gratification, will experience the therapist as another cold, hateful parent who does not understand him/her or who wants to push their own depression into the patient. The patient, hurt and attacked, will retaliate with an aggressive attack on the therapist, thereby appearing to prove that the therapist was right in the interpretation but not necessarily right to interpret that the patient is really full of rage and hate.

In a study testing the competing models of narcissism proposed by Kernberg and Kohut, Glassman (1988) used the method of causal modeling to identify characteristics central to each of the models. Causal modelling assumes that the pattern of free associations of the patient (observed variables) is generated by the existence of unconscious constellations of affect and motive (latent variables). The effects of the latent variables on the observed variables is reflected by the latters' correlations. From Kernberg's model, some of the main characteristics identified were: parental hostility; aggression and envy; conflict over dependency; splitting; devaluation; omnipotent control; and grandiosity. From Kohut's model: parental empathic failure; failed idealization; unmet needs for admiration; and disappointment in significant others. The data provided support for both models, and Glassman concluded that Kohut's self psychology is a special case of Kernberg's ego psychological-object relations theory.
6.1 History Of Psychodynamic Formulations Of Addiction

Psychodynamic formulations of compulsive drug use have evolved from an early emphasis on a regressive search for pleasure to more complex accounts of affect regulation focusing on relief from unbearable affects and theories concerning the prosthetic role drugs may play in those individuals who lack the psychological structures involved in affect regulation. The latter accounts look to the early emotional life of the individual with particular attention to the processes of internalization, maturation and integration of internal psychic structures and functions necessary for healthy identification, differentiation and tolerance of intense emotion, with some authors such as Kernberg, emphasizing conflict and aggression in particular:

A psychodynamic perspective of mental life attempts to examine the forces at work within an individual related to drives, affects, and those psychological structures that are responsible for regulating drives and affects. Such a perspective also attempts to take into account an appreciation of how developmental challenges have been handled and
managed from the earliest phases of life... a contemporary psychodynamic understanding of drug dependence attempts to explain how addicts' dependence on drugs is related to difficulties in coping with their internal emotional life and problems in adapting to their environment (Khantzian & Sneider, 1986, p323).

Early psychodynamic formulations viewed addiction and compulsive drug use as arising out of a desire for regressive pleasure states. Rado (1957) emphasized the seeking of "super-pleasure" from opiates. In his view, the destructive liberation of the instincts through drugs, is countered by the superego and a need for punishment, thus entrapping the addict in a vicious cycle of elation and depression. Savitt (1954) focused on the use of heroin for the relief of tension and distress, rather than the seeking of pleasure, but still viewed the end result as a pleasurable regressive state, comparing the feeling induced by injecting heroin, to the desire for fusion with the umbilical cord experienced by the foetus. Weider and Kaplan (1969) also described the effects of heroin as producing a "blissful narcissistic state" where psychic pain is relieved through fusion and regression. In a review of the psychoanalytic literature, Yorke (1970) pointed out that early theories viewed drug use as fulfilment of unconscious regressive wishes, such as libidinal wishes, wish for a love object or wish for liberation from inhibitions, as in alcohol intoxication.
In a review of the literature, Yorke (1970) included many early formulations which emphasized the narcissistic qualities of drug use whereby the addict can experience sexual pleasure or emotional gratification from oneself, magically removing the need for others so that the self becomes the only and best source of pleasure. Rado (1926) compared drug intoxication to a drawn out orgasm. He viewed this as a move away from object-directed love; sexual pleasure is achieved without the involvement of sexual organs or others. Fenichel (1945) also emphasized libidinal aspects and describes drug use in terms of oral longing, erotic and narcissistic satisfaction. Objects are not valued in themselves but only in so far as they deliver supplies. Rado (1933) described compulsive drug use as providing elevation of mood and self-esteem and freedom from life's pain and frustration. This is achieved magically, bolstering the ego's omnipotence. Rado described this as the ultimate narcissistic state; total elation, no need for love objects and belief in magical invulnerability. Simmel (1930) emphasized narcissistic fulfilment of aggressive wishes to poison the introjected hated mother. All these formulations emphasised instincts and a return to a regressive state.

Glover (1956) was one of the first theorists to conceptualize addiction, not as instinct but as defence, viewing drug use as a therapeutic or defensive behaviour rather than a regressive one. This view of drug addiction emphasized the individual's attempts at coping with aggression and sadism, suggesting that drugs are used as
an external sadistic agent taken into the body to attack
the internal sadism. According to this view, the drug can
become an object into which the person can project his
conflicts. In this way, instead of regressing to a more
psychotic state, the person can temporarily move into a
more mature neurotic state, thereby defending against
paranoid-sadistic tendencies.

Rosenfeld (1960) emphasized defences against
anxieties and conflicts with objects. Anxiety is denied
and bad parts of the self are split off. The drug is an
ideal object which can be physically internalized, thus
bolstering omnipotence. In this way drugs bolster
splitting into idealized and denigrated objects via
"magical" omnipotent control of objects. In the
candidate's experience, the drug often seems to become an
object into which the addict can project his/her split-
off bad parts as well as the good parts of the self. For
example, addicts will often attribute the worst and most
desired aspects of self to the drug. Intense conflict
arises as the drug is sought yet hated. Much aggression
and violence is tolerated in our society because the
perpetrator was "under the influence" of a drug or
alcohol. Many people believe that alcohol causes an
otherwise non-violent person to behave violently. Another
example of the way the boundary between the person and
the drug becomes blurred is seen during assessments when
the patient is asked about their emotional functioning;
how they deal with anger, anxiety, depression and so on.
People will often report that they do not experience such
emotions and portray themselves as being very balanced and calm individuals. What they are in fact describing is not their own personality, but how it feels to be "stoned" all the time. When this is pointed out to them, the response is often one of hostility or "indifferent" disregard.

Rosenfeld (1960) also viewed drug use as a way of coping with painful internal states and related this need to ego and superego pathology, particularly in the area of severe narcissistic pathology. Chein, Gerard, Lee and Rosenfeld (1964) concluded that all addicts have personality disorders and use narcotics for adaptive purposes. They describe heroin as a tranquillizer of emotional pain, not a source of pleasure, but also stress the narcissistic gain obtained from this magical control and relief. Hartman (1969) also emphasized the defensive aspect of compulsive drug use. Wieder and Kaplan (1969) described the role of ego pathology, resulting in a failure or deficit in the person's ability to deal with distress. Drugs are used to induce regressive states that resemble primitive phases of psychic development because more mature ways of coping are not possible. In this way, they view drug use as serving the function of a corrective prosthetic.

Krystal and Raskin (1970) provided a more detailed account of deficits in the personality structure of addicts and view drug taking as an attempt at 'self-help' for the ego. Due to this deficit, emotions are not effectively regulated and result in an overwhelming
intense state of anxiety fused with depression that is more akin to total infant distress than to mature differentiated affect states. Intoxication blocks or numbs this intolerable experience. In this way, drugs provide a defence against traumatic and primitive affects that would otherwise be overwhelming. Intoxication also blocks or distracts dangerous impulses arising out of ambivalent object relationships involving the longing for union and separation. According to their view, in early psychic development undifferentiated affects become differentiated, desomatized and verbalized and can be used to mobilize the ego. This normal development may be interrupted in two ways. The infant's parents may fail to act as models in managing affects so that the infant has no experience which can be internalized. Alternatively, trauma in early life may lead to a de-differentiation of affects. Addicts are unable to make use of anxiety and feelings as signals or guides because these feelings are undifferentiated and overwhelming.

According to Krystal and Raskin (1970) narcotics can reverse regressive states through a direct anti-aggression action, thereby providing protection for defective or nonexistent ego mechanisms of defence. According to this view, early developmental impairments in ego structures and self structures predispose individuals to defects in affect defence, self-care, dependency and need satisfaction, resulting in problems with affects like rage and depression. For example, due to defects in affect and drive defence, painful affects
lead to psychological fragmentation and disorganization, resulting in uncontrolled aggression or fear of uncontrolled aggression. Similarly, defects or absence of structures for the regulation and maintenance of self esteem, self satisfaction and dependency will lead to an excessive need and demand for others to provide feelings of comfort and worth. When these desperate demands are not met, there will be overwhelming rage and depression. Khantzian and Krystal emphasized that all programmes for addicts must provide a clear structure to compensate for defects in ego and self structures. They warn that without a strong policy of limit-setting and structure, patients will act on aggressive tendencies.

In summary, psychodynamic theories of compulsive drug use first emphasized the use of drugs for pleasure, viewing drug use as a regressive act. Later, drug use was viewed as an adaptive act defending against painful regressive states due to impairment in ego structures, particularly in the area of affect tolerance (Krystal & Raskin, 1970; Milkman & Frosch, 1973; Weider & Kaplan, 1969; and Wurmser, 1974) and drive defence (Khantzian, 1974). These formulations, focusing on early impairment of psychological structures, are related to formulations of the genesis of narcissistic problems that contribute to a predisposition to addiction and related psychopathology. All the prominent contemporary authors in the field of the psychodynamics of compulsive drug use, such as Wurmser, Khantzian and Dodes, agree that
6.2 The Role Of Pathological Narcissism And Narcissistic Rage In Addiction

In his account of narcissistic rage (NR) in addicts, Dodes (1990) defines NR as "the drive ... to ward off a sense of helplessness and re-establish a sense of internal power... The drive to re-establish the power to which one feels entitled" (p.414). This definition links the rage to the "narcissistic expectation" of control over affective experience. He points out that in addiction to mood-altering substances, there is a paradoxical seeking of control (over one's affective state) while being out of control (of one's addiction). There is a further paradoxical loss of control in pathologically narcissistic individuals because NR enslaves the ego, and behaviour and motivation become subservient to the rage. Dodes' formulation focuses on the rage against feelings of powerlessness and helplessness, which in the addict has special significance, as, through their drug use, they attempt to control their own affective states.

Dodes (1990) draws a comparison between the relentless, compulsive drive in addiction with the relentless compulsive drive in NR. He maintains that addiction and NR are parallel processes and share many characteristic features. First, substance abuse and NR both serve to re-establish a sense of internal control
over one's affective state. In addiction this is achieved via mood-altering substances; in NR this alteration of mood is achieved via aggression, such as in destructive fantasies or devaluing attitudes towards others who interfere with one's own view of the world. Second, and somewhat related, Dodes describes both NR and addiction as representing a struggle to survive, in this case psychologically. In both instances, survival is perceived to be threatened by aversive affective states which are experienced as being dangerous and unbearable. Both addiction and NR are employed to restore a feeling of omnipotence and power over one's internal state. Third, in both addiction and in NR there is a loss of ego autonomy. An individual can become a slave to addiction and, in the same way, to NR, as both phenomena come to rule conscious and unconscious behaviour and ideation. The aims and goals of the person become increasingly subservient to the compulsive drive (be it NR or addiction). Khantzian (1977) also noted that the ego of the addict is shaped and developed to serve the addiction. Fourth, Dodes draws a parallel between addiction, as a chronically relapsing disorder, and NR, which is also characterized by a pattern of chronic propensity to narcissistic vulnerability. Both conditions require long-term interventions due to the "permanent regressive potential" (p.416) of the disorders; indeed both may involve a lifelong struggle, relying on Alcoholics Anonymous or the therapist's interpretations
to identify and curb compulsive tendencies. Dodes concludes:

the striking overlap between the characteristics of addiction and those of narcissistic rage... [can be explained] because a central aspect of addiction is its function as response to a narcissistic sensitivity to powerlessness, in which the addiction is both a restorative defence against powerlessness and an expression of the narcissistic rage it produces. The role of narcissistic rage as the drive behind regaining a sense of internal power is a major cause of the "unrelenting compulsion, utter loss of ego autonomy which are characteristic of addiction" (Dodes, 1990, p.416).

Wurmser (1978) emphasizes the role of NR in the psychodynamics of compulsive drug use. He points out that, while the rage is often acted out and experienced by others as sociopathic aggression, addicts are not without a conscience but rather suffer from an archaic conscience that is very fragmented, externalized and impaired in its ability to manage anxiety and conflict. It is this deficit that leads to undirected rage in situations of narcissistic conflict.

Khantzian and Wurmser particularly emphasize the adaptive use of narcotics to counteract the disorganizing influences of regressive rage and aggression. As these authors have provided the most recent and elaborated accounts of the psychodynamics of compulsive drug use, particularly narcotic addiction and methadone treatment,
Khantzian's Theory Of The Psychodynamics of Compulsive Drug Use

Khantzian (1974) studied the effects of heroin and methadone on addicts. He observed six addicts in psychotherapy, took careful histories from 20 patients seeking treatment for heroin addiction, observed over 200 addicts in treatment and gathered extensive follow-up data on patients who had participated in methadone treatment. He concluded that narcotic addicts have special problems with aggression and use opiates to relieve dysphoria associated with unmitigated aggression. He therefore recommended that treatment must focus on their problems with rage and aggression.

Khantzian (1977) points out that because addicts are excellent at manipulating people and situations, they are usually characterized as people who are very adept at getting their needs met. Unfortunately, this apparent success and the negative countertransference feelings experienced by those who have been manipulated, has blocked an appreciation of how poorly addicts cope. Their manipulation of external factors is merely a desperate attempt to compensate for a lack of control and structure in their internal world, resulting in total dependence on external help, which, being excessive, will not generally be forthcoming and must often be extracted by aggressive means.
Khantzian (1977, 1978) attributes deficits in affect and drive defence and in self-care and self-regulation functions in addicts to problems during the process of internalization; "a process by which the developing infant acquires qualities and functions from parental figures in the process of maturation" (p.103). Problems with the normal development of self-care functions in infancy also account for the high risk-taking behaviour seen in addicts, usually pre-dating the onset of their drug use and continuing after the drug problem has been resolved. Khantzian disagrees with the idea that addicts show a conscious disregard for danger or are unconsciously driven to be self-destructive or follow a death wish. Instead he maintains that danger is not sought, it simply is not perceived due to impairments in ego self-care functions. Similarly, Krystal and Raskin (1970) suggest that addicts lack normal "signal anxiety" that alerts us to external dangers, and deficits in addicts' self-care functions have also been described by Khantzian and Mack (1983). Khantzian (1977) also suggests that addicts have not developed a normal capacity to tolerate distress and frustration because the parent's function as a stimulus barrier has also not been internalized by the infant. With the usual mature defences against intolerable affects missing, these individuals use narcissistic defences and processes to compensate for developmental impairments.

Kohut (1971) proposes that problems with internalization are due to a narcissistic deficient
mother. "The drug serves not as a substitute for loved or loving objects, or for a relationship with them, but as a replacement for a defect in the psychological structure" (p.46). Khantzian (1974) stresses that treatment programs for addicts should focus on clear structure and limit-setting and suggests that internalization of program rules may provide the beginnings of some kind of internal psychological structure and organization, just as internalization of the mother's caring, regulating and monitoring functions should have fostered psychic development in the infant.

Khantzian (1985,1989) proposed that drug abuse is not self-punishment or self-destruction but self-medication of painful affects and related psychiatric disorders:

Affects are traumatic because they are undifferentiated and confusing. Therefore they are threatening and feel out of control... [addicts] try to change the passive, nameless dysphoria they do not control to an active dysphoria associated with drug effects which they do control" (Khantzian, 1989, p.75).

O'Brien & Rickels, 1979) provide evidence for the coexistence of psychopathology in drug dependent individuals and Khantzian (1985) cites these as evidence for a self-medication hypothesis of drug addiction.

6.4 **Wurmser's Formulation Of The Psychodynamics Of Compulsive Drug Use**

Khantzian has suggested that addicts use narcissistic defences and display narcissistic attitudes and traits. Kohut (1971) and Kernberg (1975) discuss how disturbances in early childrearing can lead to narcissistic disturbance later in life, predisposing these individuals to drug addiction. Wurmser (1974, 1977, 1978,) has systematically explored the relationship between narcissism and addiction and has proposed a model to explain the interaction between pathological narcissism, defect in affect defence, faulty ego ideal formation, pathological dependency, and problems with rage and shame.

The literature reviewed emphasizes the core role of narcissistic disturbance in the genesis of drug use and relapse back to drug use after periods of abstinence. Wurmser agrees with Khantzian that narcissistic disturbance in addicts is related to a lack of inner structures which are normally developed in the first two to three years of life when the child comes to terms with frustrations to his omnipotence and when boundaries between self and others are established. If this is successfully achieved the infant will learn to regulate
self-esteem, and to differentiate and manage affects. In the absence of these fundamental developments, the damages "express themselves as massive narcissistic conflicts and primitive aggressions, directed with little differentiation against others and the self, as a general problem about boundaries and limitations, as archaic forms of defences, as structural deficiencies of manifold nature" (Wurmser 1978, p.232).

For individuals with a narcissistic disturbance, the conflict between expectations and reality forms a narcissistic crisis for the individual, involving overwhelming affects such as rage, shame, shattering disillusionment, terror and despair. Initially, aggression may be employed to force an expansion of boundaries and limits. If attempts to force a change in the external world fail, primitive internal defences such as splitting, fragmentation and somatotization will follow. According to Wurmser if these psychic defences are ineffective, the search for external defences becomes paramount. Drugs provide the ideal affect defence because they quickly and "magically" alter or alleviate unbearable internal states. Wurmser (1974,1978) describes this chain of events as affect regression and breakdown of affect defence. Affect regression refers to the generalization, radicalization and totalization of affects. Krystal and Raskin (1970) describe this as dedifferentiation, resomatization and deverbalization. When this occurs, feelings become overwhelming and out of control because they flow into each other in an
undifferentiated whole. Hyposymbolization, the curtailed ability to symbolize, results in affects being translated into somatic complaints like craving and physical discomfort. Generalization of emotions leads to exaggerated feelings where one hurt becomes a life of hurt. This potent mixture of feelings can also serve to express repressed instinctual drives, mainly aggression.

Overwhelmed with unmanageable affects and intense destructive wishes, the search for affect defence begins. These typically take the form of types of avoidance defence such as denial and repression; dissociative defences such as splitting; action or fight defences such as externalization; and boundary and limitation types of defence which achieve fusion and blurring, such as introjection, projection, idealization and devaluing. Pharmacogenic defence in the form of drugs will be sought as a substitute for deficient psychological defences and structures. Denial, splitting and externalization bolstered by the effects of the drug produce a magically heightened self-esteem.

Wurmser points out that externalization, "the action of taking magical, omnipotent control over the uncontrollable" (1978, p.146), is an extremely important defence in this process yet it rarely receives adequate attention in the literature. Externalization is akin to acting out instead of working through and is a total denial of the true locus of the problem. Wurmser agrees with Khantzian (1977) that what appears to be a talent for manipulation is really an archaic superego struggling
for self-esteem. He cites the example of the patient who does not turn up for an appointment. While the countertransference of the therapist may be that this is an aggressive act designed to wipe out or devalue the therapist, Wurmser suggests the message is designed to bolster the self-esteem of the patient; "I do not need you. You wait for me while I have my fun. Once I waited in vain for a meaningful other person, I am not fooled a second time. You mean nothing to me" (1978, p.150). In the same way, lying to cover up drug use is done to avoid crippling shame rather than to dupe the therapist; "I am well; I do not need you. I am in control of the situation. What temerity on your part to declare me in need of treatment?" (1978, p. 150). Wurmser maintains that all forms of externalization represent magical power and are central to narcissistic pathology. With the magical transformation of the person's internal and external world, triumph over boundaries is achieved and all limitations are transcended and breached. This in turn brings regressive gratification, that is, narcissistic pleasure.

Wurmser (1974, 1978) breaks down the factors leading to the craving for, and compulsive use of, drugs into a "hierarchy of causes". The necessary precondition for the addictive search is a massive narcissistic disturbance in the personality. The immediate specific cause for the addictive search is a narcissistic crisis. The concurrent cause refers to factors which may not
Wurmser's model of the psychodynamics of drug use

- Acute narcissistic crisis
- Affect regression (narcissistic rage & shame)
- Search for affect defence and use of denial and splitting
- Breakdown of affect defence
- Externalization as defence by magical power (drugs)
- Aggression mobilized and used
- Superego split
- Pleasure

From: The Hidden Dimension
Wurmser, 1978, p.112
An elaborated way of expressing this would be:

Narcissistic disturbance: 
personality disturbance characterised by unresolved 
struggle for power and belief in omnipotence 
(this may be a central component of 
a number of personality disorders)

↓

Narcissistic crisis: 
any situation in which the struggle for power and the belief in one's omnipotence is thwarted or contradicted 

↓

Overwhelming Affect: 
shame or rage is experienced when the idealized omnipotent self is threatened 

↓

Aggressive Reaction:  
Some form of overt or covert aggression is employed in an effort to override the situation

↓

a) Defensive Mobilization 
Primitive defence mechanisms such as splitting, projection and denial will be employed 

↓

b) Breakdown of Defences 
If defence mechanisms fail, some kind of external means of relief (drugs) are sought. Drugs eliminate the overwhelming affects and restore a feeling of inner control 

↓

Narcissistic pleasure: 
This triumph over the narcissistic crisis leads to renewed feelings of power and omnipotence
always be present and cannot cause the effect alone if the precondition and specific causes are not present. These concurrent factors reflect value conflicts in our society. The precipitating cause is the "adventitious entrance" of the drug, chronologically the last factor immediately preceding drug use. Thus he describes the essential factor as a personality structure that predisposes the individual to acute psychic crisis evoking the craving for something to alleviate this experience.

While drug addiction is often referred to as a "vicious cycle", Wurmser (1978) suggests that the psychodynamics go deeper than the overt cycle of abstinence and relapse, pleasure and guilt. According to his model, during a narcissistic crisis, due to underlying defects in affect defence, overwhelming affects will lead to affect regression. Simultaneously, splitting and fragmentation in the form of denial will become the main defence mechanisms. Drugs provide a pharmacogenic defence via externalization and magical power. In order to achieve this externalization there must be an archaic aggressive splitting of superego and defence against superego functions which in the short-term bring narcissistic pleasure and alleviate narcissistic conflict. However, real self esteem has been damaged and the self is even less able to cope with reality, again making the individual prone to narcissistic crisis. Wurmser (1985a, 1985b) maintains that when defences are directed against the superego,
superego functions, as with all material that is denied and repressed (suppressed), will return in a primitive, externalized form. For example, the self-criticism functions of the superego return in the form of retaliation and humiliation from the outside; the denied ego ideal will take the form of a new ideal state of narcissism through drug induced narcissistic intoxication; self-punishment functions appear as social ostracism, penalties, imprisonment, death; self-protection functions become reliance on external objects such as drug dealers and NA sponsors; denied self-observation functions appear as shame (an affect arising from external scrutiny) instead of guilt and remorse arising from internal superego self-evaluation.

In summary, the chain of events according to Wurmser (1974) is as follows: (1) acute narcissistic crisis, (2) affect regression, (3) search for affect defence and use of denial and splitting, (4) externalization as defence through magical power, (5) aggression mobilized, (6) superego split and (7) pleasure.

6.5 Summary Of Psychodynamic Formulations Of Compulsive Drug Use

6.5.1 Structural Deficit Explanations Of Compulsive Drug Use

Contemporary psychoanalytic theorists view the management of affects as the major function of abuse of mood-altering substances. Dodes (1990) builds on the work of Wurmser and Khantzian and discusses the central role
of feelings of powerlessness and rage in the initiation of, or relapse to, addictive behaviour. The self-medication hypothesis (Khantzian, 1985) proposes that an individual's drug of choice will be determined by the particular affect they are seeking relief from. It has been suggested, for example, that heroin is mainly abused for the alleviation of anger. Once aggressive affects have been dulled, the resulting emotional state may become so boring and empty that the addict will periodically abuse stimulants in order to experience some alive feelings (Wurmser, 1974). In this way, drugs are chosen to relieve or induce affects in a kind of "simulation" of the normal range and control of human emotion. There has been much work on the relationship between compulsive drug use and affect management, including management of depression, aggression, anxiety rage and shame (Khantzian, 1978; Milkman & Frosch, 1973; Wurmser, 1974). This raises the question of why addicts require drugs for affect-management. Non-addicted people seem to be able to manage their affects without drugs.

Krystal and Raskin (1970) proposed that individuals prone to addiction suffer a basic impairment in their ability to manage affects. They suggest that the stimulus barrier in these individuals is defective, leaving them unable to ward off unbearable affective states. Drugs are used as a substitute for this defective psychic structure. In normal development, the infant should progress from this early stage to a more mature stage where they internalize the parent's ability to
contain and process emotions. It has been suggested that addicts have not internalized psychic structures for managing their emotions and, in their drug use, have found a parental substitute to perform the function of affective management for them. In a similar vein, McDougall (1984) suggests that the anxiety and narcissistic fragility that is experienced by some individuals in the face of emotional arousal arises from a disturbance in the original mother-infant relationship, where the infant's right to exist is negated by the mother simultaneously controlling but being out of touch with the infant's emotions. The kind of mother McDougall (1984) describes would not provide the emotional support Bion (1988) describes as containment, leaving the infant (and later the adult) to develop other ways of dispersing emotional arousal. McDougall (1984) used the term "disaffected" to describe patients who disperse emotions in actions such as drug and alcohol use as a means of avoiding affective flooding. Kohut (1971) also suggests that drug use serves as a replacement for a defect in the psychological structure of the individual.

6.5.2 Object Relations Perspective Of Compulsive Drug Use

Other authors (Krystal & Raskin, 1970; Wieder & Kaplan, 1969; Wurmser, 1974) have further suggested that the drug is yearned for, not only as a substitute psychic structure or function, but as a substitute object for a yearned-for parent. Kernberg (1975) saw addictive behaviour as a reunion with a forgiving parental object.
This may correspond to Kohut's emphasis on the dual role of parents as mirror for the infant's omnipotence and omnipotent ideal objects that the infant can merge with. Dodes (1990) suggests that the appeal of handing over control for one's life to a higher power, as prescribed by Alcoholics Anonymous, lies in the fulfilment of the desire to find and merge with an omnipotent object. The author recalls one patient who claimed to be instantly cured of all "nasty" traits through his relationship with his higher power. He magically found that he was no longer aggressive, abusive, vengeful or selfish, but instead had become serene, forgiving and loving. The extent of his new-found goodness was almost god-like. His usual narcissism now took on a new complexion. Instead of being self-righteous about his superiority compared to others, he now boasted about how forgiving and humane he was. When he spoke of his higher power, it was not with the humility of a servant of God but with the complacency of one who is so close to God, he himself has become a god.

6.5.3 Pathological Narcissism and Compulsive Drug Use

According to psychodynamic theory, individuals with pathological narcissism also have a defect in affect management. Theories of the development of pathological narcissism suggest that the omnipotent infant may in some way miss out on or block the internalizing of the mother's ability to manage affects. Kernberg maintains
that this is due to a constitutionally high amount of aggression that cannot be managed by the parent, and can only be managed by the child through defences rather than psychic structures. Kohut argues that the parent's failure to mirror and be idealized blocks development of ego structures based in internalization of parents. In Rosenfeld's view, pathologically narcissistic adults use others for their affect-management capacities but also envy this capacity in others. This can lead to a negative therapeutic reaction if the patient envies the therapist's ability to be calm in the face of intense emotions in the patient and to contain his own emotions. Through projective identification the adult still, as they did as an infant, tries to put the emotions into the "mother therapist" so they can be processed, because the patient cannot do this himself.

The general consensus among psychoanalytic theorists is that pathologically narcissistic people abuse drugs to gain omnipotent control over internal (affective) states. Their desire for this control comes from their narcissism. Their inability to effect this control through natural psychic capacities is due to a related deficit in their psychic structure. Drug use serves a self-soothing function which is akin to the self-preservation functions of the ego (Khantzian & Mack, 1987).

Wurmser (1984) conceptualizes drug use as a special kind of affect management, that is, the cessation of unpleasant, archaic, punitive superego-induced affects.
such as shame and guilt. Aggression in response to some narcissistic injury is inhibited by the superego via shame. He suggests that drugs are used, not just to alleviate the affects, but more to end the tyranny of the superego and thereby restore the power of the ego.

Much has been written (Khantzian, 1985; Milkman & Frosch, 1973) about the way an addict's drug of choice will be determined by the predominant affect the individual is seeking relief from. However, many features of addiction support the notion that drugs are being sought, not for the alleviation of specific affects, but as a means of effecting the more global aim of altering internal states and thereby restoring omnipotent control over the self. Wurmser (1974) points out that heroin addicts will often use other drugs interchangeably depending on availability, and many addicts are polydrug abusers.

Wurmser (1974) has based his model of addiction on the notion of affect-management, particularly the alleviation of painful affects arising from narcissistic injury. Dodes (1990) suggests that the primary role of addiction is the desire for omnipotent management of one's own affective state, as a defence against feelings of helplessness and powerlessness. Loss of control is the greatest form of psychic trauma. The insistence on power over one's internal state, according to Dodes, is the essence of narcissism. In describing the "catastrophic reaction" of individuals to acute brain damage, Kohut (1972) referred to the narcissistic importance of being
in control of one's mind. Kohut also described the enraged reaction of patients, especially early in analysis, to slips of the tongue which are experienced as the sudden exposure of their lack of control over their own mind. Dodes (1990) concludes "in light of the core narcissistic importance of maintaining psychic control, it is significant that drugs are a device par excellence for altering, through one's own intentional control, one's affective state" (p.401). Feelings of helplessness and powerlessness are the greatest insult to omnipotence, therefore drugs will be sought because "by acting to take control of one's own affective state, addictive behaviour may serve to restore a sense of control when there is a perception that control or power has been lost or taken away" (pp.401-402) (that is, in a narcissistic crisis). Dodes emphasizes that drug use does not merely serve, as suggested in the self-medication hypothesis, to alleviate painful affects, but to alleviate the terror of helplessness one feels when flooded by affects. Kohut and Wolf (1978) referred to addictions as "narcissistic behaviour disorders".

The important implication of these conceptualizations is that the relief brought by drug or alcohol use may not solely arise from the pharmacological properties of the drug but also from the active intention to regain affective control. Smoking is another interesting example because nicotine does not produce the kind of intoxication that is associated with other drugs of addiction. Although nicotine is a stimulant, most
smokers report that smoking calms their nerves. Smokers also report that they smoke to alleviate a variety of affects including anxiety, anger and depression. There is no pharmacological explanation for this. Blatt (1990) has suggested that cigarettes are used to maintain affective equilibrium and that smokers will reach for a cigarette whenever they experience a shift from affective neutrality. Blatt has drawn a parallel between smoking and the soothing properties of a mother. The oral gratification of smoking may be linked to earlier experiences of being comforted by sucking a nipple, irrespective of the specific nature of the infant's distress. Non-drug addictions, such as compulsive eating and gambling, may also provide a more general affect-management function than the alleviation of any specific affect. This would also explain why some alcoholics begin to feel relief from tension at the point of ordering a drink, or why heroin addicts can feel intoxicated when they inject an empty needle ("needle-freaking"). The steps involved in preparing various modes of drug use, such as injecting, smoking, sniffing and drinking, often become ritualized and produce considerable pleasure in themselves. This suggests that something has been accomplished merely by the act of obtaining the drug, i.e., a signal of re-establishment of internal mastery. Behaviourists such as Wikler (1971) explain these phenomena in terms of conditioned responses. Psychodynamic formulations explain non-drug intoxication as resulting from the re-affirmation of potency, rather
than just a conditioned response. Experiences of powerlessness are central to addiction, as reflected for example in the first step of the Alcoholics Anonymous programme which involves admitting powerlessness. From a psychoanalytic perspective the common factor in all addictions is the desire for total omnipotent control.
7.1 Programme Policy Regarding Extracurricular Drug Use In Methadone Patients

There has been much research into extracurricular drug use during methadone treatment, as reviewed by Mattick and Hall (1993). The authors concluded that abstinence from heroin and other drugs is not a realistic treatment goal: programmes should aim to retain patients in treatment and implement standard policies for addressing/accepting extracurricular drug use. One study found that while 35% of patients had ceased heroin use or used heroin less than once a month, 20% used heroin 1-2 days per month, another 20% used heroin on 3-8 days per month and 25% used heroin on three or more days per week. Overall, 38% of urine screens in a three month period were positive for morphine (Howard 1993).

One response to the high rate of drug use reported in methadone patients has been the policy of blockade doses; providing such high doses of methadone that, theoretically, the effects of other drugs will be blocked pharmacologically. The disadvantage of this solution is that patients will find it difficult and undesirable ever to come off methadone, often sentencing them to a lifetime of methadone. Also, the quality of an individual's emotional life must surely be at issue with
this type of "chemical straight-jacket" approach, especially when blockade dosing may not always stop extracurricular drug use as evidenced by modest rates of heroin cessation and reduction (Mattick & Hall, 1993).

Another approach to the problem of extracurricular drug use in methadone patients has been incentive systems that reward patients with special privileges if they do not use drugs. The right to take-home doses, transfers to other methadone units for the purpose of a holiday, less frequent urine testing etc can be earned by refraining from using drugs, as evidenced by urinanalysis. The existence of such rewards can become a source of intense frustration and rage in those patients who simply cannot control their compulsion to use drugs even in the face of such attractive incentives. Some of these people will, as described earlier, feel compelled to resort to deception in order to "earn" privileges that would otherwise be denied to them. Efforts to use punishments such as programme termination, increased urine testing etc, as disincentives for drug use also face the same problems, with patients employing deception, intimidation etc to avoid detection or to forestall the enforcement of the punishment.
Given the importance of the individual's underlying psychodynamics and psychopathology in our understanding of compulsive drug use in general, these principles can also be applied to the problem of extracurricular drug use in methadone patients. This is particularly the case, given the fact that patients are receiving sufficient doses of methadone to meet their physical need for opiates and therefore any extra drug use can be viewed in terms of the patient's psychological need for mood-alteration.

It is well known that heroin addicts receiving methadone often continue to use drugs or will use drugs periodically (Mattick & Hall, 1993). Methadone dosage generally follows one of two principles. The first is blockade dosing; providing a very high dose (120mg or more) to block the effects of any additional heroin the person uses. The other approach is to find the right dose for each individual that will be high enough to prevent physical withdrawal but not high enough to make the person intoxicated. The methadone unit used in this study adopts the latter approach, resulting in daily doses generally ranging from between 30mg and 100mg.

Nicholson and Treece (1981) reviewed the literature on extracurricular drug use in methadone patients and point out that studies have generally focused on biological factors such as variations in metabolic rates, residual withdrawal effects and conditioned craving.
While these factors may account for initial problems during the stabilization period, for many, drug use persists and becomes a chronic pattern. The initial period of 'testing' that is often observed, related to curiosity about the potency of methadone compared to street heroin, or to a fear that street heroin is required to supplement the methadone, also does not explain persistent drug use. Given that following a period of dose stabilization and initial experimentation, patients receiving methadone do not experience physical withdrawal symptoms, any extracurricular drug use must be attributed to psychological rather than physical needs. This phenomenon can also be seen in smokers who continue to smoke even when a sufficient dose of nicotine is administered through a nicotine patch or nicotine gum. Again, the smoking cannot be attributed to the individual's physiological need for nicotine. When taking a psychological perspective, as is the focus of the present thesis, drug use during agonist therapy must be attributed to psychological rather than physiological factors. Nicholson and Treece note that studies in this area are usually limited to investigating psychological functioning in terms of specific psychiatric diagnoses, and individual differences in response to methadone have been linked with diagnosable psychiatric disorders, usually schizophrenia or depression. Treece and Nicholson (1980) have taken this a step further, and found a strong correlation between stabilization dose and different personality disorders.
Beyond diagnosable disorders, different rates of extracurricular drug use may also be related to differences in personality development or ego structure. Psychodynamic theories of drug addiction, rather than diagnostic nomenclature, can be utilized to understand the possible dynamics underlying drug use in methadone patients. An example of this is the study of object relations and differential response to methadone treatment by Nicholson and Treece (1981). Subjects were divided into two groups, defined by high and low extracurricular drug use, and were compared on the dimensions of separation/individuation, narcissistic development and self and object representations. The strongest differences between high and low drug users were found in the area of narcissistic development, lending support to psychodynamic formulations of drug use that emphasize a core disturbance in the narcissistic development of the individual. While the authors acknowledge that the findings must be interpreted cautiously given the small sample size and the use of a newly developed, unvalidated scale, any empirical support for the hypothesized central importance of object relations, particularly in the realm of narcissism, is encouraging for psychodynamic theory. Another study by Rutherford, Alterman, Cacciola and Cook (1996) investigated object relation impairment in 146 methadone patients and found that severity of extracurricular drug use was related to an impairment in egocentricity. These studies also lend support to the application of general
psychodynamic formulations of drug addiction to the specific area of investigation in the present studies: extracurricular drug use in methadone patients.

Wurmser (1974, 1977, 1978) has written extensively on narcissistic rage in methadone patients. According to his view, when the patient's unfounded expectations of exemptions from rules, laws and standard practices are not fulfilled, efforts to extort special treatment will reach desperate proportions, often leading to aggression. Similarly, when the person encounters their own limitations, there will be a desperate attempt to deny the external psychic reality. According to Wurmser, when aggression, deception and denial fail, affective control is still sought via mood-altering substances, as a means of escaping from the psychic pain of narcissistic injury, because the stabilization dose of methadone will be insufficient to overcome the intense emotional pain. Again, the assumption here is that compulsive drug use, in this case extracurricular drug use in methadone patients is due to narcissistic rage arising from pathological narcissism.

Unrealistic narcissistic beliefs about self and others will not be confirmed. For example, the person believes that now they will conquer all problems but in fact, problems persist. They believe that they will be treated as someone special but in fact they will be subject to the same rules as everyone else. A crisis will ensue when things come to a head, for example, the person arrives after closing time and cannot get their methadone. Wurmser (1985a, 1985b) describes how, in addiction and underlying narcissism, defences are directed against the superego such that self-observation, self-care and self-critical functions are externalized and experienced as coming from harsh external punitive authorities, in this case, the methadone staff. The world, like the superego is attacked because it contains limits, authorities, responsibilities commitments and consequences. The id's wishes (I will come for my methadone any time I feel like it and I will be served on demand) are no longer modified by the superego. Unrestrained by the denied repressed superego, the patient will try any means to gain gratification with no self-evaluation of their wishes or actions. Perhaps denial will be employed and the person will insist that they did not realize the unit would be closed, or will insist it was not their fault. If that does not work, they may try manipulation. They may claim that if they do not get methadone, they will have to use heroin and this will put their child at risk. Alternatively they may try to break in or they may actually go and use heroin straight away; not because
they are in physical withdrawal but because they are so angry: the affect-stabilization function of the superego also denied and replaced externally.

Wurmser (1974) made the following observations working extensively with methadone patients in psychotherapy. All sought relief from intense feelings of murderous rage or profound shame and abandonment. They reported that methadone dampened these moods and brought great relief. However, the resulting emptiness and boredom that occurred once their emotions were dampened became unbearable and led to the use of other drugs such as amphetamines and cocaine. In addition to the alleviation of emptiness, these drugs restored feelings of invincibility and grandeur. At other times, when their rage or shame was so intense that methadone did not provide sufficient relief, drugs that would help to dampen emotion further were sought, such as heroin, alcohol or valium. Wurmser found that rage was the most prominent emotion, arising when the external or internal world did not live up to idealized expectations. If this experience continued unabated, total devastation in the form of intense shame followed. All extracurricular drug use appeared to function as a defence against intense affects resulting from narcissistic conflict. Khantzian (1974) observed patients in methadone treatment and found that methadone subdued aggressive behaviour associated with narcissistic pathology in some patients (although this effect disappeared as soon as patients were withdrawn off methadone) but others with more severe
forms of narcissistic pathology needed to supplement their methadone with other drugs. Khantzian concluded that "how one responds to methadone maintenance is related to the capacity that an individual has to relinquish his narcissistic orientation to life..." (1974, p.66). Wurmser concluded that the underlying conflict is always narcissistic and the extracurricular drug of choice will depend on which affect is strongest. Wurmser's hypothesis that methadone patients, like all compulsive drug users, will use drugs to alleviate the pain of a narcissistic crisis, forms the basis of the second study in this thesis.

The above conclusions are supported by the results of a study by Treece and Nicholson (1980) which indicate that patients with no personality disorder are most likely to be on the lowest doses of methadone. From an analysis of the ego functioning status of the high dose patients they concluded that:

the characteristics of addicted patients described by Khantzian and others parallel our research observations very closely. Disorders of thinking without formally impaired reality testing, narcissistic pathology, and self-esteem, and inadequate management of affects, particularly rage, and the conviction that narcotics supply the needed buffer to give life a semblance of balance and normality - all have been mentioned repeatedly in the literature (Treece & Nicholson, 1980, p.627).

This case material from Wurmser and Khantzian, supported
by the study by Nicholson and Treece and the study by Treece and Nicholson suggests that the psychodynamics of compulsive drug use outlined earlier, in particular the role of narcissistic pathology and need for alleviation of narcissistic rage, can be applied to extracurricular drug use found in methadone patients.

In summary, psychodynamic formulations of drug addiction focus on the relationship between a compulsion to take drugs and the personality organization of the individual. Psychotropic drugs provide relief from painful internal states that arise from deficits in ego functions, dating back to difficulties in the infant's psychological development. Early object relations, particularly in terms of the mother/infant matrix, determine the structure of the personality, and therefore can lead to pathological functioning in adult life, including problems with autonomy/dependence, manifesting as narcissistic personality structure and associated drug dependence. Object relations theory explains narcissism in terms of the infant's self representations, or phantasized self which does not evolve into a more accurate image of self. The infant's mental image of itself as being omnipotent is retained, either due to a stunting of development (Kohut) or as a defence against development (Kernberg). The result is an adult whose mental image of himself (self representation or self object) retains its infantile narcissistic qualities. Wurmser's formulation represents an in-depth study of narcissistic disturbance in compulsive drug users.
Through mood-altering drugs, individuals attempt to re-establish or reinforce self-representations which are grandiose and idealized. Without drugs, overwhelming feelings of rage and shame are experienced when reality does not correspond to the individual's self representation. In the specific group of drug users in the present study, methadone patients, this narcissistic rage is manifested in the methadone clinic in the patient's aggressive, denigrating and demanding behaviour towards methadone staff (transference) and is experienced and responded to by those staff members (countertransference). The two main psychodynamic theorists in the area of methadone treatment, Khantzian and Wurmser, have both emphasized the central role of narcissistic pathology to account for high rates of extracurricular drug use among methadone patients. Khantzian suggests that methadone serves to relieve painful affects and concludes that whether or not an individual will give up their drug use will depend upon their capacity to relinquish this kind of narcissistic gratification. Wurmser suggests that the personality structure of addicts predisposes them to be vulnerable to narcissistic injury. Methadone provides relief from the psychic pain of narcissistic crises. Extra drugs may be sought when the methadone needs to be supplemented for relief from painful affects or to alleviate the boredom and emptiness that can ensue when all affects are medicated away. From these formulations, we might expect to find that the main difficulties that arise in
methadone clinics involve high levels of narcissistic disturbance and behaviour in patients, high levels of extracurricular drug use among patients, and high levels of stress among staff.

Nicholson and Treece (1981), in their study of the relationship between object relations and extracurricular drug use among methadone patients, found that the strongest and most unambiguous difference between high and low drug use groups was the level of narcissistic disturbance. Further research is needed to investigate their important findings. In the present studies, an instrument for observer measurement of the level of narcissistic rage in a methadone patient was constructed and validated and this instrument was then used in a study to investigate the possible relationship between a patient's level of narcissistic rage and their level of extracurricular drug use.

7.3 Summary and Conclusions: Rationale for the Present Study

Methadone treatment has been identified as an important area for research, particularly the issue of treatment outcome as measured by extracurricular drug use. To date, studies have found that the most important factor affecting methadone treatment outcome is the presence and severity of concomitant psychopathology. Rather than studying psychopathology via diagnostic categories, an alternative approach is to focus on
disturbance in intrapsychic functioning as it is reflected in pathological behaviour.

It has been suggested that the most prominent and problematic kind of pathological behaviour seen in methadone patients is pathological anger. This anger is distinguished from normal reactive anger. Given the consequences of pathological anger in methadone patients, in terms of implications for both staff and patients, it would appear to be an important area for research, particularly with regard to its possible effect on treatment outcome.

An analysis of the psychodynamics of the individual yields insights into the possible cause of the pathological anger displayed by some methadone patients. Narcissistic personality structures in compulsive drug users, predispose individuals to narcissistic crises involving the experience and expression of intense anger; narcissistic rage. This rage will lead to hostility, aggression or deception which is designed to force a change in the external environment. When these attempts fail, relief is sought by forcing a change in the individual's internal environment: mood-altering drugs are used to restore psychic control. To date, this formulation of the psychodynamics of compulsive drug use has not been sufficiently tested. Further, there are no existing instruments that could be used by general staff at a methadone clinic for measuring an individuals' level of narcissistic rage. This has limited the scope of
research into the possible influence of narcissistic rage on methadone treatment outcome.

Given that many compulsive heroin users may suffer from narcissistic disturbance, AND given that methadone treatment, with its controls and regulations, provides fertile ground for the experience of narcissistic crises, it becomes clear why so many methadone patients seem to display a high frequency of narcissistic rage. The study of the psychodynamics of narcissistic rage and drug use in methadone patients, provides possible explanations for the high frequency of extracurricular drug use reported in methadone patients. By definition, high rates of extracurricular drug use mean poor treatment outcome, since the goal of MMT is the reduction or cessation of drug use. The implication is a possible link between narcissistic disturbance (manifested as narcissistic rage) and extracurricular drug use among patients in methadone maintenance treatment. Nicholson and Treece (1981) found a relationship between level of extracurricular drug use in methadone patients and level of disturbance in narcissistic development. This relationship is an important area for research, both in understanding differential response to methadone maintenance treatment, and the psychodynamics of compulsive drug use. In the present study, the need for a psychometric instrument for the measurement of an individual's level of narcissistic rage is addressed, with the aim of developing an instrument that combines theoretical foundations with
broad, accessible clinical application. The instrument is then used to investigate the relationship between level of narcissistic disturbance and extracurricular drug use among methadone patients.
CHAPTER 8

STUDY 1: DEVELOPMENT OF THE NARCISSISTIC RAGE SCALE FOR METHADONE PATIENTS

8.1 Construction and Validation Of the Pilot Narcissistic Rage Scale

8.1.1 Background and Rationale: Existing Methods for Measuring Pathological Narcissism

Existing methods for measuring an individual's level of narcissistic pathology have important limitations in terms of their relevance and usefulness for the purposes of the present study.

One method for assessing or identifying individuals with narcissistic pathology is to employ diagnostic criteria. At face value one approach might seem to be to study patients with Narcissistic Personality Disorder, using DSM IV criteria or the MMPI Narcissistic Personality Disorder Scale. However, many other personality disorders are associated with narcissistic disturbance, in fact we would expect to find varying levels of narcissistic disturbance in anyone with a personality disorder.

All character defences have, among other functions, a narcissistic one: they protect self-esteem. In addition, there are patients with all kinds of character pathology who present marked character defences especially erected to protect or enhance self-esteem. These latter cases have "narcissistic
character defences” in an essentially non-narcissistic personality structure, which has to be differentiated, therefore, from the narcissistic personality in the narrow sense...(Kernberg, 1970, p.62).

Dodes (1990) emphasizes that the sense of helplessness that is central to addiction, may arise from conflict at any level of psychological development and may not be implicated in any one syndrome. He suggests that “narcissistic fragility” is not solely the domain of narcissistic personality disorders and adds that most addicts are not narcissistic characters. For example, a narcissistic blow may be experienced within the context of separation-individuation/autonomy issues or oedipal issues.

Put another way, since narcissistic injuries occur at all psychosexual levels without resulting in a character that is dominantly narcissistic, the sensitivity to feelings of impotence or powerlessness, which I suggest is important to addiction, may occur in a wide variety of character structures. The narcissistic disturbance I am suggesting as a predisposition to addiction is, in fact, narrower than that in narcissistic personality disorder (Dodes, 1990, p.409).

Similarly, Khantzian and Mack (1987) have also suggested that there are narcissistic sectors in the personality structures of alcoholics.
Even if narcissistic pathology can be shown to be associated with particular personality disorders, additional problems remain. The personality disorders cover a multitude of features and often entail difficult diagnostic dilemmas. The DSM IV cautions that diagnosis of personality disorders is difficult and depends on assessment of traits over time and across different situations, often necessitating multiple interviews spaced over time, not relying on self report (American Psychiatric Association, 1994). Also, an individual may fulfil the criteria for more than one personality disorder, indeed some personality disorders are often found to co-exist (DSM IV, 1994) and this has particularly been the case in studies of personality disorders in opiate addicts (Kosten et al. 1989). Many personality disorders including Paranoid Personality Disorder, Borderline Personality Disorder, Antisocial Personality Disorder, Narcissistic Personality Disorder, Histrionic Personality Disorder and Passive Aggressive Personality Disorder are all associated with pathological anger and narcissistic features (Kernberg, 1970). Sensitivity to feelings of impotence and powerlessness which lead to pathological rage occur in a wide variety of character structures (Dodes, 1990). Kernberg (1985) maintains that narcissistic pathology can exist at various levels, corresponding to less or more severe types of psychopathology. He suggests that narcissistic problems are involved in all neurotic reactions and character pathology, as evidenced by "a pathological
defended against by pathological character traits" (p.322). These factors make research on pathological narcissism, based on personality disorders, very difficult. In general, diagnostic categories may not provide the most fruitful basis for research into the relationship between level of psychopathology and outcome in MMT (Nicholson & Treece, 1981).

Problems in classifying Personality Disorders have been exacerbated by the clustering system which groups Personality Disorders according to descriptive similarities. Cluster A groups disorders characterized by odd or eccentric presentation and includes the Paranoid, Schizoid and Schizotypal Personality Disorders. Cluster B groups disorders characterized by dramatic, emotional or erratic presentations and includes the Antisocial, Borderline, Histrionic and Narcissistic Personality Disorders. Cluster C groups disorders characterized by anxious and fearful presentations and includes the Avoidant, Dependent and Obsessive-Compulsive Personality Disorders. As discussed previously, the DSM IV cautions that the clustering system for Personality Disorders "has serious limitations and has not been consistently validated. Moreover, individuals frequently present with co-existing Personality Disorders from different clusters" (p.630). Despite these problems, the clustering system has been widely utilized in research based on diagnostic categories. In an attempt to address some of these problems, DSM IV has proposed a new axis for
further study, the Defensive Functioning Scale, which classifies patients according to the type of defence mechanisms that most characterize their coping style, which provides more information than the Personality Disorder classifications. The defences are categorized according to adaptive level, ranging from optimal adaptation defences through to minor reality distortion and finally, major reality distortion and defensive dysregulation. While individuals with primarily narcissistic defensive styles may be classified into various Personality Disorders, therefore appearing as if they are different entities, according to the Defensive Functioning Scale, they would be classified in the same groups; Minor image-distortion level (devaluation, idealization and omnipotence) and in more severe cases the Major image-distortion level (autistic fantasy, projective identification and splitting of self-image or image of others). Of course this scale requires further study but does highlight the fact that the Personality Disorders classification system and the associated clustering system for Personality Disorders may have largely contributed to the masking of the similarities between many of the Personality Disorders, particularly with regard to predominant defensive style, which is the major factor in the treatment and prognosis of these individuals. Kernberg (1970, 1974, 1975) emphasizes that all character disorders involve narcissistic character defences to protect self-esteem which can form part of an
Since most addicts have a psychiatric disorder, some studies have investigated the relationship between psychiatric diagnosis and outcome in methadone treatment (Kosten, Kosten & Rounsaville, 1989; Kosten, Rounsaville & Kleber, 1982; Treece & Nicholson, 1980). Treece and Nicholson (1980) found a strong relationship between personality disorder and methadone dose. Patients were clustered into Types A, B and C as described previously. Patients with schizoid-like disorders had significantly higher doses than patients with other diagnoses. Clinical narrative material was also utilized and revealed that patients on higher doses exhibited high levels of narcissistic pathology including poor object relations, identity, and self-esteem, and inadequate management of affects, particularly rage. All seemed characterized by intense defensive processes. The authors concluded that diagnosis alone does not tell the whole story and they recommended the development of other ways to tap subtle dynamic structures involved in compulsive drug use.

Given that most addicts have a diagnosable personality disorder (Khantzian & Treece, 1980; Kleber, 1983; Kosten, Kosten & Rounsaville, 1989; Kosten, Rounsaville & Kleber, 1982; Rounsaville, Weissman, Kleber & Wilbur, 1982; Strain, Brooner & Bigelow, 1991), identifying addicts with personality disorders may not provide a useful way of differentiating between patients. So, while early studies attempted to identify an essentially narcissistic or non-narcissistic personality structure.
"addictive personality", it is now accepted that personality disorders among addicts are common and heterogeneous. Could it be, then, that a psychic structure or disturbance common to many personality disorders may be at the core of compulsive drug use? The prime candidate here is a disturbance in ego functioning; a narcissistic disturbance. For example Kosten et al. (1989) point out that borderline opioid addicts have the greatest severity of psychiatric problems and need special treatment. Kernberg argues that borderline patients have major problems in the narcissistic realm and utilize primarily narcissistic defences. Kaplan (1977) lists the salient features of borderline syndrome and includes four elements central to narcissistic pathology: (1) intense self-centredness and preoccupation with need satisfaction, with obliviousness to the rights, needs and desires of others; manipulative relationships where they using others as a supplier of needs; (2) insufficient demarcation of self-boundaries and intensely dependent relationships where the other is not viewed as separate but as part of the self; (3) self-esteem is highly volatile and dependent on external sources rather than inner resources; (4) self-control is poor and dependent on external sources. In addition to general limitations associated with identifying narcissistic pathology through diagnostic categories, diagnosis was not used in the present study because patients would not consent to participating in one or more interviews for the purpose of being diagnosed. Further, a diagnosis may
indicate the presence but not the level of narcissistic disturbance in an individual.

A second method sometimes used for measuring narcissistic disturbance is the use of the Narcissistic Personality Inventory (Raskin & Hall, 1979), a 54 item forced-choice questionnaire based on DSM IIIR diagnostic criteria for Narcissistic Personality Disorder. The inventory is not necessarily a measure of a personality disorder and the authors suggest it should be regarded as a measure of pathological narcissism. This inventory was not used in the present study for three reasons. First, although it is purported to be a measure of pathological narcissism, it does rely heavily on diagnostic criteria for Narcissistic Personality Disorder. Second, for the purposes of the present study, the probability of getting sufficient numbers of methadone patients to complete an inventory was very low. Third, the inventory has been validated in studies employing undergraduate students (Emmons, 1981; Emmons, 1984; Watson et al. 1984) and the subjects in the present study may not have the same level of insight into their own behaviour. The DSM IV cautions that the traits seen in Personality Disorders are often ego-syntonic and the individual may not regard these characteristics as being pathological or problematic, making self-report material unreliable. Woody (1977) suggests that, given that addiction is associated with serious ego pathology, researchers must be aware of the limited reliability of information obtained from the client's point of view. He suggests that the
psychoanalytic perspective should be utilized more in our understanding of addicts because it provides a unique way of getting information about personality structures. This would possibly result in the identification of personality types that will lead to modification in treatments, or in the identification of a subgroup of addicts that may benefit from psychoanalytic-oriented psychotherapy. Another instrument, the Narcissism Scale in the MMPI, presents similar problems.

A set of scales measuring object relations dimensions used by Nicholson and Treece (1981) included six items measuring the narcissistic dimension: (1) self reference in interaction with others; (2) presence of empathy; (3) exploitative and parasitic qualities in relationships; (4) contradiction between self-concept and need for approval from others; (5) omnipotent and grandiose fantasies; (6) presence of real sadness and mourning. The scale was developed from clinical concepts generally associated with this dimension. Although the study used a small sample and the scale was not validated, this observer-based instrument comes closest to fulfilling the requirements of the methodology of the present study. However, the scale relies on observers making sophisticated clinical judgements and, therefore, would not be suitable for use in the present study which set out to find an instrument accessible to the general staff in a methadone clinic.
8.1.2 Aim of the Study

The aim of Study 1 was to develop a psychoanalytically-based observer instrument to measure a patient’s level of narcissistic rage. This was later used to test the hypothesis which forms the basis of Study 2; that methadone patients with high levels of narcissistic rage use more extracurricular drugs than patients with low levels of narcissistic rage.

Since existing instruments did not meet the needs of the present study, that is, did not specifically measure narcissistic rage, and were not applicable to methadone patients, it was necessary to design an instrument for this purpose. In summary, when choosing a method for measuring narcissistic rage in the present study, there were four main considerations. First, the data would need to come from observers, not the individual. The instrument would eventually be used with a population of methadone patients and, as discussed previously, there are too many problems associated with the collection and reliability of self-report data in this population. Second, the measure should tap narcissistic rage, not narcissistic personality disorder or other diagnostic categories. Third, the aim was to collect data that were rich enough to tap complex psychodynamics, yet be easily and reliably obtained without the use of specialised clinicians and interviews. In the second study, the raters, generalist staff at a methadone unit, would not be expected to make sophisticated clinical judgements about the presence or level of pathological narcissism.
Therefore, the aim was to construct an instrument that could be used by anyone working in a methadone unit, based on the patients' observable behaviour. Fourth, the data should reflect a comprehensive knowledge of the individual over time, based on observable manifestations of pathological narcissism rather than pathological narcissism as a theoretical construct. It was decided that an individual's level of narcissistic rage, that is, the pattern and level of response to narcissistic conflict typically displayed by an individual, in this case, methadone patients, would provide the kind of observable data necessary for the purposes of this study.

As discussed previously, a narcissistic conflict can arise when reality does not match the individual's idealized view of self and others. Many different kinds of "behaviour" can be employed in an effort to force a change in the external world so that it more closely corresponds with the individual's internal world. The individual's behaviour also indicates the kind of beliefs and expectations they have about the situation and other people involved. This spectrum of responses may start with gentle questioning of others and assertion of one's own beliefs, and can progress to heated arguing and then open hostility.
A profile of features characteristically seen in narcissistic rage was compiled from the psychodynamic literature. Selection of relevant literature was based on two sources. The first source included prominent contemporary authors in the field of the psychodynamics of narcissism; in particular, Heinz Kohut and Otto Kernberg. The second source included prominent contemporary authors in the addictions field who formulate the psychodynamics of compulsive drug use in terms of underlying narcissistic character disturbance: Leon Wurmser and Edward Khantzian. The profile was largely based on the work of Leon Wurmser as he is the only author to provide a detailed account of narcissistic rage rather than pathological narcissism in general. The profile compiled also utilized descriptions of observable rather than hypothesized unconscious constructs in order to develop a profile of observable rather than theoretical features typical of narcissistic rage. The resulting list of features represents four areas of observable data; 1) the individual's stated or implied beliefs about themselves in relation to the interpersonal world, 2) the individual's stated or implied beliefs about and expectations of others, 3) the individual's efforts to change the external and interpersonal world so that it more closely corresponds with this internal world, that is, their observable behaviour, and 4) the individual's observable emotional reaction to
### TABLE 1: Features of Narcissistic Rage

<table>
<thead>
<tr>
<th>A) EXPECTATIONS AND BELIEFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of idealised unlimited capacity of self</td>
</tr>
<tr>
<td>grandiose, exaggerated, unrealistic sense of being omnipotent and without limitations, manifested as</td>
</tr>
<tr>
<td>* lack of recognition of boundaries in relationships</td>
</tr>
<tr>
<td>* lack of recognition of limits</td>
</tr>
<tr>
<td>* lack of recognition of limitations of self</td>
</tr>
</tbody>
</table>

Unfounded expectations as to how he will be treated and regarded

manifested as expectations and demands for

* being exempt from rules, laws, requirements
* special treatment and consideration
* automatic entitlement and "deservedness"

Unfounded expectations of idealised others

manifested as expectations and demands that

* the other be all-knowing and all-giving (that the other will never say "no" to him)

<table>
<thead>
<tr>
<th>B) BEHAVIOURAL REACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour designed to override limits and rules</td>
</tr>
</tbody>
</table>

manifested as

* denial of knowledge of the existence of the rule
* blurring of rules --> demands for exemptions
* deception
* aggression, intimidation, threat, seduction
* violation of rules

<table>
<thead>
<tr>
<th>C) EMOTIONAL REACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>An intense, disproportionate emotional reaction to anything that embodies a &quot;no&quot;, or that creates a discrepancy between expectations and reality, manifested as</td>
</tr>
</tbody>
</table>

* rage, aggression, violence, threat
* disapproval / disappointment in the other
* lack of empathy with the "offender"
TABLE 2: The Pilot Narcissistic Rage Scale

<table>
<thead>
<tr>
<th>Place a tick in the box if the patient displays or reports the experience/behaviour described</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. PERSONAL AND INTERPERSONAL CONSTRUCTS</strong></td>
</tr>
<tr>
<td>A) inadequate recognition of <strong>limitations of self</strong> []</td>
</tr>
<tr>
<td>B) inadequate recognition of <strong>boundaries in relationships</strong> []</td>
</tr>
<tr>
<td>C) inadequate recognition of <strong>limits, rules, and the constraints</strong> embodied in basic codes of behaviour []</td>
</tr>
<tr>
<td><strong>II. BELIEFS AND EXPECTATIONS</strong></td>
</tr>
<tr>
<td>D) <strong>unfounded expectations</strong> of being exempt from rules, laws, requirements, basic interpersonal responsibilities []</td>
</tr>
<tr>
<td>E) <strong>unfounded expectations</strong> of receiving <strong>special treatment</strong> and consideration []</td>
</tr>
<tr>
<td>F) <strong>unfounded expectations</strong> of <strong>automatic entitlement</strong> and &quot;deservedness&quot; []</td>
</tr>
<tr>
<td><strong>III. BEHAVIOURAL RESPONSE</strong></td>
</tr>
<tr>
<td>G) <strong>denial</strong> of any knowledge of the existence of rules, limits, codes of conduct (as an explanation for their behaviour) []</td>
</tr>
<tr>
<td>H) <strong>denial</strong> of any behaviour that contravenes or overrides rules, limits etc; ie asserting innocence []</td>
</tr>
<tr>
<td>I) <strong>deception</strong> performed in order to avoid, override or undermine rules, limits etc []</td>
</tr>
<tr>
<td>J) <strong>aggression, intimidation</strong> or <strong>seduction</strong> in order to avoid, override or undermine rules, limits etc []</td>
</tr>
<tr>
<td>K) <strong>open violation</strong> of rules, limits, codes of conduct []</td>
</tr>
<tr>
<td><strong>IV. EMOTIONAL RESPONSE</strong></td>
</tr>
<tr>
<td>L) <strong>intense</strong> and disproportionate <strong>rage</strong> (perhaps vented as violence, threats etc) <strong>in response</strong> to anything that embodies a &quot;no&quot; (ie to any limitation or boundary) []</td>
</tr>
<tr>
<td>M) <strong>intense, disproportionate disappointment</strong> in or <strong>disapproval</strong> of the person who enforces the &quot;no&quot;; lack of empathy for the enforcer []</td>
</tr>
</tbody>
</table>

TOTAL SCORE ---
discrepancies between their expectations/ beliefs and the real world, as manifested during a narcissistic crisis (see Table 1).

From this profile, a 13 item inventory, the Narcissistic Rage Scale, was constructed, covering 4 categories of observable characteristics: (1) personal and interpersonal constructs, (2) beliefs and expectations, (3) behavioural responses, and (4) emotional responses. These were put into the form of a scale where raters tick "yes" if the patient displays or reports the behaviour or belief, and "no" if the patient does not (see Table 2).

The scale was not designed to be used at an interview or as an initial assessment instrument. A one-off session would not provide enough opportunity to observe the person's characteristic reactions in the face of narcissistic crises. Instead, the scale was designed to be used by an observer who has had sufficient experience of the individual over time, so that there has been ample opportunity for interacting with the person, and for hearing about and observing the person's thoughts and experiences.

8.1.3.1 Face Validity of the Narcissistic Rage Scale

Face validity was established by mailing the scale to 30 experienced psychodynamically-orientated clinicians who were asked to state what they thought the scale was measuring (see Appendix 1). The clinicians were chosen
randomly from the membership lists of two major professional bodies: the NSW Institute of Psychotherapy and the NSW Institute for Psychoanalysis.

8.1.3.2 Content Validity of the Narcissistic Rage Scale.

If the scale were a true measure of narcissistic rage, then it should reliably discriminate between patients with high levels of narcissistic rage (NR), compared with patients with low levels of NR. That is, patients with high levels of NR should obtain a high score on the scale, while patients with low levels of NR should obtain low scores or even no score on the scale, and there should be a statistically significant difference in scores for high NR and low NR patients. To establish whether this was the case, three copies of the newly constructed scale were sent to 90 experienced psychodynamic therapists and analysts, mainly from Sydney but also from other parts of Australia. Membership of a psychoanalytic professional institute was again used as the criterion for inclusion. The members of this group of 90 clinicians were different from the group of 30 clinicians contacted for the face validity study. Each clinician was asked to use the scale to rate two patients, one whom they considered to be high in narcissistic rage, and one whom they considered to be low in narcissistic rage.

To address the question of whether the scale was biased towards those with antisocial characteristics obtaining a high score, due to the emphasis on observable
aggressive behaviour, the clinicians were also asked to use a third copy of the scale to rate a patient with diagnosed Antisocial Personality Disorder (see Appendix 2). If the scale was a true measure of narcissistic rage, then patients with APD would be expected to obtain high scores given that narcissistic disturbance is a feature of this disorder. However, if the scale was biased in their favour, their scores might consistently be particularly high or even higher than scores obtained for high NR patients.

8.1.4 RESULTS

8.1.4.1 Face Validity

Out of 30 clinicians contacted for the face validity study, 15 responded. Given that the responses received were anonymous (as per instructions) it was not possible to determine how representative these 15 were of the original 30 and the larger population in terms of theoretical orientation and work experience.

All the clinicians identified the scale as tapping "narcissism" or "narcissistic disturbance". Some commented that particular items on the scale can be associated with the various personality disorders that involve core narcissistic disturbance. This is in accordance with the theoretical framework presented here, consistent with the idea that the scale is tapping
narcissistic rage and not just narcissistic personality disorder.

One potential problem was identified by some of the clinicians. The scale is an attempt to measure narcissistic rage, that is, the person's reactions (cognitive, behavioural and affective) during narcissistic crises. Also, the scale needs to utilize operational data. Consequently, the scale relies heavily on observable behaviour, that is, acting out. The problem identified by some clinicians was that people with Antisocial Personality Disorder are far more likely to act out in extreme, direct ways when it comes to expressing rage. Particular items in the scale were identified by some clinicians as characterising antisocial behaviour. These items were subjected to further analysis as described in sections 8.1.5.1, 8.1.5.2 and 8.1.5.3.

8.1.4.2 Content Validity

8.1.4.2.1 The Scale's Ability to Discriminate Between Patients with High Versus Low Levels of Narcissistic Rage

Out of the 90 clinicians contacted for the content validity study, 35 replied (38.89%), 27 (30%) participated in the study, 2 wrote that they had retired and could not provide current data, 2 wrote that they had other pressing commitments and 4 wrote that they did not wish to participate, expressing general concerns (both
practical and theoretical) about attempts to derive empirical data from psychodynamic material.

The 27 clinicians who participated consistently allotted high scores for those patients they chose as being high in narcissistic rage, and low scores or no score for patients chosen as being low in narcissistic rage (see Appendix 3 and Figure 1). Patients considered to have high levels of narcissistic rage were allotted scores between 2 and 13, with a mean score of 7.63 (S.D. = 2.727) and a mode of 8. Patients considered to have a low or no level of narcissistic rage were given scores between 0 and 3, with a mean score of 0.74 (S.D. = 0.908) and a mode of 0. Paired t-test found the difference between scores for the high NR group and the low NR group was statistically significant (t with 25 degrees of freedom = 12.98; p < 0.0001). Given that these ratings were based on clinicians' understandings of the concept of narcissistic rage, it was concluded that the way NR is conceptualized in the scale is consistent with conceptualizations of NR by highly trained and experienced clinicians in the field. In this way, the content validity of the scale was considered to be sufficiently established.
8.1.4.2.2 Construct Validity: The Scale's Ability to Discriminate Between Narcissistic Rage and Antisocial Personality Disorder

The clinicians contacted for the validity study consistently allotted high scores on the Narcissistic Rage Scale for those patients diagnosed with Antisocial Personality Disorder. Out of the 22 clinicians who rated a patient with (APD), 14 rated their APD patients higher on the scale than their high NR patients, suggesting a bias in the scale items towards antisocial behaviour. Scores ranged from 2 to 13 with a mean score of 9.36 (S.D. = 3.04) and modes of 9 and 13 (see Appendix 3 and Figure 1).

8.1.5 Construction of the Revised Pilot Narcissistic Rage Scale

Due to the scale's bias towards APD patients, it was modified based on the following analyses. Three separate types of statistical analysis were used: discriminant analysis, stepwise discriminant function and logistic regression. All were performed on the 13 items of the scale (A-M) to identify those items which tapped High NR patients and those which tapped APD patients, (see Appendix 4 for raw data). The three analyses produced similar results, confirming that, regardless of how the data were analysed, the results remained the same.
8.1.5.1 Discriminant Analysis of the 13 Items in the Narcissistic Rage Scale

Based on the way clinicians differentially rated high NR and APD patients, discriminant analysis calculates weightings for each item to produce two identifiable groups of subjects. Of the 13 items in the scale, 7 were identified as being the best discriminators between the two groups. These were I, C, E, A, M, H and D. This revealed that approximately 5/6ths (41/48) of the subjects were accurately classified on these items as belonging to either group 1 (high NR) or to group 2 (APD), indicating that there is a statistically identifiable difference between the pattern of scoring for the two groups of patients. The discriminant analysis also identified a subset of patients who were atypical according to the general differences between the pattern of scoring items scored for High NR and for APD patients.

8.1.5.2 Stepwise Discriminant Function of the 13 Items in the Narcissistic Rage Scale

The stepwise discriminant function identified the same 7 of the 13 items in the scale as being the best discriminators between group 1 (high NR patients) and group 2 (APD patients) as the discriminant analysis. The items were I, C, E, A, M, H and D. Items A, E and M best represented the High NR group. Items C, D, H, I best
FIGURE 1: Comparison of Scores on the Narcissistic Rage (NR) Scale for High NR, Low NR, and Antisocial Personality Disorder (APD) Patients, Seen in Private Practice
represented the APD group. The same 41/48 subjects were identified by the stepwise discriminant function as having been classified as belonging to the right group as were identified in the discriminant analysis. The other items were not reliable discriminators between the two groups: that is, these items could be equally characteristic of a high NR patient or an APD patient. The stepwise discriminant function also identified the same subset of atypical patients as was identified by the discriminant analysis.

8.1.5.3 Logistic Regression

Logistic regression was used to calculate the probability that a patient belongs to a specific group (High NR versus APD) as a linear combination of the 13 predictor variables (the 13 items on the Narcissistic Rage Scale). The logistic regression identified those items in the scale which had the greatest probability of tapping Narcissistic Rage versus Antisocial Personality Disorder, according to the pattern of items scoring positive for the two patient populations. The results were the same as those obtained from the discriminant function and stepwise discriminant function. The same subset of atypical patients identified by the discriminant analysis and the stepwise discriminant function was also identified by the logistic regression. All three analyses also identified a subset of patients who were atypical according to the general differences
between the pattern of items scored for High NR and for APD patients.

8.1.5.4 **Descriptive Features of the Pattern of Scoring on the Narcissistic Rage Scale**

Identification of those items in the scale scored most often in the high NR versus the APD patients also yielded information of clinical use (see Appendix 4). Both the NR and APD groups frequently scored positive on item J (open aggression, intimidation and seduction), as might be expected on clinical grounds, but the two groups also showed a distinctly different pattern of scoring for other items. High NR patients most frequently scored on items M (intense disappointment in and lack of empathy for the enforcer); E (expectation of receiving special treatment); B (inadequate recognition of boundaries in relationships); and J (use of aggression, intimidation or seduction to override limits). APD patients most frequently scored on items I (use of deception to override limits); J (use of aggression, intimidation or seduction); C (inadequate recognition of limits, rules and constraints in basic codes of behaviour); K (open violation of rules); and L (intense rage, perhaps vented as violence or threats, in response to anything that embodies a "no"). Item G (denial of knowledge of the existence of rules and limits) was chosen the least. These general trends in scoring are consistent with some of the scoring patterns found to be statistically significant and are also consistent with theoretical
conceptualizations and clinical observations of the differences between NR and APD patients.

In order to revise the scale so that it optimally tapped NR and was without bias towards antisocial characteristics, the following modifications were made. First, only those items most frequently scored positive in the high NR patients were retained. Second, those items that best discriminated High NR patients from APD patients, were also included. Item J was retained, as it seemed to be a common factor important in both high NR and ADP. All items retained in the revised pilot Narcissistic Rage Scale are shown in Table 3. All other items (Items C, D, G, H, I, K and L) were excluded as they did not optimally tap narcissistic rage.

**TABLE 3: Revised Narcissistic Rage Scale**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1)</td>
<td>Inadequate recognition of limitations of self</td>
</tr>
<tr>
<td>2)</td>
<td>Inadequate recognition of boundaries in relationships</td>
</tr>
<tr>
<td>3)</td>
<td>Unfounded expectations of receiving special treatment and consideration</td>
</tr>
<tr>
<td>4)</td>
<td>Aggression, intimidation or seduction employed in order to avoid, override or undermine rules, limits and codes of conduct</td>
</tr>
<tr>
<td>5)</td>
<td>Intense, disproportionate disappointment in or disapproval of the person who enforces the &quot;no&quot; and lack of empathy for the enforcer</td>
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8.2 MODIFICATION OF THE PILOT NARCISSISTIC RAGE SCALE FOR USE WITH METHADONE PATIENTS: CONSTRUCTION OF THE NARCISSISTIC RAGE SCALE FOR METHADONE PATIENTS

8.2.1 Aim

Training the staff in the use of the revised Narcissistic Rage Scale, by providing a handbook that gave examples of how the broad items in the scale might manifest in a methadone patient, was considered. For instance, to illustrate item E, expecting special treatment, an example might be: a patient asking to be exempt from programme rules or asking for take-away doses without meeting the criteria for such privileges. This method was piloted and was found to make the rater's job very laborious and difficult, resulting in dubious data. Training the raters to recognize behaviours as clearly as experienced psychodynamic clinicians also did not seem to be viable; the majority of the staff would not have a sufficiently sophisticated understanding and experience of the broad concepts contained in the scale to be able to use the scale reliably and accurately. Therefore, it was decided that a scale based on the staff member's observations and experience of the patient was preferable to a scale relying on sophisticated clinical judgements. Also, designing an instrument that could be used by methadone staff at any clinic, regardless of their training, was an important consideration because it would increase the potential for future use of the scale and
future research. Therefore, the next step was to "translate" the items within the Narcissistic Rage Scale into items pertaining specifically to the population of subjects in the main study, that is, methadone patients.

8.2.2 Method and Results

TABLE 4: Conversion of the General Pilot Narcissistic Rage Scale into the Narcissistic Rage Scale For Methadone Patients.

<table>
<thead>
<tr>
<th>Items 2,3,4</th>
<th>The Pilot Narcissistic Rage Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Item A: Inadequate recognition of limitations of self</td>
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| Items 6,7,8,9 | Item B: Inadequate recognition of boundaries in relationships |
|              | |

| Items 1,10,11,12 | Item E: Unfounded expectations of receiving special treatment and consideration |
|                 | |

| Items 13,14,15 | Item J: Employs aggression, intimidation or seduction in order to avoid, override or undermine rules and limits |
|               | |

| Items 16,17,18,19 | Item M: Displays intense disproportionate disappointment in or disapproval of the person who enforces the "no": lack of empathy for the enforcer |
|                  | |
### TABLE 5: The Narcissistic Rage Scale for Methadone Patients.

**INSTRUCTIONS**

Please read each statement and circle the most accurate answer:

- 0: NO
- 1: YES
- 2: VERY
- OR
- SOMETIMES
- OFTEN

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<table>
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<tbody>
<tr>
<td>1.</td>
<td>At assessment, displayed a belief in his/her special right to receive methadone, and felt an assessment was unnecessary or unfair AND/OR was angry or disregarding when this belief was contradicted or not confirmed.</td>
<td>0</td>
</tr>
<tr>
<td>2.</td>
<td>At assessment believed that with methadone, he/she would have total control over his drug addiction AND/OR was angry or disregarding when this belief was contradicted or not confirmed.</td>
<td>0</td>
</tr>
<tr>
<td>3.</td>
<td>At assessment believed that with methadone, he/she would solve all his problems AND was angry or disregarding when this belief was contradicted or not confirmed.</td>
<td>0</td>
</tr>
<tr>
<td>4.</td>
<td>Displays a belief in his/her capacity to do everything he wants, even if there are obvious impediments or constraints; eg an obvious problem of overload, a lack of talent or qualifications AND/OR gets angry or disregarding when this belief is contradicted or not confirmed.</td>
<td>0</td>
</tr>
</tbody>
</table>
5. Totally denies or is oblivious to the obvious ways in which his/her drug use/psychiatric problems limit his/her capacity to function normally, e.g., believes he/she can drive, work, think, parent effectively while stoned

OR blames these difficulties on external factors AND gets angry or disregarding when this belief is contradicted or not confirmed.

0 1 2

6. Believes that he/she can make people and things be the way he wants them to be. Believes if he/she wants something he/she should be able to make it happen AND/OR gets angry or disregarding when this belief is contradicted or not confirmed.

0 1 2

7. Expects or demands unrestricted access to his/her counsellor or doctor or the unit manager etc OR is angry about any restriction in access, e.g., having to wait to see someone, having to make an appointment, having to leave when the appointment is over, not having access after hours.

0 1 2

8. Is overly personal or expects a personal relationship within professional relationships e.g., asks personal questions, expects home phone number OR expects personal help outside professional duty e.g., asks for money, a lift, expects social interaction, expects friendship or romance OR expects personal favours (e.g., the bending of rules) AND gets angry or hostile when these expectations are not met.

0 1 2

9. Disregards normal codes of interpersonal behaviour, e.g., is physically too close, too familiar, too sexual, too affectionate to counsellor, doctor etc AND/OR gets angry or disregarding when this behaviour is confronted or thwarted.

0 1 2
10. Has unfounded expectations of receiving special treatment or consideration AND/OR gets angry or hostile when these expectations are not met
eg expects to be accepted onto programme even if he/she does not meet the criteria
eg expects his/her applications for methadone, transfers takeaways, dose change etc, to be processed more quickly, or given special priority.

| 0 | 1 | 2 |

11. Has unfounded expectations of "automatic" entitlement and "deservedness" for privileges without having to earn these through the usual criteria, eg takeaways, chemist pick ups, holiday transfers, reduced urine screens AND gets angry when these expectations are not met.

| 0 | 1 | 2 |

12. Has unfounded expectations about being treated as special and not having to adhere to programme rules and standard procedures like everyone else AND gets angry when these expectations are not met
eg expects special consideration for arriving after closing time, not providing a urine, not keeping appointments, using drugs, arriving stoned.

| 0 | 1 | 2 |

13. Employs verbal aggression or threat of aggression as a means of overriding rules, procedures and limits.
OR
employs verbal aggression or threats as a response to being thwarted, either on impulse or as an act of revenge; eg displays hostility, intimidation, verbal violence.

| 0 | 1 | 2 |


| 0 | 1 | 2 |

15. Employs emotional blackmail or exploitation eg uses presence of child, welfare of child, pregnancy, ill health etc as a lever.

| 0 | 1 | 2 |
|   | Complains about the person who enforces a rule or limit, and insists they are in some way inadequate or incompetent, rather than attributing the person's behaviour to the necessary enforcement of rules and codes of conduct, ie no understanding of the other person's situation. eg sees the enforcer as being unfair, harmful or lacking in compassion, logic, competence etc; eg is irate with the person who enforces dispensing hours, programme reviews, doing urines, daily pick-up, appointments, lab results, not dosing when stoned. | 0 1 2 |
|---|---|
| 17. | Feels so much disappointment or disapproval of the person who enforces a rule, limit or code of behaviour that he/she breaks off or changes his relationship with that person. | 0 1 2 |
| 18. | Displays or reports intense disappointment in and/or disapproval of people who cannot perfectly live up to his/her expectations eg spouses, children, helping professionals, friends, family; or eg expects counsellor to cure him/her, expects dispensers should never make a mistake, expects things to be done for him/her immediately or perfectly even when this is not humanly possible. | 0 1 2 |
| 19. | Displays or reports experiencing, intense and disproportionate rage in response to things that embody a "no" ie to being thwarted, refused, contradicted etc | 0 1 2 |

The revised NR scale was "translated" into a scale for methadone patients (see Table 5), by representing each item in the scale with approximately equal numbers of methadone-specific exemplars, as shown in Table 4. The translation was largely based on the candidate's ten
years experience working in a methadone clinic and also on any literature containing descriptions of methadone patient behaviour and transference material. The resulting instrument, the Narcissistic Rage Scale for Methadone Patients, contained explicit descriptions of behaviours typically encountered by staff in a methadone unit, rather than general categories of behaviour, as used in the pilot Narcissistic Rage Scale.

8.3 DISCUSSION

Through validating the pilot Narcissistic Rage Scale, the present study has shown that there is strong agreement among a representative sample of psychoanalysts and psychotherapists as to what constitutes narcissistic rage. Although narcissistic rage is not a commonly used term outside of the literature on the psychodynamics of compulsive drug use, clinicians appear to understand its meaning within the wider context of pathological narcissism.

The encouraging results in terms of validation of the Narcissistic Rage Scale must be viewed within the context of the level of participation, and the letters of concern/criticism received from some of those who declined to participate, which indicate a negative attitude towards the present study by a small proportion of the clinicians who replied. While the response rate was not outside what can normally be expected, there could have been a number of specific reasons why some of
the clinicians contacted did not respond. The amount of work required may have been thought to be excessive; others may not have felt comfortable with the task, particularly given that analysts do not generally use psychometric instruments and are wary of attempts to translate complex psychodynamic concepts into simple scales. Clinicians may have felt that the participation requested was not based on sound grounds, or that the actual scale was considered to be flawed. Given that they did not know the specific nature of the study, some of these judgements may also have been premature. This kind of scepticism can often be a problem when participants are "blind".

Another possibility suggested by the content of some of the letters received, was that the author may have inadvertently tapped into the on-going heated debate in the psychoanalytic community as to how narcissism should be conceptualized. If this is the case, it may simply reflect wider theoretical contentions, such as Kernberg and Kohut's competing models of the development of pathological narcissism. This debate has filled journals for years and only recently has there been an attempt (Glassman 1988) to test the two models empirically. Most letters received by the author contained lengthy discussions about the many ways narcissism can be conceptualized and defined. Given that the scale was restricted to a narrow representation of narcissism, it may have been viewed as being too simplistic.
Alternatively, the clinicians' letters and the response rate may reflect concern about, perhaps even opposition to, subjecting psychodynamic concepts to scientific testing methods, as discussed in the introduction. During the writing of this paper, the author attended a series of lectures presented by Professor Otto Kernberg and Dr Pauline Kernberg, and noted the general surprise among the audience in hearing of the excellent research being done in the United States and Europe on psychodynamic concepts and theory. Australia may be lagging behind the rest of the world in this regard, perhaps because psychoanalysis here does not generally enjoy the close affiliation with universities and teaching hospitals that exists in the States. This in turn may be due to a failure in Australia to recognize the need for empirical credibility, if psychoanalysis is to stay within mainstream institutions.

By turning to the psychoanalytic community in order to validate the scale, much has been revealed, not only about the scale and the concept of narcissistic rage, but about the conflicts and concerns within the community itself.

The present study demonstrates that the extensive body of literature on a complex psychoanalytic concept such as narcissistic rage, can be utilized to develop an instrument for measuring this phenomenon in a specific patient population, based on observable behaviour. However, the resulting Narcissistic Rage Scale for Methadone Patients must be viewed with caution due to
methodological limitations of the study. First, the process of developing the pilot Narcissistic Rage Scale contains a number of weaknesses. There was no systematic process of selection of literature upon which definitions and descriptions of narcissistic rage were based. This was in part a reflection of the nature of the literature in this area, with various prominent authors describing the phenomenon from different viewpoints. Also, while most authors gave detailed accounts of pathological narcissism or narcissism in relation to drug addicted individuals, Wurmser is the only author to provide a detailed account of narcissistic rage, and so the scale is largely based on his work. However, it could be argued that the heavy reliance on one source constitutes an important factor to consider when evaluating the methodology.

Another factor in the development of the scale involves the use of relatively old literature to develop the candidate’s theoretical position. The only justification for this is that Wurmser’s formulation, and elaborations provided by authors such as Khantzian, though somewhat dated, remain the only detailed accounts of the subject. Therefore, the use of these sources reflects the richness of the material and the absence of comparable material in recent literature.

A second methodological concern in the development of the Narcissistic Rage Scale involves the elimination of items in the scale that confounded Antisocial Personality Disorder. The rationale for eliminating these
items is detailed in section 8.1.3.2 on content validity, section 8.1.4.1 on face validity and section 8.1.4.2.2 on construct validity. It was hoped that the resulting scale would be a more true measure of both realms of narcissistic rage, that is, the individual's own experience of the rage as well as his/her expression of narcissistic rage, rather than reflecting a bias towards observable antisocial behaviour and specifically, patients with Antisocial Personality Disorder. Many items in the scale related to antisocial functioning but only those that were statistically shown to tap Antisocial Personality Disorder as a distinct patient group, were removed. Therefore, antisocial functioning in general, was still reflected in the scale. However, it may be argued that removing items that clinically and statistically pointed to a bias towards patients with Antisocial Personality Disorder attracting the highest scores, may have introduced an artificial and clinically unsound element to the scale.

Once constructed, the general pilot Narcissistic Rage Scale was then "translated" into specific situations and examples pertaining to methadone patients, to form the Narcissistic Rage Scale for Methadone Patients. This translation was largely based on the candidate's ten years experience working in a methadone clinic and also any literature containing descriptions of methadone patient behaviour. While the lack of research in this specific area necessitated heavy reliance on clinical experience, the face and content validity of the
Narcissistic Rage Scale for Methadone Patients was not formally tested but was assumed because this second version of the scale was merely a translation of the original scale which had been formally validated. Face and content validity for the methadone-specific items should have been established, for example, by consulting the methadone staff, prior to the scale being used in the main study, described in Chapter 9. A pilot study to test whether the scale was viable for use by methadone staff and whether it could be used reliably should also have been conducted, rather than deriving this information subsequently, from the main study.

While it is acknowledged that the Narcissistic Rage Scale for Methadone Patients may be viewed by some as a primitive attempt at translating a global concept into a specific set of criteria, such attempts are an important first step if we are to go on to test the validity and usefulness of psychoanalytic concepts.

By translating the scale into a standardized instrument based on observable behaviour, psychodynamic concepts are made accessible to professionals outside the psychoanalytic field. While some may criticize this on the grounds that those who have not been formally trained should not be encouraged to "dabble" in the field, such attempts at exporting and promoting psychodynamic understanding can be important for a number of reasons. First, whilst ideally all methadone patients might benefit from the opportunity to be assessed by a psychoanalyst or psychotherapist, in reality this rarely
happens. There are not enough analysts, heroin addicts are not likely to seek the help of an analyst and many analysts are unwilling to take heroin addicts into therapy. The fact remains that the availability of methadone maintenance treatment has been the main factor responsible for attracting large numbers of addicts to the public health system and these patients will be assessed and treated by nurses, psychologists and psychiatric registrars, not psychoanalysts. Explorations of the psychodynamics of addiction in the psychoanalytic literature are practically limited when only a handful of patients will be seen by analysts and psychotherapists: this important body of knowledge is left under-utilized and unrecognized. Second, by providing an opportunity for psychodynamic concepts to be more widely accessed and utilized, we may attract more psychoanalytic professionals to the field, with the potential for cross-fertilization. As discussed previously in the introduction, this remains a controversial area.

The Narcissistic Rage Scale for Methadone Patients will only be a potentially useful tool if it can be shown to be reliable, valid and to be highly relevant to the on-going assessment and management of methadone patients. In study 2 the hypothesized relationship between level of narcissistic rage and extracurricular drug use in methadone patients is explored, utilizing the scale. If level of narcissistic rage is shown to be a predictor of extracurricular drug use and therefore treatment outcome, then the scale could be used in methadone units to
identify high risk patients and to plan specialized interventions for these patients based on our knowledge of effective treatments for underlying narcissistic pathology. The demonstration of such a relationship would also contribute to the construct validation of the measure. In terms of day-to-day management of patients, a greater appreciation of the problems arising from underlying pathological narcissism in addicts could be utilized in the policy, procedures and structure of methadone programmes, and could form the basis for debriefing and supervision sessions for staff.
CHAPTER 9

STUDY 2: COMPARISON OF EXTRACURRICULAR DRUG USE IN METHADONE PATIENTS WITH HIGH VERSUS LOW LEVELS OF NARCISSISTIC RAGE

9.1 Rationale for the Present Study

As discussed in detail in earlier chapters, Leon Wurmser's formulation of the psychodynamics of compulsive drug use describes narcissistic personality structures in compulsive drug users which predispose individuals to narcissistic crises involving the experience and expression of intense anger; narcissistic rage. This rage will lead to hostility, aggression or deception which is designed to force a change in the external environment. When these attempts fail, relief is sought by forcing a change in the individual's internal environment: mood-altering drugs are used to restore psychic control. To date, this formulation has not been sufficiently tested. Further, there are no existing instruments that could be used by general staff at a methadone clinic for measuring an individuals' level of narcissistic rage. This has limited the scope of research into the possible influence of narcissistic rage on methadone treatment outcome. The instrument developed in Study 1, the Narcissistic Rage Scale for Methadone Patients provides an opportunity to investigate this area.
Aims of the Study

The second study aimed to test empirically the theoretical connection between narcissistic rage and compulsive drug use. Specifically, this study is a pilot attempt to utilize Wurmser's formulation of the psychodynamics of drug use, to understand extracurricular drug use in methadone patients. Wurmser has pointed to the fact that his clinical experience with methadone patients seemed to confirm his theory of compulsive drug use: that patients used drugs when they sought relief from narcissistic injury. The main hypothesis derived from the theoretical material discussed previously is that methadone patients with high levels of narcissistic rage will use more extracurricular drugs than patients with lower levels of narcissistic rage. Put another way, it is hypothesized that the methadone patient's level of narcissistic rage will be a significant predictor of extracurricular drug use, and therefore of response to treatment.

Methadone patients are an ideal population for the study for three reasons. First, literature on transference phenomena in methadone units seems to support Wurmser's formulation as discussed in Chapter 5. Second, methadone patients are monitored through regular urinanalysis, thus providing a reliable source of data on drug use. Third, since methadone patients receive a sufficient dose of methadone to satisfy their physiological need for opiates, any extra drug use can be attributed to a psychological need for drugs.
Since methadone maintenance treatment (MMT) is a treatment for compulsive heroin use, extracurricular heroin use is the main indicator of treatment outcome. However, as most methadone patients tend to use a variety of drugs whilst in treatment, noticeably opiates, amphetamines and minor tranquillizers, and given that many heroin addicts are polydrug abusers, the use of any extra psychotropic drugs must be included.

In applying Wurmsers's formulation to methadone patients in the study, it is hoped that the results will provide information about the psychodynamics of compulsive drug use and about factors affecting outcome in methadone treatment.

In addition to the main hypothesis, based on theories of the psychodynamics of compulsive drug use, we would also expect to find a high rate of narcissistic disturbance in this population. Further, perhaps those heroin addicts who choose methadone treatment over other forms of treatment, do so because their high level of pathological narcissism makes it impossible for them to consider a drug-free option. Alternatively, a spectrum of narcissistic disturbance may be found.
9.2 METHOD

9.2.1 Design

The study involved a one-group design, the subjects being patients in methadone maintenance treatment. The dependent variable was the patient’s level of extracurricular drug use, as measured by urinanalysis results indicating the proportion of total urine samples positive for extracurricular drugs. The independent variable was the patient’s score on the Narcissistic Rage Scale for Methadone Patients. Statistical analysis was performed to determine if there was a relationship between level of extracurricular drug use and level of narcissistic rage in the sample.

9.2.2 Subjects

Subjects were patients participating in a free public methadone maintenance treatment programme in Sydney. When compared to the general population of methadone patients and the typical profile of methadone programmes across Australia, as described by Mattick and Hall (1993) in a survey of 60 methadone clinics, the programme and the patients used in the present study appear to be representative of the general trends in methadone treatment in terms of average duration of treatment, goal of treatment, average dose, provision of adjunct counselling, provision of AIDS prevention information and services. The only way in which the
9.2 METHOD

9.2.1 Design

The study involved a one-group design, the subjects being patients in methadone maintenance treatment. The dependent variable was the patient’s level of extracurricular drug use, as measured by urinanalysis results indicating the proportion of total urine samples positive for extracurricular drugs. The independent variable was the patient’s score on the Narcissistic Rage Scale for Methadone Patients. Statistical analysis was performed to determine if there was a relationship between level of extracurricular drug use and level of narcissistic rage in the sample.

9.2.2 Subjects

Subjects were patients participating in a free public methadone maintenance treatment programme in Sydney. When compared to the general population of methadone patients and the typical profile of methadone programmes across Australia, as described by Mattick and Hall (1993) in a survey of 60 methadone clinics, the programme and the patients used in the present study appear to be representative of the general trends in methadone treatment in terms of average duration of treatment, goal of treatment, average dose, provision of adjunct counselling, provision of AIDS prevention information and services. The only way in which the
programme in the present study was not typical of most methadone programmes in Australia was that some psychodynamic therapy was offered but only attended by a small percentage of patients. (For a full discussion of representativeness of the sample, see chapter 10.)

All patients on the methadone programme in 1985 to 1993 were included in the study, with the following exclusions:

1. Patients with active psychosis, on major tranquillizers

2. Patients known to have repeatedly substituted urines, rendering their urine results unreliable.

3. Patients strongly suspected of substituting urines, therefore rendering those results as having a high probability of being unreliable.

4. Patients known to have supplemented their dose on a regular basis with black market methadone. As urinanalysis detects only presence or absence of methadone, using extra methadone is an effective way of concealing extracurricular drug use.

5. Patients with urinanalysis data missing due to lost or incomplete records.

6. Patients with a maximum programme duration of less than one year, after a three month stabilization period. This would ensure sufficient time in treatment to indicate the patient's response to treatment, minus the initial stabilization period. Both the DARP (Drug Abuse Reporting Programme) and TOPS (Treatment Outcome Prospective Study) projects found that a minimum programme duration of one year was required for treatment gains to be evident and for these gains to be maintained after leaving treatment.
TABLE 6: Patients Excluded From The Study

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Psychosis</td>
<td>1</td>
</tr>
<tr>
<td>Urine Substitution</td>
<td>4</td>
</tr>
<tr>
<td>Black market methadone</td>
<td>1</td>
</tr>
<tr>
<td>Data missing</td>
<td>3</td>
</tr>
<tr>
<td>Programme duration &lt; 1 Year</td>
<td>36</td>
</tr>
</tbody>
</table>

The total number of subjects was 77; 49 males and 28 females.

9.2.3 Measures

9.2.3.1 Narcissistic Rage Scale for Methadone Patients

The Narcissistic Rage Scale for Methadone Patients is produced in full in section 8.2.2. Each item on the Narcissistic Rage Scale for Methadone Patients was rated on a 3-point scale. A score of 0 indicated that the behaviour/attitude was observed not at all; a score of 1 indicated that the behaviour/attitude was observed sometimes; a score of 2 indicated that the behaviour/attitude was observed often and/or in extreme proportions. The patient could achieve a possible total score of 38. Raters were instructed to base their rating on their impression of the patient, given what they knew and had experienced about the patient. The raters were blind to the aims and design of the study. The raw data are presented in Appendix 5.
Treatment outcome was measured in terms of a patient's frequency of extracurricular drug use. This is the most widely used direct measure of outcome in methadone programmes (Howard, 1993). Although some studies have advocated the use of self-report as a reliable method for monitoring extracurricular drug use (Hanrock, Hennrikus, Henry, Sanson-Fisher, Walsh & Lewis 1991; Magura, Goldsmith, Casriel, Goldstein & Lipton, 1987), most methadone programmes use urinanalysis which has been found to be superior, particularly when programme privileges are contingent upon patient's frequency of drug use (Howard, 1993). Howard concludes that "...drug use seems reasonably consistent in treatment, and urine tests can generalize over longer time periods, giving the most useful measure of individual drug use" (p36).

In the present study, all drug screens from the first year of each patient's treatment, after an initial three month stabilization period, were included. It was hoped this would represent the patient's response to treatment, once initial teething problems were overcome, including dose stabilization, lifestyle changes reflecting cessation of the need for daily drug-seeking activities etc. All urine samples containing psychotropic drugs and pain-relieving medications with a codeine base were categorized as "extracurricular drug use". Patients' urines were classified as positive for
extracurricular drugs or negative for extracurricular drugs. The measure was based on the proportion of total urine samples that were classified as positive. The patients had varying numbers of total urines, simply due to differences in the number of urine screens performed for each patient during the period specified. For example, patients who regularly arrived intoxicated were often asked to provide more frequent urine samples. In general, patients on this methadone programme had their urine tested once or twice weekly.

Urinanalysis tested for virtually all commonly used drugs, with the exception of cannabis and alcohol, these drugs being too expensive and problematic to screen as standard procedure for government programmes. The drug screen included all benzodiazepines except rohypnol; this specific test was requested for those patients suspected of abusing rohypnol (ie. patients who appeared often to be under the influence of minor tranquillizers but kept testing negative for benzodiazepines.) The raw data are presented in Appendix 6.

9.2.3.3 Alcohol Consumption Survey

While the drug-screen used for the urinanalysis tested for the presence of most psychotropic drugs, it did not include a screen for the presence of alcohol. There are two reasons for this, in addition to the factor of cost. First, as alcohol may be frequently used for recreational purposes, it may often be present in
anyone's urine and it is considered to be a waste of time and money to routinely test for this drug when performing urinanalysis for methadone patients. Second, because the urinanalysis only detects the presence or absence of alcohol but does not measure the quantity of alcohol present, it does not provide useful information concerning whether or not the alcohol present represents excessive consumption (indicating compulsion and abuse) or simply moderate consumption (non-compulsive use) of alcohol. There is much research to suggest that alcohol is frequently abused by methadone patients and many patients may be addicted to alcohol (Hubbard, Marsden, Rachal, Harwood, Cavanaugh & Ginzburg, 1989; Hunt, Strug, Goldsmith, Lipton, Robertson, & Truitt, 1986; Joseph & Appel, 1985; Kleber, 1983; Regier, Farmer, Rae, Locke, Keith, Judd, & Goodwin, 1990; Roszell, Calsyn & Chaney, 1986; Stastny & Potter, 1991; Stimmel, Cohen, Suriano, Hanbury, Korts & Jackson, 1983). This means that some patients could be using alcohol to alleviate the experience of narcissistic rage and this extracurricular drug use would be undetectable, thereby influencing the results of the present study. Therefore, it was considered that it might be useful to supplement the urinanalysis results with some information on patients' alcohol consumption.

In an attempt to ascertain information about alcohol consumption in the present sample, an anonymous, voluntary survey was conducted at the methadone clinic.
(see Appendix 7). For one day, dispensary staff asked patients if they would like to participate in a survey about alcohol use, and handed them an information sheet (see Appendix 8) which explained that the survey was anonymous and confidential, and that it was for an external research project, clearly explaining that the survey was not conducted by the staff and was not part of the methadone programme.

9.2.3.4 Hypothetical Case Vignettes

While the raters were blind to the study's design, it might still be argued that knowing the patient's urinanalysis record influenced their ratings. In other words, it is possible that the raters may have had a more lenient attitude towards the patient's behaviour if the rater knew that the patient was generally refraining from using extracurricular drugs. Conversely, the raters may have tended to judge more harshly those patients known to be engaging in a high level of extracurricular drug use, particularly if these patients were perceived by the raters to be unmotivated in terms of addressing their drug addiction. In an effort to test this possibility in a follow-up study, six short hypothetical case vignettes were designed for the original group of 4 raters, each vignette of equivalent length, form and content (see Appendix 9). The vignettes were designed to manipulate the reader's knowledge of the patient's urinanalysis results. For each of the six vignettes, three conditions
were constructed; the first version gave no information about extracurricular drug use, the second version included a statement that the patient's urinanalysis results were satisfactory, indicating no or little extracurricular drug use, and the third version included a statement that the patient's urinanalysis results were unsatisfactory, indicating excessive extracurricular drug use. In this way, for each of the six case vignettes, three conditions were set up: no information (NI), extracurricular drug use (E), and no extracurricular drug use (NE), respectively (see Table 7). The four raters used in the main study were asked to use the Narcissistic Rage Scale for Methadone patients (again titled The Methadone Patient Behavioural Checklist) to rate each of the six patients described in the vignettes. Each rater was randomly assigned one of the three versions of each vignette. The first three vignettes were very simplified and it might be argued that they contained a rather obvious demand characteristic. The last three vignettes were more complex, but still contained only a brief account of a few aspects of a patient and so were not in any way as complex and complete as the information one would have from knowing a real patient. It was expected that if there was no demand characteristic present, the raters would allot a similar score for the patient described in the vignette, regardless of which version of the vignette they read, i.e. regardless of whether or not the vignette did or did include information concerning the patient's urinanalysis record and regardless of
whether or not the information was favourable or unfavourable.

**TABLE 7: Design of Hypothetical case Vignette Study**

<table>
<thead>
<tr>
<th>Vignette</th>
<th>NI (no information about extra-curricular drug use)</th>
<th>E (high level of extra-curricular drug use)</th>
<th>NE (no extra-curricular drug use)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette 1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vignette 2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vignette 3</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vignette 4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vignette 5</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Vignette 6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**total = 18**

9.2.4 **Procedure**

The staff at the methadone unit used in the present study consisted of three nurse counsellors/dispensers one psychologist and one prescriber, which reflects the general pattern of staffing in public methadone programmes in Australia (Mattick & Hall, 1993). Staff who
had daily contact with the patients and/or had provided counselling or case management for patients since the commencement of the methadone programme were asked to use the scale to rate those patients they knew well. There were four raters in total: three nurse dispensers/counsellors and one psychologist. The current prescriber, a psychiatric registrar, was not included as a rater because, unlike the other staff members, he held a locum position and had not been a permanent full-time staff member since the commencement of the methadone programme. The scale was labelled "Methadone Patient Behavioural Checklist" in order that the specific nature of the scale was not revealed to the raters. Each subject was rated independently by two staff members. Training consisted of supervising the raters during practice ratings until the rater reported feeling comfortable using the scale. Practice training consisted of rating ten patients on average.

Re-test reliability for the Narcissistic Rage Scale for Methadone Patients was established by comparing scores allotted six months later, with the original scores allotted by the same raters for a sub-set of the same patients.
9.3.1 Narcissistic Rage Scale for Methadone Patients

The 77 patients obtained the full range of total scores possible (0 - 38) on the Narcissistic Rage Scale for Methadone Patients (see Appendix 5). The higher of the two ratings obtained for each patient was used in the statistical analysis as the NR score for that individual. This procedure was adopted because, it was judged by the candidate that the raters in this study, having been desensitized over the years to extreme behaviour from patients, had lost some perspective and tended to discount some episodes of behaviour which would otherwise be viewed as inappropriate. In future studies, a more prolonged period of training for the raters would probably be useful.

Using the higher of the two scores obtained for each patient as the final score, the mean score was 14.87 (S.D.= 9.616). To put these results into a more clinically meaningful context, scores on the NR Scale were put into 4 categories, from low to extreme. This categorization was based on the clinical judgement of the candidate on extrapolation from the results of the original scores obtained from the clinical experts during the validation of the scale; a score of 0 to 2 was considered low and scores for high NR patients were above 8. Of course, the high NR patients in this sample tended to attract higher scores than the high NR patients in Study 1 who were patients in private psychoanalysis and
psychotherapy. This difference in the shape of the distribution at the positive end of the scale was to be expected given the different nature of the two patient populations. The frequency and percentage distributions of scores on the Narcissistic Rage Scale for Methadone Patients are presented in Table 8 and presented visually in Figure 2.

**TABLE 8: Frequency and Percentage Distributions of Scores on Narcissistic Rage Scale for Methadone Patients, Categorized into 4 Levels of Narcissistic Rage**

<table>
<thead>
<tr>
<th>Score</th>
<th>Level of Narcissistic Rage</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2</td>
<td>Low</td>
<td>6</td>
<td>7.8</td>
</tr>
<tr>
<td>3-8</td>
<td>Significant</td>
<td>15</td>
<td>19.5</td>
</tr>
<tr>
<td>9-20</td>
<td>High</td>
<td>38</td>
<td>49.3</td>
</tr>
<tr>
<td>21-38</td>
<td>Extreme</td>
<td>18</td>
<td>23.4</td>
</tr>
</tbody>
</table>

Of the 77 patients, 6 (7.8%) were rated as having a low level of narcissistic rage, 15 (19.5%) were rated as having a significant level, 38 (49.35%) were rated as having a high level, and 18 (23.4%) were rated as having an extreme level of narcissistic rage (see Figure 2). Therefore approximately 73% of patients currently on the methadone programme used in this study have high to extreme levels of narcissistic rage as measured by the Narcissistic Rage Scale for Methadone Patients.

Gender differences were as follows. Males tended to have higher NR scores on average (14.714) than females (13.379) but t test revealed that this difference was not statistically significant. Males' doses of methadone were
on average higher (62.14mg) than females (58.79mg) but this difference was also not statistically significant. Therefore in this sample, on average, males and females who are on similar doses of methadone were given similar scores on the NR Scale.

FIGURE 2: Percentage of Patients Obtaining the Four Categories of Scores on the Narcissistic Rage Scale for Methadone Patients

9.3.1.1 Inter-Rater Reliability

Inter-rater reliability for the two sets of NR scores obtained for each of the patients was calculated
using the coefficient known as unweighted Kappa (K) (Cohen, 1968). This method is suitable for scores involving categorical data. Since categorization of individuals into one of 4 possible NR groups represents only one possible way of categorizing the scores, it was decided also to calculate the inter-rater reliability using another system of categorization. This was done to ensure that the inter-rater reliability estimates were not merely an artifact of one particular way of categorizing the scores. In this second classification individuals were categorized into one of 5 possible groups on the basis of clinical judgement. Both systems of categorization are presented in Table 9. Given that there was a total of 4 raters, inter-rater reliability was calculated for the 6 combinations of rater pairs (see Table 10). There were uneven numbers of patients rated by each rater because only those staff members who knew the patient well were asked to rate a particular patient.

TABLE 9: The Two Systems for Categorizing Scores on the Narcissistic Rage Scale in the Inter-rater Reliability Study

<table>
<thead>
<tr>
<th>Score</th>
<th>Category</th>
<th>Score</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 2</td>
<td>low</td>
<td>0 - 3</td>
<td>low</td>
</tr>
<tr>
<td>3 - 8</td>
<td>significant</td>
<td>4 - 10</td>
<td>significant</td>
</tr>
<tr>
<td>9 - 20</td>
<td>high</td>
<td>11 - 20</td>
<td>high</td>
</tr>
<tr>
<td>21 - 38</td>
<td>extreme</td>
<td>21 - 28</td>
<td>very high</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29 - 38</td>
<td>extreme</td>
</tr>
</tbody>
</table>
### TABLE 10: Inter-Rater Reliability (K) for the Two Scores Obtained for Each Patient, Grouping the Scores According to Category System 1

<table>
<thead>
<tr>
<th>Number of Patients Per Rater</th>
<th>Rater Pair</th>
<th>K</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>raters 1 and 2</td>
<td>0.62300</td>
</tr>
<tr>
<td>12</td>
<td>raters 1 and 3</td>
<td>1.00000</td>
</tr>
<tr>
<td>7</td>
<td>raters 1 and 4</td>
<td>0.7878</td>
</tr>
<tr>
<td>21</td>
<td>raters 2 and 3</td>
<td>0.8055</td>
</tr>
<tr>
<td>8</td>
<td>raters 2 and 4</td>
<td>1.0000</td>
</tr>
<tr>
<td>10</td>
<td>raters 3 and 4</td>
<td>0.5833</td>
</tr>
<tr>
<td>total 77</td>
<td>all raters combined</td>
<td>0.7798</td>
</tr>
</tbody>
</table>

For system 1 categories, inter-rater reliability ranged from 0.5833 to 1.0000. Perfect agreement was achieved by 2 sets of rater pairs across 20 patients (25.97% of patients). Inter-rater reliability was around 0.8 for another 28 patients (36.36% of patients). For all raters combined, the inter-rater reliability was 0.7798. The inter-rater reliability based on system 2 categories was very similar, suggesting that the results...
of the inter-rater reliability study are unlikely to be an artefact of the way the scores were categorized. It is also important to note that the overall inter-rater reliability was lowered by 7 patients who were rated very differently (a discrepancy of 10 or more points) by each of their two raters. For example, there was a 17 point difference between the two ratings obtained for patient 18. These 7 patients may be peculiar in some way, as discussed in detail in chapter 10, and so may be "artificially" detracting from the generally pleasing level of inter-rater reliability.

The average numerical difference between each pair of ratings was 1.7318 points.

9.3.1.2 Re-test Stability

Six months after the scores on the Narcissistic Rage Scale for Methadone Patients were obtained for the 77 patients in the main study, the original four raters were again asked to use the scale for a random subset of 40 patients. As on the first occasion, the scale was titled The Methadone Patient Behaviour Checklist. The same raters allotted scores for the same patients they had scored on the initial occasion. The resulting scores were then categorized, as previously described in Table 9 (see Appendix 10 for raw data). When comparing the category for initial and repeat scoring occasions, using either category system one or system two, t test revealed there
was no statistically significant change in category from the initial occasion to the repeat occasion, indicating good re-test stability for the scale.

9.3.2 Urinanalysis

Levels of extracurricular drug use in the sample (as measured by urinanalysis) ranged from 0% to 100% of total urine samples, with a mean of 28.337%, SD = 29.351 (see Appendix 6 for raw data). While urinanalysis results indicate that 20.8% of patients did not use any extracurricular drugs, 27.2% of patients had between 10% to 39% of total urines positive for extracurricular drugs and 31.2% of patients had between 40% to 100% of total urines positive for extracurricular drugs. (see Table 12). The sample showed some interesting gender differences. Females tended to have a greater average proportion of positive urines (urines containing extracurricular drugs)( 36.5%), than males ( 22.9%); this difference was statistically significant (t=2.01, df=76).

9.3.3 Relation Between Narcissistic Rage and Extracurricular Drug use.

The main hypothesis was that patients with high levels of narcissistic rage would use more extracurricular drugs than patients with lower levels of narcissistic rage: that is, that a patient's level of
narcissistic rage would be a predictor of the level of extracurricular drug use.

**TABLE 12: Level Of Extracurricular Drug Use Among Methadone Patients as Measured by Proportion of Urines “Positive” for Opioids and Other Drugs of Abuse.**

<table>
<thead>
<tr>
<th>Level of EDU</th>
<th>Number of patients</th>
<th>Percentage of Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>16</td>
<td>20.8</td>
</tr>
<tr>
<td>very low (1-9%)</td>
<td>16</td>
<td>20.8</td>
</tr>
<tr>
<td>low (10-19%)</td>
<td>7</td>
<td>9.0</td>
</tr>
<tr>
<td>substantial (20-39%)</td>
<td>14</td>
<td>18.2</td>
</tr>
<tr>
<td>high (40-69%)</td>
<td>15</td>
<td>19.5</td>
</tr>
<tr>
<td>extreme (70-100%)</td>
<td>9</td>
<td>11.7</td>
</tr>
</tbody>
</table>

It is very common to model a response variable in terms of one or more predictor variables using linear or multiple regression. However, this assumes in general that the response variable has a Normal distribution. In the present case, the response variable (proportion of positive urine samples) is not normally distributed, and standard regression is not appropriate. Logistic regression was performed to find the probability that an individual's urine sample, given their NR score, is "positive". A statistically significant correlation (r = .433, p < 0.001) was found between score on the Narcissistic Rage Scale (maximum ratings) and proportion of "positive" urines (see Figures 3a and 3b). In other words, a patient's level of narcissistic rage was a reasonable predictor of level of extracurricular drug use, providing modest support for the main hypothesis.
Figure 3a Scattergram Showing Relationship Between Narcissistic Rage Score and Percentage of Positive Urines
Figure 3b: Relationship Between Extracurricular Drug Use and Level of Narcissistic Rage; Range of Percentage of Positive Urines (with Means Indicated) Compared Across the Four Levels of Narcissistic Rage
FIGURE 4: Influence of Methadone Dose Level on Mean Narcissistic Rage Score

FIGURE 5: Influence of Gender on the Relationship Between Narcissistic Rage Score and Percentage of Positive Urines
Given that the correlation was not a very strong one, two other variables, methadone dose and sex, were investigated to see if they accounted for the unexplained variation (see Appendix 11 for raw data). Dose was classified into three levels; low (up to 30mgs), medium (35-70mgs) and high (75-120mgs) The results indicated that as methadone dose increases, so does the probability of having a greater proportion of "positive" urines. That is, patients on higher doses of methadone tended to use more extracurricular drugs than patients on lower doses of methadone. However, dose did not influence NR score (see Figure 4). Sex rather than dose accounted for most of the variation in NR scores, the trend being stronger for females than for males. A pooled two-sample t-test found that the difference between the maximum rating coefficients for males and females was highly significant ($t = 2.01$, $df = 76$; $p = 0.048$). Mean positive urines for females was 34.2 and mean positive urines for males was 23.0. Thus, when males and females with the same methadone dose and the same score on the Narcissistic Rage Scale were compared, the females had a higher proportion of "positive" urines than the males (see Figure 5). However, although the significant value of $t$ was positive, meaning that the proportion of positive urines for females was significantly greater (at the 5% level of significance) than the proportion for males, the value of $p$ is only just less than 5%, therefore the result is not of great clinical importance. The combination of NR Scale score and sex of the patient,
provided the best predictor of level of extracurricular drug use; methadone dose is also a useful predictor but not to the same degree. Although this relationship between sex and NR score was important, there was no significant relationship found between sex and dose or dose and NR score. In summary, while the patient's NR score was a statistically significant predictor of extracurricular drug use, the relationship was not a strong one, as much of the variation was attributable to the sex of the person.

9.3.4 Alcohol Consumption Survey

The results of the alcohol consumption survey were as follows. Out of 90 patients who attended the dispensary that day, 62 agreed to participate in the survey. The dispensers noted that most people, when asked to participate in a survey on alcohol use, first responded by reassuring the dispensers that they never drank alcohol. Hence the results of the survey may need to be interpreted with caution, possibly representing an underestimate.

The results of the survey show that 42% of respondents stated that they do not drink alcohol, 34% state that they are moderate consumers of alcohol and 21% state that they abuse alcohol, either by binge drinking or regular heavy drinking. Among those who abuse alcohol, 14.5% stated that they prefer drinking/getting drunk to taking drugs/getting "stoned".
The hypothetical case vignettes were designed to test the possibility that ratings on the Narcissistic Rage Scale for Methadone Patients could be influenced by manipulating whether or not the rater has any knowledge concerning the patient’s urinanalysis record, and if so, whether this was the case both when the information was favourable or unfavourable. The results of the statistical analyses comparing the hypothetical case vignettes indicates that the raters generally allotted the level of NR rating that the vignette was designed to produce. That is, the patient in vignette 1 was rated as exhibiting an extreme level of NR, the patient in vignette 2 was rated as exhibiting no level of NR, the patient in vignette 3 was rated as exhibiting a medium level of NR and the patient in vignette 6 was rated as exhibiting a high level of NR. The exceptions were vignette 5 which was intended to portray a patient with a medium level of NR but actually resulted in a rating of a low level of low NR, and vignette 4 which was designed to portray a patient with a low level of NR but actually resulted in a rating of medium NR (see Table 8 and Appendix 12). Some statistically significant differences were found between at least some of the vignettes ($F_{5,10} = 88.67; \ p< 0.001$). The LSD (Least Significant Difference) was 6.5217. Vignettes 6 and 1 had a greater effect in increasing NR ratings than vignettes 3 and 4,
which in turn had a greater effect in increasing NR ratings than vignettes 2 and 5. Vignettes 3 and 4 were not significantly different from each other in their effects on NR ratings. Also no significant difference was found between vignettes 6 and 1 in terms of their influence on NR ratings. As intended by the content of the vignettes, Vignette 1 had the greatest effect in increasing NR ratings, while vignette 2 had the greatest effect in lowering NR ratings.

Some statistically significant differences were found between at least some of the conditions (F2,10 = 7.700; p = 0.009, LSD = 3.4585), see Appendix 12 for raw scores. The Bonferroni multiple comparison procedure indicated that the effect of condition NI was significantly less (p< 0.05) than the effect of condition NE, but there was no significant difference (p>0.05) between the effect of condition E and the effects of the other two versions (NI and NE). This means that when the raters had information indicating that the patient did not use extracurricular drugs, this information significantly influenced (lowered) the ratings they allotted for that patient compared to ratings allotted when the raters had no information about that patient's level of extracurricular drug use, but not compared to when the raters were given information indicating that the patient had a high level of extracurricular drug use. Therefore, there was no significant difference in NR
ratings when the raters were given no information about extracurricular drug use compared to when they were told that the patient's records indicated a high level of extracurricular drug use. In summary then, it was only the knowledge that the patient's urinanalysis results indicated no extracurricular drug use that influenced (lowered) the rater's scoring on the Methadone Patient Narcissistic Rage Scale.

TABLE 13: Comparison Of Intended And Actual Narcissistic Rage Ratings Allotted For Patients In Hypothetical Case Vignettes

<table>
<thead>
<tr>
<th>NR Score</th>
<th>Intended Vignette</th>
<th>Actual Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>extreme</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>high</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>medium</td>
<td>5</td>
<td>4 and 3</td>
</tr>
<tr>
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This is consistent with the idea that demand characteristics may have played a role in the finding of a relationship between narcissistic rage and extracurricular drug use in the main study, but only when the rater was aware that the patient had a record of satisfactory urine results.
10.1 Introduction

The present studies represent an attempt to test empirically a model of addiction based on psychoanalytic theory. Psychodynamic concepts were operationalized into observable behaviours, and, as there is no strong tradition of research in this area, the results must be treated with caution. Clearly any attempt to translate complex phenomena into behavioural responses will run the risk of being simplistic and reductionistic. Such endeavours are often viewed by both the psychoanalytic and scientific method communities as representing an unsatisfactory dilution of basic principles. However, this kind of research is important if psychoanalytic theory is to stay within mainstream psychiatry and psychology. Untested theories and concepts do not attract funding and are not generally utilized in government policy, methadone treatment policy being a case in point. When Australian Government policy committees conclude that there is no place for interpretive therapies in the areas of heroin addiction and alcoholism, psychoanalysis has lost credibility. So, rather than reject research that attempts to bridge the gap, it is important to identify the conceptual and methodological problems inherent in such research, which is still very much in
its infancy and will need to undergo much refinement before more confident conclusions can be drawn.

In the present studies, a new methodology for testing psychoanalytic theory was attempted. This involved testing a hypothesis derived from a specific psychoanalytic model, Wurmser's model of compulsive drug use, in a specific population, methadone patients. The theoretical foundation of the model, the concept of pathological narcissism, was synthesized and the concept of narcissistic rage was operationalized to form an observable measurable datum. In this way, from a psychoanalytic theory, a new psychometric instrument was designed based on the operationalization of a psychoanalytic concept, and a hypothesis was generated and then tested using the new instrument. The results may have important implications for the addiction field in general and, in particular, the understanding of factors affecting treatment outcome and patient/staff dynamics in methadone treatment. In this way the studies contribute to our understanding of what Wurmser refers to as "the hidden dimension" of addiction and specifically the psychodynamics of extracurricular drug use in methadone patients, with important implications for the assessment and treatment of patients and the training and supervision of staff. However, these results must be viewed as preliminary only and considered within the context of the methodological and conceptual limitations of the studies. These limitations include the process of translating a complex phenomenon into a psychometric
instrument and the process of modification of that instrument from a general scale to a scale designed for use by generic workers with a highly specific population. With these limitations and cautions in mind, the following issues and conclusions are discussed.

10.2 The Narcissistic Rage Scale for Methadone Patients

The present study demonstrates that a complex psychodynamic concept such as narcissistic rage can be operationally defined and translated into an instrument that can be used by general staff in a methadone unit. Reliable judgements were made by staff, some with little or no specific psychodynamic training, after minimal instruction in the use of the scale. So, while the concept of narcissistic rage may be complex and relatively unfamiliar to the methadone staff, the expectations, behaviours and affects characteristic of this phenomenon would seem to be very familiar to them. This suggests that the scale has good face validity and is measuring something that is central to the way staff perceive clients.

Given that the scale was designed to be used by staff in a methadone unit, it is important to ask how representative were the staff and how representative the patients used in the present study. With regard to the staff, they comprised three nurse counsellors/dispensers and one psychologist, which reflects the general pattern of staffing in public methadone programmes in Australia.
(Mattick & Hall, 1993). Although three of the four raters had received no formal psychodynamic training, they attended clinical supervision sessions based on a psychodynamic model, where transference and countertransference issues were addressed. Therefore, the staff used in this study would be less psychodynamically naive than staff at other methadone units where this kind of supervision is not provided, and may therefore not be representative of the majority of staff working in methadone units. It might be argued that this may have contributed to the ease and reliability with which they were able to use the scale. However, there is evidence to suggest that this was not the case. Rater 1 was far more qualified and trained than the other raters and yet did not rate patients significantly differently from the less qualified raters, suggesting that the ratings were based more on identification of the behaviours and expectations specified in the scale, than on sophisticated clinical judgements. Therefore, one of the original aims of the study - to design a scale that could be used reliably by anyone working in a methadone unit - may have been achieved. Similar studies using the scale with staff from other methadone units would be necessary to test this conclusively.

The second question is: how representative were the patients in the methadone unit used in the present study? When compared to the results of surveys reported in the literature (Mattick & Hall, 1993) the subjects in the present study seem to be typical Australian methadone
patients, with an average dose of 60mg (compared to the most common national average dose range of 40-80mg) and an average programme duration of 3 years and 7 months (compared to the national average duration of 4 years). However, there were some unusual features of the sample in terms of gender differences and this issue is discussed in more detail below with reference to the relationship found between level of narcissistic rage and treatment outcome.

10.3 Levels of Narcissistic Rage in the Sample

The results indicate that 73% of clients on the methadone programme studied had high to extremely high levels of narcissistic rage and 19.5% had significant levels of narcissistic rage. This finding reflects the high level of comorbid psychopathology found in methadone patients reported in the literature. It has long been recognized that methadone patients and compulsive drug users in general have high rates of psychiatric symptoms; depression, anxiety and antisocial personality disorder are the most common diagnoses. However, the results of the present study indicate that a core narcissistic disturbance may be central to, or at least is common to many patients, as proposed by Nicholson and Treece (1981). Further investigation is necessary to determine the precise nature of the relationship between pathological narcissism and the other kinds of psychopathology found in methadone clients. Narcissistic
defence mechanisms such as splitting, devaluation, idealization, omnipotence and projective identification can be a feature of many personality disorders (DSM IV, 1994).

In providing information about the population being treated at the methadone unit, the results confirm clinical impressions concerning the high proportion of pathologically angry, demanding patients seen in methadone treatment generally. Within this, there is also recognition of the high levels of stress experienced by methadone staff as they try to contend with a large proportion of patients who hold unrealistic beliefs and expectations. The high sustained levels of criticism, abuse and rejection received from patients, as staff fail to live up to their idealized fantasies and fail to confirm the patients' idealized fantasies of themselves, represents a specific and serious source of stress for staff which is rarely acknowledged in the literature. High levels of burnout in staff would be predicted, especially in clinics where countertransference issues are not addressed in clinical supervision. The present study highlights the need for training and supervision aimed at developing an understanding of pathological narcissism and skills for interacting with narcissistic patients to improve staff performance and reduce stress and disillusionment in methadone treatment programmes.

The results also suggest that patients in methadone treatment experience high levels of frustration, anger and disappointment. It may be that staff do not attempt
to resolve consequent conflict in the most constructive way. Indeed, in the candidate's experience, clients' grievances, that might best be dealt with clinically, are often taken to committees and tribunals where they are listened to with a judicial rather than a clinical ear. The recent trend towards harm reduction policies has also resulted in more latitude being given to patients who cannot function according to usual conventions. While loosening boundaries may have a role in providing harm reduction for some, there can also be a failure to acknowledge and treat pathology that precludes some clients from responding to conventional programmes and the real world in general. Learning about interpersonal boundaries and forming realistic expectations of self and others could be included as an important treatment goal, with methadone programmes structured to provide a realistic and consistent environment where expectations can be reality-tested.

10.4 Relationship Between Level of Narcissistic Rage and Extracurricular Drug Use

As suggested by Wurmser's formulation of the psychodynamics of compulsive drug use, a statistically significant relationship was found between narcissistic rage and extracurricular drug use in methadone patients. Level of narcissistic rage in a patient was a modest predictor of level of extracurricular drug use, with patients scoring high levels of narcissistic rage tending to use more drugs than patients with lower levels of
narcissistic rage. However, from these results, the exact nature of the relationship between narcissistic rage and extracurricular drug use cannot be specified. Wurmser suggests that methadone patients will use drugs to alleviate the experience of narcissistic rage during a narcissistic crisis. While the design of the present study does not permit this precise chain of events to be established here, the results do point to a patient's level of narcissistic pathology being a factor affecting level of drug use and therefore treatment outcome. Also, by using methadone patients to study compulsive drug use, the role played by physiological requirements for opiates can be eliminated as a factor affecting extracurricular drug use, assuming that patients were stabilized on sufficient doses of methadone to meet physiological needs. In the present study, urinalysis results from the first three months of the patients' programme were not included so that the data used would reflect the patients' performance after an initial period of stabilization and dose adjustment. The variety of drugs used also suggests a need for mood-alteration rather than a physiological need for heroin.

The findings provide general support for Wurmser's formulation of the psychodynamics of compulsive drug use. They are also consistent with the results of studies by Nicholson and Treece (1981) and Rutherford et al. (1996) investigating object relations and extracurricular drug use in methadone patients, suggesting that patients with impairments in the narcissistic realm tend to use more
extracurricular drugs. However, some features of the results require closer examination; first, the failure to find a stronger relationship between level of narcissistic rage and drug use; second, the significant gender difference found in the level of extracurricular drug use and third, the relationship found between dose and drug use.

The first possible explanation for the weaker than expected relationship found between level of narcissistic rage and extracurricular drug use is that the instrument used may not be optimally tapping narcissistic rage, and therefore, the ratings obtained may not accurately reflect a patient's level of narcissistic rage. One possible weakness of the Narcissistic Rage Scale For Methadone Patients is that it only includes aggressive components of narcissistic rage. Extreme shame and humiliation may also be experienced during a narcissistic crisis, but these may be less apparent to observers, due to the usual tendency to hide such affects. For this reason, items relating directly to shame and humiliation were not included in the scale. Anger, hate and disappointment are all more likely to be enacted in a very overt way due, in particular, to the intense desire for revenge and justice, which forms a central feature of narcissistic pathology. In general, the scale was based on the assumption that narcissistic rage would be expressed in distinctive ways by the patient, and would therefore lead to observable behaviours of the particular kind described here.
It is also possible that some patients can hide even the most intense rage, perhaps displaying their anger to others but not to the "offender". For some, this secret revenge may be sweeter. In the methadone unit used in this study, there were cases of patients who were always warm and friendly in face to face interactions with staff but were reported frequently to malign these same staff members when not in their presence. Perhaps this form of 'tricky behaviour' gives these patients a feeling of superiority over staff, and is a more powerful form of denigration than open criticism.

The candidate recalls one patient, Mr R, who was thought of by all staff as a very gentle, polite, lovely man. However, later in psychotherapy, Mr R gradually divulged that his thoughts were so angry and violent, he lived in fear of becoming a serial killer. He stated that he made sure he was extremely kind and gentle to everyone so that no-one would ever suspect the true nature of his personality. Although his urine results were always perfect, confirming the staff's impression of him as being motivated and compliant, he later admitted that he was using large amounts of black-market methadone (undetectable by urinanalysis) to supplement his prescribed dose. No-one ever suspected him of such deception. The patient said that it was essential to him that everyone thought he was perfect, and that he could maintain a feeling of superiority. To be thought of as flawed was intolerable. He also admitted that, in addition to hiding his true self from staff, his
deception also made him feel extremely contemptuous of the staff, bolstering his feelings of superiority. Mr R's relationship with the therapist was a striking example of Rosenfeld's concept of narcissistic omnipotent object relationships. He projected into the therapist those attributes in himself which he found intolerable, particularly his coldness and his madness, while imagining that he was endowed with those attributes and capacities of his therapist of which he was most envious, namely her sanity and her ability to contain anger. This case is not conclusive but does seem to illustrate that narcissism is a complex phenomenon, and attempts to reduce it to observable behaviour will always have limitations. It is interesting to note that this patient was excluded from the present study because, given that he had confessed to using blackmarket methadone, his urine results were judged unreliable. In addition to deceptively good urine results, he would have probably also been given a deceptively low score on the Methadone Patient Narcissistic Rage Scale. Once again this illustrates the limitations of the scale and of the present study in cases where so-called observable and measurable data are distorted by the patient's narcissistic drive to conceal and deceive in order to maintain a superior image. Overall, the scale's reliance on observable behaviour may be its greatest strength and also its greatest limitation.

A second possible explanation for the weaker than expected relationship found between narcissistic rage and
extracurricular drug use concerns the exclusion of some subjects from the study. Out of the 83 patients currently in methadone treatment who met all other criteria for inclusion in the study, five were excluded due to the unreliable nature of their urinanalysis results: they were strongly suspected of, or had been caught, substituting or in some way tampering with their urine specimens. Such deception may represent a narcissistic need to override rules and limits. A narcissistic sense of entitlement may be involved ("I deserve all privileges and should not have to earn them"). Also, deception may be employed to deny personal limitations ("my urine record will be perfect"). In other words, the very patients who were excluded from the study may represent both those patients with the highest levels of narcissism, and those patients with the highest levels of drug use.

Another possible explanation for the weaker than expected relationship found between level of narcissistic rage and extracurricular drug use related to urinanalysis results involves the level of deception practiced and the possibility that the more narcissistic a patient, the more likely they will resort to deception. Although patients are informed that there will be random supervision of urines at the unit (through a one way mirror), the fact that some patients still openly use deception may be testimony to the intensity or drivenness of their narcissistic perception of reality. They practice deception even though it is likely that they
will be caught. One example, from the candidate's experience of working in a methadone unit, involves a patient who handed in an ice-cold urine sample. When the nurse dispenser asked him why the urine jar felt as if it had been in a fridge, he replied in a straight faced manner; "I drank a can of coke from the fridge before I came". This obviously ludicrous explanation made sense to the patient, either because his narcissistic self-image did not include the concept of being deceitful, or of being stupid enough to be caught at it, or perhaps because his idealized (or denigratory) image of the nurse was that she would agree with anything he said. In either case, the narcissistic need to deny his use of, and therefore his psychological dependence on, a drug was paramount, overriding a more "honest" response to being caught out.

Of course, most clients are more realistic and know that such grandiose attempts at deception will fail. In the clinic used in the study, many patients used to bring "clean" urines from home that they had previously bought, or urine saved from a previous time. The staff were alerted to this when they started to realise that many patients liked to run the hot water tap in the bathroom for a while. In fact, so many patients were heating up their refrigerated urine specimens that eventually the staff removed the hot water tap from the sink. This illustrates that many patients will substitute their urines if they can get away with it. It also suggests that while steps were taken to ensure that the
urinanalysis results were as reliable as possible, some deception may still go on undetected, and the extent of drug use as measured by urinanalysis may still be an underestimation for some patients. Indeed it is possible that the few patients who did not seem to fit the general pattern of results, specifically, those with a high level of narcissistic rage but a low level of extracurricular drug use, may have been substituting their urine specimens. Perhaps the more narcissistic a patient, the more likely he/she will be to resort to elaborate (and therefore undetectable) deception, thereby skewing the results of the study. However, this is merely an intriguing possibility.

The picture is even more complicated because some patients do not even bother to conceal their drug use because they believe they are entitled to receive methadone, regardless of whether or not it is reducing their drug use. An example of this from the candidate's experience was a married couple who used heroin on a daily basis while receiving methadone. When a decision was made by staff to terminate treatment and recommend another form of treatment, the couple were outraged and insisted that methadone treatment was working for them. At their request, an external appeal panel was convened. The couple argued that if being on methadone stopped them from using heroin only one day a year, then it was worthwhile because on that one day they may have injected with a used syringe and contracted AIDS. To the staff's dismay, the panel supported the argument that methadone
was serving a harm-reduction function for this couple, and the staff's decision was overturned! Formulations describing countertransference and projective identification reactions may be useful in understanding the psychodynamics at work in these kinds of situations, although political or sociological factors are also relevant.

It may be that there is no single pattern or relationship between a patient's level of narcissistic rage and their deception with urine specimens. An individual's narcissism may move them to use obvious deception, elaborate undetectable deception or not bother with deception at all. In summary, it is not possible to determine whether a significant level of urine substitution still occurs undetected. However, the clinic's policy of random supervised urines does, as far as is possible, serve as a method of deterrent and of detection of urine substitution. Unfortunately, deception, even in the face of staff attempts to prevent or monitor it, may always be a problem and its impact on the results of the present study difficult to determine.

As well as problems attributable to the scale, and to urine substitution, other possible explanations for the weaker than expected relationship found between narcissistic rage and extracurricular drug use involve the limitations of urinanalysis in detecting all drug use and its inability to provide quantitative information.

The first possible explanation of this kind may involve another undetectable form of deception, the use
of black-market methadone. Because urinanalysis results indicate only the presence/absence of methadone, there is no way of detecting whether a patient is supplementing their prescribed dose of methadone with illegally obtained black-market methadone. People are periodically apprehended selling methadone to patients outside the unit. Some patients admit their use of black-market methadone when their source runs out and they request a dose increase to prevent the onset of withdrawal. Therefore, while the existence of this form of extracurricular drug use is a recognized fact, it is not possible to determine what effect it may have had in the present study in terms of underestimation of the level of drug use in some patients. Again, patients with high levels of narcissism may be the very patients who are most likely to rely on an undetectable form of extracurricular drug abuse. Using black-market methadone may be a way of bolstering narcissistic fantasies about no longer needing heroin. Many patients believe that because they no longer use heroin, they no longer have a dependence problem. The fact that they are now dependent on methadone is denied. When the need for mood-alteration is high and black-market methadone is used, the person can simply view this as "topping up their methadone dose" and many rationalizations can be employed to justify this move. Patients will believe that their prescribed dose is inadequate and will take it upon themselves to make the necessary changes, defending against their dependence on the prescriber. Others will justify their episodic use of
black-market methadone on the grounds that "the methadone did not work today" or "the dispenser gave me the wrong dose today", a common complaint. The candidate recalls one patient who experienced almost daily mood swings and became so convinced that the dispensers were sadistically tricking him by giving him a different dose every day, that he became quite paranoid and aggressive. This paranoia may be viewed as a defence to persuade himself that he had total control over his moods from day to day.

A second and related possible explanation for the weaker than expected relationship found between narcissistic rage and drug use, in terms of the limitations of urinanalysis, may involve undetectable alcohol abuse. Urinanalysis results would not provide useful information about alcohol consumption because, as with methadone, urinanalysis results indicate only the presence/absence of a substance, but not the quantity of the substance present. Therefore, testing for alcohol does not provide useful information because most patients probably consume at least small amounts of alcohol on a regular basis. In other words, urinanalysis results do not differentiate between consumption of alcohol and alcohol abuse. For this reason, the urinanalysis does not include a screen for alcohol and yet studies indicate that alcohol abuse is a serious and common problem among opiate abusers and methadone patients (Hubbard et al. 1989; Hunt et al. 1986; Joseph & Appel, 1985; Kleber, 1983; Regier et al. 1990; Roszell...
et al. 1986; Stastny & Potter, 1991; Stimmel et al. 1983). An inverse relationship has been reported between alcohol use and opiate use, so that when opiates are abused, alcohol use drops, whereas when addicts are in treatment (drug-free or methadone) and opiates abuse is reduced, alcohol abuse increases (Anglin et al. 1989). The TOPS study (Hubbard et al. 1989) also found that alcohol use increases when addicts are in treatment, including methadone treatment, although this trend reversed in patients who were retained in long-term treatment. A study by Joseph and Appel (1985) and the Drug Abuse Reporting Programme (DARP) study (Bracy & Simpson, 1982-83; Simpson, 1981; Simpson, Joe & Bracy, 1982; Simpson, Joe, Lehman & Sells 1986; Simpson & Sells, 1982) found that alcoholism was a major cause of death among methadone patients after they had left treatment. This means that a potentially high incidence of alcohol abuse in the present sample may be another undetectable factor influencing the results of the study: if methadone patients are abusing alcohol rather than other drugs to obtain relief from narcissistic injury, the present study would not be able to detect this. Given that alcohol is probably the cheapest and most accessible mood-altering substance available, it may be the most commonly used drug during a narcissistic crisis.

The results of the anonymous alcohol survey are of relevance in this connection. The dispensers noted that most people, when asked to participate in a survey on alcohol use, first responded by reassuring the dispensers
that they never drank alcohol. This would be surprising, given that most people drink alcohol, and the literature indicates that a high percentage of methadone patients abuse alcohol. Regier (1990) found that people who abuse or are dependent on opiates were thirteen times more likely to abuse or be dependent on alcohol compared to the general population. One explanation might be that, although the results of the actual written survey were anonymous and confidential, patients were defensive when approached verbally by the dispensers on the topic of alcohol use. Alternative approaches were considered but rejected. For example, one way of avoiding this would have been to conduct the survey without the involvement of the methadone staff, either by writing to patients (which one would predict would produce a low response rate) or by approaching patients outside the methadone unit, which presented many other problems.

The results of the survey indicated that 43% of respondents stated that they do not drink alcohol, 35% stated that they are moderate consumers of alcohol and 22% stated that they abuse alcohol, either by binge drinking or regular heavy drinking. Among those who abuse alcohol, 14.5% stated that they prefer drinking/getting drunk to taking drugs/getting "stoned". These results are inconsistent with the literature on alcohol consumption in methadone patients, also suggesting either that, despite the reassurances given, many patients were not completely honest in their responses or that our sample was atypical. Another factor may have been the wording of
the survey. To maximize the participation rate, care was taken to avoid statements that would be too confronting. For example the words "moderate drinker" were used but what constitutes moderate drinking was not specified because this usually causes much controversy among alcohol abusers. In this way, accuracy may have been sacrificed in an attempt to increase participation. The main problem here may have been that some may regard their alcohol abuse as constituting normal moderate drinking, thereby skewing the results towards an underestimation of alcohol use. In addition to problems associated with conservative response rate and results, another factor limiting the usefulness of the results is the time delay between collecting the main data and conducting this survey; patients included in the main sample were not necessarily the same patients who later participated in the survey. While all these limitations are acknowledged, they were to be expected, and the survey was intended simply as an attempt to get a general impression about alcohol consumption among patients typically attending the methadone programme. Even with all these limitations taken into consideration, the results do indicate that at least 21% of the respondents abused alcohol, and this must be assumed to be a conservative estimate. Therefore, it is possible that a significant percentage of substance abuse, in this case, alcohol abuse, was not detected by the urinanalysis, and may have influenced the results of the study.
In a similar limitation of urinanalysis, cannabis is also a commonly used drug that was not identified, providing another relatively cheap, easily accessible and undetectable source of mood-alteration. Again, the recreational use of cannabis may not represent a problem but some patients may be abusing the drug. In a study of extracurricular drug use among methadone patients in three Sydney public clinics, Ward (1995) found that 60% of patients self-reported having used cannabis in the last month, with 40% reporting daily use.

Another type of drug use which may have influenced the results of the present study is rohypnol abuse. Benzodiazapine abuse is a common problem in methadone patients (Ward, 1995). While the urinanalysis screened for all other benzodiazapines, it did not screen for rohypnol, unless this special drug screen was requested. Staff would request this if a patient appeared often to be sedated, when their urine results did not indicate any extracurricular drug use. It is possible that some patients could be abusing rohypnol but be so tolerant to it that they display no visible signs of sedation. Despite all the limitations discussed, urinanalysis remains the most reliable and widely used method of monitoring extracurricular drug use over long periods in methadone programmes (Howard, 1993).

When considering all the possible limitations of urinanalysis results, it is interesting to examine the five patients in the present study whose level of narcissistic rage did not seem to have any relationship
to their extracurricular drug use. All five of these patients obtained NR scores that placed them in the extreme category, yet their proportion of positive urines respectively was 0%, 0%, 0%, 6% and 9%. This stands in contrast to the other thirteen patients who scored in the extreme NR category whose proportion of positive urines ranged from 26% to 100%, with a mean of 63%, and with four of these patients having over 90% positive urines. At the time of writing this thesis, one of the five patients was imprisoned for his participation in a major crime ring involving stolen video players, an unlikely occupation for someone abstaining from illicit drugs. While there was no proof that he was substituting his urines, staff believed that he was using heroin but was avoiding detection. By contrast, the staff believed they had no reason to suspect that the other four patients were using extracurricular drugs. Therefore, it does appear that at least four of the five patients did not display the general relationship found between level of narcissistic rage and level of extracurricular drug use. In these cases, undetected drug abuse may not be the reason for the weaker than expected relationship found. Despite high levels of narcissistic rage, these patients do not appear to use drugs in order to alleviate their emotional pain. One possible explanation is that these four patients were atypical. Detailed case studies of these patients might reveal how they experience their narcissistic rage and how they cope with it. Perhaps their ability to contain intense emotions is superior, or
perhaps they derive some kind of sadomasochistic pleasure from the experience of this pain, as has been suggested by Wurmser (1978, 1985) and Kernberg (1970, 1974, 1975, 1992) in their discussions of stalemates in the therapeutic relationship. In summary, the relationship between a patient's level of narcissistic rage and extracurricular drug use may not be as straightforward as that hypothesized.

Finally, before concluding this section on the finding of a relationship between level of narcissistic rage and extracurricular drug use, a number of methodological points concerning the data analysis will be addressed. The first methodological point for discussion is the use of the higher of the two ratings for each subject on the NR Scale in the statistical analysis. As outlined in section 9.3.1 the rationale for this was to make a clinical point and it did not influence the finding of a statistically significant relationship between level of narcissistic rage and level of extracurricular drug use. However, it may be argued that it is more usual to use an average of the two ratings for data analysis. While this may have been more methodologically typical, it was not incorrect and did not affect the results.

A second possible methodological concern is the rationale for categorizing the data for the purposes of analysis, and for the specific cut-off points used. Again as outlined in section 9.3.1, this decision was based on clinical rather than statistical grounds but ultimately
this did not affect the results. Also it is very common to categorize data in order to give raw numbers some kind of clinical meaning and so the decision to do so in the present study does not represent a departure from usual methodological practice.

10.5 Gender Differences in the Sample

In addition to the weaker than expected relationship found between level of narcissistic rage and extracurricular drug use, another related feature of the results was the gender difference found. Females had a higher proportion of positive urines than males, and this difference was statistically significant. This means that, overall, the results indicate that females used more extracurricular drugs than males. The same gender difference has been found in other recent studies of Sydney methadone clinics (Bell, Ward, Mattick, Hay, Chan & Hall, 1995; Capelhorn, Bell, Kleinbaum & Gebski, 1993; Capelhorn, Riley & Wodak, 1993; Darke, Swift, Hall & Ross, 1994; Ward 1995). In the present study, for example, a male and female with a high level of narcissistic rage both tended to use more extracurricular drugs than patients with a low level of narcissistic rage, but the female will use more drugs than the male. This means that gender accounted for much of the variation in level of extracurricular drug use, and in this way diluted the relationship between NR score and level of extracurricular drug use. Therefore, the
narcissistic rage score combined with gender provided the strongest predictor of extracurricular drug use.

One possible explanation for this is that there may be gender differences in undetected alcohol consumption with males consuming more than females. As discussed previously, it is possible that some patients abuse alcohol to relieve narcissistic injury but due to the limitations of the urinalysis performed, any alcohol abuse was undetectable. This possibility is not supported by the survey on alcohol use described earlier which did not obtain any significant gender differences in reported alcohol consumption. Ward (1995) also found no gender differences in self-reported alcohol consumption in a study of three Sydney public methadone programmes. Another possible explanation involves deception and urine substitution. Perhaps males are better at substituting their urines than females, with the result that females appear to use more drugs than males. This could be related to the higher incidence of Antisocial Personality Disorder in males (DSM IV, 1994), which may be associated with higher levels of deception and fraud.

Another factor contributing to the gender differences found in levels of extracurricular drug use could be gender differences in polydrug abuse. Reports indicate that doctors prescribe tranquillizers twice as often for women as for men, and women are more likely to have a history of polydrug abuse (Kelly & McGregor, 1994; Mant, 1989). Leiffer, Goldman and Finnegan (1983) studied a methadone programme for pregnant women and found that
74% continued to use heroin and 98% were polydrug abusers. Women on higher doses tended to abuse more diazepam than those on lower doses. In the present study, given that all urines containing psychotropic drugs were classified as "positive", it is not possible to determine the extent of heroin use relative to other drug use in the present sample. However, polydrug abuse in females, particularly benzodiazapine abuse, may have contributed to the differences in overall drug use found between males and females. An exception to the bias towards females abusing benzodiazepines is the recent study by Ward (1995) who found that males tended to use more benzodiazapines than females, although this difference was not statistically significant.

Another possible explanation for the gender difference in drug use could be the relationship between heroin use and prostitution in women, as suggested by Ward (1995) who found that the difference between male and female extracurricular heroin use disappeared when the data were controlled for prostitution. However, this was only found to be the case in the two inner city clinics (close to the "red light" district). It was not found in the suburban clinic studied which is more comparable to the suburban clinic studied here.

While this gender difference does not alter the overall support obtained for the main hypothesis, it might be thought to raise questions concerning how representative the sample might be. However, the evidence from other comparable studies (Bell et al. 1995;
Capelhorn et al. 1993; Capelhorn et al. 1993; Darke, Swift, Hall & Ross, 1994; Ward, 1995) is that this gender difference is a feature across six other Sydney methadone programmes. Given that males and females were fairly equally matched in terms of dose and NR scores, it is clear that gender accounts for much of the variation in the relationship between level of NR and extracurricular drug use in this population.

10.6 Representativeness of the Sample

The encouraging results obtained in terms of the reliability of the Narcissistic Rage Scale for Methadone Patients and support for the main hypothesis concerning a relationship between level of narcissistic rage and level of extracurricular drug use and therefore treatment outcome, must both be examined within the context of the representativeness of the methadone programme and of the patients used in the present study. From a survey of public methadone programmes across Australia, Mattick and Hall (1993) compiled a profile of a typical methadone programme based on data from 60 agencies (a response rate of 80.6% of all agencies). The majority of programmes offered methadone on a long-term basis with an average programme duration of up to four years. The most common treatment goal pursued across 162 units was eventual abstinence (48%) with many agencies aiming for a combination of abstinence and non-harmful drug use (19.3%) and some limiting their aims to non-harmful drug
use (12.3%). Dosing policy was fairly consistent with an average dose of 40-80mg (51.2%), with the next most common dose range being less than 40mg (33.1%), followed by 81-120mg (11%) and only a small percentage of patients maintained on more than 120mg of methadone (1.5%). In a review of the literature the authors conclude that the ideal dose should provide freedom from discomfort for the patient. Adjunct counselling of some kind was offered to patients by 93% of agencies. In total, 44% of all patients received regular counselling. Most agencies offered supportive counselling, crisis intervention or confrontational counselling. Psychodynamic therapy, encounter groups and psychodynamic groups were almost never used. Nearly half the agencies provided aftercare as needed and AIDs prevention information and services were common. Most programmes incorporated treatment for other drug use, particularly alcohol, minor tranquillizers and illicit drugs. Urinanalysis was used in all programmes as an indicator of treatment performance.

When the methadone programme used in the present study is compared with the results of the survey, it fits the profile of the typical programme. The average duration of treatment in the methadone programme used in the present study was three years and seven months (compared to national average of four years). Abstinence was generally seen as the goal of treatment for patients with a good prognosis while non-harmful drug use and perhaps later abstinence was seen as a more realistic
goal for other patients. The average dose was 60.93mg (compared to most common national dose range of 40-80mg) and dosing policy was based on a dose that would prevent withdrawal discomfort. Adjunct counselling was offered to all patients with about half the patients attending supportive counselling and many attending only during a crisis or coming to compulsory sessions when they had to be confronted about harmful or unacceptable behaviour. AIDS prevention information and services were provided by a specialized team at the clinic and all patients were offered aftercare. The only way in which the programme in the present study was not typical of most methadone programmes in Australia was that some psychodynamic therapy was offered but only attended by a small percentage of patients.

10.7 Methodological Considerations/Limitations

10.7.1 Limitations of the Narcissistic Rage Scale for Methadone Patients

The process of developing the pilot Narcissistic Rage Scale contains a number of weaknesses, previously discussed in Chapter 8. Once constructed, the general Narcissistic Rage Scale was then "translated" into specific situations and examples pertaining to methadone patients, to form the Narcissistic Rage Scale for Methadone Patients. The final scale's content and face validity were retrospectively assumed because, in the main study, the staff at the methadone unit were able to
use the scale with only minimal instruction, and good re-test reliability results were obtained. As discussed in Chapter 8, an attempt to independently validate the final scale would have strengthened the study. A pilot study to test whether the scale was viable for use by methadone staff and whether it could be used reliably should also have been conducted prior to using the scale in the main study, rather than extrapolating this information from the main study. In general, establishing the reliability of a new scale is an ongoing process requiring further research.

10.7.2 Methodological Considerations/ Limitations of the Main Study

When evaluating the overall design of the main study, some areas of the methodology involving the method of ratings employed on the Narcissistic Rage Scale for Methadone Patients require some discussion. The first area concerns the question of whether or not the raters were blind. Because the raters were staff at the methadone unit, it is possible that they were familiar with some or most of the patients' urinanalysis results. That might then constitute a demand characteristic, such that, for example, raters gave higher scores on the Narcissistic Rage Scale for Methadone Patients to patients with a high proportion of urines positive for extracurricular drugs. It could then be argued that the raters were not blind to the dependent variable in the study. There are two issues here: first, whether the
raters did in fact know the status of the urinalysis record for the patients they rated and second, whether this biased their ratings. Regarding the first point, patients were not randomly assigned to raters because the rater had to know the patient well in order to complete the scale. In the case where more than one staff member knew the patient well, that patient was randomly assigned to one of those raters. It is therefore likely that the raters were often aware of the urinalysis record of the patients they rated, particularly if it was a patient whom they case-managed; they would have been less aware if their knowledge of the patient simply came from daily contact in the dispensary. With regard to the second question, the raters were blind in that they had no knowledge of the nature of the study. For their purposes, the title of the scale (The Narcissistic Rage Scale for Methadone Patients) was deleted and the scale was simply called "The Methadone Patient Behaviour Checklist". This ensured that the raters did not know what the scale was designed to measure. Second, they did not know that their ratings were going to be compared to the patient's urinalysis results. However, although the raters were blind to the main study's design, the results of the follow-up study detailed in chapter 9, using hypothetical case vignettes, suggest that, at least in the hypothetical cases, a demand characteristic seems to have been present and affecting ratings when the rater knew that the patient had a record of good urine results, indicating little or no extracurricular drug use.
However, it is interesting that while knowing that a patient did not tend to use extracurricular drugs influenced the raters in the hypothetical vignette study to lower their NR ratings, the opposite was not true; that is, knowing that a patient was using high levels of extracurricular drugs did not seem to influence the raters to increase the NR score for that patient. So, when the rater knew that the patient was abstaining from using extracurricular drugs, the rater seemed to be more tolerant of or judge less harshly, any pathological behaviour displayed by the patient, yet did not judge the patient more harshly when they were known to be engaging in a high level of extracurricular drug use. This result is difficult to explain.

Overall, no firm conclusions about the presence or absence of a demand characteristic in the main study can be drawn from the results of the hypothetical case vignette study. First, the use of hypothetical case vignettes may be considered a rather artificial means of attempting to provide case material that is equivalent to actually knowing a real patient, and the results of the case vignette study may be an artifact of the methodology. Second, the way the vignettes were written may have constituted an obvious demand characteristic that did not exist in the main study: in the vignette, the rater's attention was drawn to the patient's urinanalysis results and they were asked to rate the patient on the basis of this information, whereas in the main study, the raters were not in any way reminded of
the patient's urinanalysis results at the time the ratings were made. Therefore it is difficult to determine confidently whether or not there was a demand characteristic present in the main study, and if so, the extent to which this may have influenced the finding of a relationship between narcissistic rage and extracurricular drug use in the main study.

The second area of methodology that requires discussion concerns the timing of the ratings made using the Narcissistic Rage Scale for Methadone Patients. Ratings were based on the rater's observations of the patient's behaviour over the course of treatment. Only staff members who had been involved with a particular patient since the commencement of their treatment, were asked to rate that patient. This raises two concerns. First, it could be argued that the ratings were made retrospectively and therefore, may have been subject to memory interferences, making the data unreliable. However, given that the patients were still in treatment at the time the ratings were made, the ratings were not retrospective in that the ratings were based on current behaviour as well as previous behaviour, in a continuum of observation over time to the present. Ratings based on the patient's behaviour at assessment, however, as specified in items 1, 2, and 3 of the scale, were made retrospectively and therefore might have been subject to memory interferences.

The second area of concern arising from the timing of the ratings is the variations in treatment lengths for
the patients. All the subjects for the study were patients currently participating in the Chatswood Methadone Maintenance Programme. Criteria for inclusion in the study were that patients had completed a three month stabilization period and had then been in treatment for at least one year following stabilization. This means that the patients included in the study had commenced methadone treatment at various points spanning the programme's 8 year history, with varying amounts of time elapsing between the patient being assessed for commencement of methadone treatment and the NR ratings being obtained. For example, one patient may have been in methadone maintenance treatment for 2 years while another may have been in treatment for 5 years. This was not an oversight or a design fault but a necessary aspect of the design. The ratings were to be based on the raters' total knowledge of the patient over a specified period of time sufficient to ensure that the rater had comprehensive knowledge of the patient based on a long period of observation. This was designed to produce an assessment of the patient which would be more reliable than a one-off interview at the point of entry onto the programme. It also made it possible for untrained staff to identify characteristics based on repeated observable behaviour rather than on diagnostic criteria or knowledge of psychodynamic concepts and theory. This was central to the aim of designing an instrument that could be used by general staff in a methadone unit. However, the inclusion in the study of patients with varying treatment lengths
raises questions concerning the possible influence of
differential memory effects on the NR ratings and the
possible effect of different treatment lengths on both
the patient's level of narcissistic pathology and the
patient's level of extracurricular drug use.

With regards to the first two questions, in
designing the main study, the generalizability of the
narcissistic rage ratings was not considered to be a
methodological problem because a patient's level of
narcissistic rage is conceptualized in the literature as
a core personality or characterological feature which,
without specific intervention, remains stable over time.
The DSM IV (American Psychiatric Association, 1994)
specifies that personality disorders involve long-term
dysfunction, first apparent in childhood or adolescence,
which is pervasive and is not limited to episodic
behaviour. Even when treated, patients with pathological
narcissism require many years of psychotherapy for any
change to occur (Goldberg, 1973; Kernberg,
(1979a, 1979b, 1982) found that narcissistic traits did
not respond to methadone treatment. Therefore, there is
no reason to expect that participating in methadone
maintenance treatment, or even receiving case management
sessions or supportive counselling, would modify such
fundamental personality structures. Also, given that
pathological narcissism has been conceptualized as
originating in infancy when the individual's core
personality structure is formed and primary narcissism is
either relinquished, retained or re-experienced through defensive regression, a patient would not be expected to develop a pathologically narcissistic personality during participation in a methadone programme (that is, as an adult). The re-test reliability for the scale shows that after an intervening period of six months, the ratings were reliable over time. Therefore the Narcissistic Rage Scale for Methadone Patients can be said to reflect, not what the patient was like at a previous point in time but what the patient is like across time, based on pervasive, consistent personality features, as evidenced by observable behaviour. Therefore, length of methadone maintenance treatment would not be expected to have any effect on a patient's level of pathological narcissism, and so the inclusion of patients with varying lengths of time in treatment should not have influenced the ratings obtained on the Narcissistic Rage Scale for Methadone Patients. Similarly, the generalizability of the ratings made based on the patient's behaviour during the course of treatment would not be expected to diminish the reliability of the ratings, as they were based on stable, pervasive behaviours over time rather than fluctuations over short time periods.

With regard to the third question concerning the effect of differential treatment lengths on patients' level of extracurricular drug use, research from both DARP (Drug Abuse Reporting Programme) and TOPS (Treatment Outcome Prospective Study) indicates that retention in treatment for at least one year following dose
stabilization is an important factor in treatment outcome, rather than the total duration of treatment. For this reason, only patients who had been retained in treatment for at least one year following a three month dose stabilization period, were included in the study.

Overall, however, the relationship found between level of narcissistic rage and level of extracurricular drug use was not a strong one, suggesting that other factors may affect patients' level of extracurricular drug use. Improving the methodology of the present study and repeating it with patients from other methadone clinics would provide more evidence to indicate whether the relationship found between level of narcissistic rage and level of extracurricular drug use is merely a methodological artefact or a feature of the present sample. It may also be that the gender difference in the present sample (which is a common finding) accounts for much of the unexplained variance and weakened the relationship between level of narcissistic rage and extracurricular drug use. Repeating the study with a population from a different methadone clinic where there is no gender difference in extracurricular drug use would be necessary to answer this question. It is important to note that the relationship between extracurricular drug use and level of narcissistic rage in the present sample is evident because males and females in this sample are matched fairly equally in terms of methadone dose and display equal levels of narcissistic rage.
In summary, the results of the present study provide modest support for the hypothesis that patients with higher levels of narcissistic rage use more extracurricular drugs than patients with low levels of narcissistic rage. This is consistent with psychodynamic theories of compulsive drug use that suggest that extracurricular drugs will be sought by methadone patients to alleviate psychic pain during a narcissistic crisis. These encouraging results must be interpreted cautiously, as the relationship found was not a strong one and should be viewed within the context of the limitations of the study; specifically the limitations of the Methadone Patient Narcissistic Rage Scale, the limitations of urinanalysis and the significant difference found between drug use in males and females which accounted for some of the variance in the sample.

When the results of the present study are compared to those obtained by Treece and Nicholson (1980), one apparent difference emerges in the amount of extracurricular drug use found. Treece and Nicholson classified their subjects into three groups according to personality type; type A included schizoid, schizotypal and paranoid personalities, all characterized by oddness and social isolation. Type B included histrionic, narcissistic, antisocial and borderline personality disorders, all characterized by dramatic, erratic emotional behaviour. Type C included avoidant, dependent, compulsive and passive aggressive personality disorders, all characterized by excessive fearfulness. In the
The results of the present study may be interpreted as providing modest support for psychodynamic theories about the relationship between narcissistic pathology and substance abuse and addiction. However, the relationship found between narcissistic rage and extracurricular drug use was not as strong as expected. While this could be
due to methodological problems in the study, features of
the present sample or problems with the scale, it may
also be that the relationship between narcissistic rage
and extracurricular drug use is not as straightforward as
was hypothesized. Perhaps while a patient's level of
narcissistic rage is a contributing variable, it may
represent a sector of a more important variable or may
interact with other variables in a way that was not
identified in the present study. The present study has
taken a theoretical phenomenon, narcissistic rage, and
has found it to be prevalent in high levels in a sample
of methadone patients, resulting in much pathological
behaviour and impaired interpersonal functioning, and
presenting important on-going problems for both patients
and staff. The present study also suggests that there is
some kind of relationship between level of narcissistic
rage and level of extracurricular drug use. However,
further investigation will be necessary to determine a
better understanding of the nature of the relationship,
its complexities and interactions with other variables.

The results of the present study provide support for
psychodynamic formulations concerning narcotic addicts
and particularly narcotic addicts in methadone treatment.
However, while the psychodynamic literature generally
views all forms of substance abuse and dependence as
arising from the same factors, caution should be
maintained when generalizing the results of the present
study to addictions to drugs other than narcotics. There
is some literature to suggest that different dynamics may
be at play in the abuse of various drugs and that an individual's drug of choice may vary according to the specific psychological needs of the person (Khantzian, 1985; Wurmser, 1978). The present study did not differentiate between extracurricular use of narcotics and other drugs and so no conclusions can be drawn about the relationship between narcissistic rage and extracurricular narcotic use and use of other drugs. Future research could investigate this further.

In addition to conclusions about the exact nature and strength of the relationship between narcissistic rage and extracurricular drug use, conclusions about causal direction must also be approached with caution. The results of the present study support the hypothesis that patients with higher levels of narcissistic rage will use more extracurricular drugs than patients with lower levels of narcissistic rage. This has been viewed as providing support for Wurmser's suggestion that drugs will be used to alleviate the psychic pain of narcissistic rage resulting from a narcissistic crisis and Wurmser's formulation of the central role of narcissistic pathology in the genesis and maintenance of addiction problems. Similarly, the results could also be viewed as providing support for Khantzian's (1974) suggestion that response to methadone maintenance will depend upon the addict's capacity to relinquish a narcissistic orientation. Finally, one cannot rule out the possibility that narcissistic disturbances in personality functioning among drug users are an effect of
drug addiction, not a cause. The results of the present study support those of Nicholson and Treece (1981), who found that methadone patients with a high level of impairment in the area of narcissistic development used significantly more extracurricular drugs than patients with lower levels of narcissistic impairment. Those authors acknowledged that the results of their study must be interpreted cautiously in terms of theoretical significance, and that the processes of cause and effect operate interactively and with a greater complexity than current models probably describe. The same must be said for the present study. Both studies can be interpreted as providing support for the widely held view in the psychodynamic literature that addicts, and in this case methadone patients, use drugs in response to narcissistic crises. Nicholson and Treece found that patients using the highest levels of extracurricular drugs were more impaired in the area of narcissistic development than those in the low drug use group. The high use group were also more impaired in other areas of object relations development, but the strongest differences were found with regard to narcissistic development. In the present study, the findings in regard to effect of impairment of narcissistic development on extracurricular drug use were replicated but this time using a scale designed to tap observable behaviour over a period of time, rather than a one-off psychiatric interview. In this way the present study, using a different instrument and different methodology has broadened support for the results of the
Nicholson and Treece study. In addition, the present study has demonstrated that these results can be obtained without the use of highly trained psychiatric staff, and that the concepts studied can be made accessible to general staff in a methadone unit.

While both studies seem to confirm the central importance of narcissistic disturbance in responsiveness to methadone treatment, further studies should focus on determining whether narcissistic disturbance pre-dates the effects of long-term addiction and intoxication. Currently, there is much literature to support the view that personality disturbance pre-dates addiction problems. Many studies have shown that Antisocial Personality Disorder is a commonly diagnosed psychiatric disorder in addicts (Khantzian & Treece, 1985; Kleber, 1983; Limbeek, Wouters, Kaplan, Geerlings & Alem, 1992; Regier et al. 1990; Rounsaville, Weissman, Kleber & Wilbur, 1982; Strain, Brooner & Bigelow, 1991; Woody et al. 1983). A pre-requisite for making this diagnosis is the presence of the diagnosis of Conduct Disorder during childhood (DSM IV, 1994), which suggests that, at least in the case of addicts with this personality disorder, psychological disturbance was evident in childhood prior to the onset of an addiction problem. As discussed previously, the high incidence of personality disorders in addicts provides evidence of pervasive intrapsychic impairment across time, first evidenced by late adolescence and, therefore, often pre-dating addiction problems. While addictive disorders and repeated
intoxication can lead to drug-induced psychiatric conditions, these must be differentiated from conditions that were present prior to addiction and continue to impair functioning long after active addiction ceases.

10.9 Clinical Recommendations

Irrespective of debates concerning cause and effect, the results of the present study indicate that narcissistic pathology is a serious and common problem among heroin addicts in methadone maintenance, and may in some way influence treatment outcome. Yet it is rarely targeted in adjunct treatment and is generally not taken into account as an important factor in decisions concerning the structure of methadone programmes. The National Drug Strategy as outlined by the Australian State and Federal Governments (1993) recommends that patients in methadone maintenance be offered the following ancillary services: crisis management counselling; supportive counselling; health monitoring and medical services; HIV testing and education; vocational counselling; psychiatric liaison; social welfare and accommodation; sexually transmitted diseases services; budget skills training; lifeskills training; parenting skills training and interpersonal relationship skills training. All this implies two things, first, that these individuals are impaired in almost every area of normal functioning and second, that these impairments represent skills deficits which can be remedied by skills
training. When looking at this list of dysfunctions encompassing virtually the full spectrum of human activity, the question arises: is this pervasive pattern of dysfunction due to skills deficits or to a core personality disturbance which precludes these individuals from implementing or pursuing more adaptive ways of behaving? Rather than splitting the problem up into individual symptoms and behaviours and committing large numbers of staff to various parts of the problem, it may be wiser to identify those patients who would be better served by receiving treatment for the underlying personality problem (research into the psychoanalytic treatment of addiction will be discussed in section 10.10.) The rationale behind diagnosis of medical conditions and psychiatric disorders is the identification of syndromes which then provide information about course, prognosis and treatment of choice, rather than the treatment of symptoms in isolation. Diagnosis of intrapsychic disturbance could, in the same way, provide information about underlying causes and their treatment, rather than providing interventions for each manifestation of this disturbance. However, research is needed to establish whether this approach would be more successful with this population. In particular, research into the treatment of patients identified as suffering high levels of narcissistic pathology should compare treatment specifically designed to address narcissistic pathology with treatments traditionally offered to methadone patients.
Policy concerning the structure of methadone programmes often caters to, rather than addresses, underlying psychopathology in methadone patients. While the efficacy of methadone maintenance is reduced in programmes that adopt a punitive approach (Mattick & Hall, 1993), and while an empathic approach to the patients' psychopathology is important, there can be a tendency for programmes to be structured along "humanitarian" lines that compensate for the patients' limitations. For example, some programmes sacrifice structure for flexibility, catering to the chaotic lifestyle of the addict. There are fundamental problems with this approach. First, it colludes with the idea that it is the staff's responsibility to minimise all difficulties that the patient might encounter, that is, that because these patients are "special" due to their addiction, others must make life easier for them. This approach creates a false environment for patients that bears little resemblance to the real world and further creates or confirms unrealistic expectations about how the world should treat them or exacerbates contempt for staff. The message as perceived by this population seems frequently to be: "you are special and are entitled to special treatment. You have a right to be extremely angry if you do not receive special treatment and others will be to blame if you get into difficulty." This bolsters rather than modifies narcissistic thinking. It is the opposite of reality testing. It also displaces the task of coping with the patients' dysfunction onto the staff,
who then experience high levels of stress as they try to live in an environment moulded to accommodate pathological ideas and expectations. Countertransference involves intense feelings of exploitation, confusion, anxiety and anger as staff struggle to become "perfect objects". Psychodynamic theory maintains that through the process of projective identification, the underlying feelings of inadequacy, fear and helplessness within the narcissistic patient are experienced by the staff, who inevitably burn out or act out.

While flexibility and a cooperative relationship between staff and patients are recommended (Mattick & Ward, 1993) Swartzman et al (1982) and Summerhill (1990) emphasise that soft boundaries and a lack of structure in a methadone clinic do not constitute healthy flexibility and may recreate dysfunctional family dynamics where the "parents" are "pushovers", leaving the "children" without a safe and reliable environment. Psychodynamic theory points to the important role parents play in providing superego functions such as self-control and self-protection which the infant can gradually internalize. Psychodynamic literature contains detailed recommendations of how programmes should be structured and how psychotherapy should be conducted to optimize outcomes for patients with severe narcissistic pathology. These involve firm structures with firm boundaries, not inconsistent, flexible structures.

Khantzian (1974) points out that although many patients on methadone become less egocentric, more
empathic and less likely to behave aggressively, when withdrawn from methadone there is a re-emergence of aggressive outbursts, projections and paranoia. This phenomenon was also noted by Wurmser (1972). Khantzian suggests that this reduction in pathological behaviour during methadone treatment may be attributable to the fact that methadone has a longer half life than heroin and therefore has a stabilizing, subduing effect on patients who would otherwise be extremely labile as the mood-altering effects of heroin quickly switch on and wear off. When defining treatment goals most clinics focus on relapse to drug abuse/dependence and specific associated behaviours such as crime but do not address relapse to personality dysfunction. There is little recognition that, for some, methadone may act like any other prescribed psychotropic medication to alleviate psychological symptoms. Khantzian suggests that a significant proportion of patients who do not modify their behaviour while on methadone have more severe pathology and cannot give up their narcissistic orientation.

Khantzian (1974) makes a number of recommendations concerning psychotherapy for methadone patients. In terms of assessment for psychotherapy, he suggests that patients should not be rejected on the grounds of insufficient motivation. "Where there are massive gaps in ego and superego functioning, motivation as a prime consideration for treatment seems hardly relevant" (1974, p.68). Certain therapy guide-lines are outlined by
Khantzian regarding the critical phase of treatment. He warns that psychotherapy will fail if there is a premature focus on the maladaptive aspects of drug use instead of focusing on understanding why the drug is needed. Encounter group approaches should be based on insight into denial and sense of entitlement, not confrontation which may be experienced as further narcissistic injury. Confrontation also prematurely forces people to give up their defences resulting in temporary compliance or even psychotic decompensation. Sanctioned ventilation of rage in a controlled setting may be useful. Therapists should watch for signs of compliance versus real change. In terms of programme structure, limit setting is recommended because it offers opportunities for gaining control over ego defects and difficulties in managing affects. Khantzian (1977) concludes that effective treatment of narcotic addicts must be based on identification of underlying psychopathology and character disturbance.

Wurmser (1978) agrees that "transference, countertransference, working alliance, and restructuring of the entire life situation help or impede the resolution of the conflicts hitherto coped with pharmacologically" (p.446). His recommendations for the transference relationship are as follows. He suggests that the therapist be strongly nurturing and supporting without becoming engulfing and intrusive (as perhaps the patient's mother was). While assuming this active stance, the therapist must also maintain distance, almost
detached, but not feed a sense of abandonment. This involves a clear boundary of separateness and respect for individuality but with room for symbiotic conflicts to be explored. Acting out should be curtailed through limit setting and external structure. As part of providing structure, Wurmser suggests a verbal contract where the patient agrees not to lie, to tell the therapist if he uses drugs because it is an important symptom, to think about constant drug use as an undermining of therapy, and to attend sessions even when it is painful. The therapist must contract to maintain reliability, honesty and consistency at all times.

Wurmser also outlines typical countertransference problems with these patients. There is always the risk of developing a sado-masochistic relationship if the therapist is pressured into constant giving and indulgence. Limits must be set without sadism and the patient's disregard of limits must be received with empathy rather than anger, otherwise the patient's fears that "no-one can be trusted" will be fulfilled. In fact limits will often be disregarded in order to provoke rage and rejection from the therapist. Wurmser suggests that if the intimacy of the therapy relationship becomes too perverted, treatment should be split up into individual, group and family therapy. When the patient's fear of intimacy and aggressive tendencies is strong there can be a distancing resulting in boredom, stagnation and despair in both patient and therapist. It is important for the therapist to interpret this apparent rejection and
indifference rather than act on it. At all times the therapist needs to keep in mind the redeeming features of the patient and maintain respect for the patient's efforts and struggle. Grandiosity in all its forms must be appreciated as a defence against deep suffering. Wurmser agrees with Kohut that the patient's narcissism must be treated with tact and sensitivity to avoid humiliation and shattering of the patient's already fragile self-esteem. Dreams of grandeur should be accepted as an important defence against hurt.

Kernberg (1985) stresses that the main obstacle to successful treatment of pathologically narcissistic patients will stem from the patient's relentless efforts to destroy what is valuable in the therapist, in order to avoid feelings of dependence and envy. Feelings of emptiness and worthlessness in combination with a corresponding devaluation of the patient can become the main feature of the therapist's countertransference. Kernberg (1985) emphasises that when working with pathologically narcissistic patients, the focus must be on the countertransference as the key to the patient's hidden intentions and struggles. However, having identified the countertransference, the therapist should not reveal these feelings in a direct verbal way to the patient but utilize the feelings to form interpretations about the patient's inner world. For example, if the patient consistently rejects all interpretations, the therapist can point out that the patient is treating him as if he wished to make the therapist feel defeated and
impotent, rather than the therapist confessing that he actually feels this way.

Rosenfeld (1987) agrees that the countertransference experiences of the therapist will prevent the formation of normal intimacy and mutual regard. Aggression and devaluation employed to defend against any possible dependence on the analyst becomes the core basis of the patient's interaction with the therapist. For the patient, to depend means to hate, envy and expose themselves to the danger of being exploited, mistreated, frustrated. When they seem to be dependent on an admired someone, they really experience themselves as part of that person, i.e the other is an extension of themselves. This "closeness" can be mistaken for dependence. There is no real involvement. This may be experienced by the therapist as a confusing and disturbing kind of pseudo-relationship and the therapy can feel productive and yet empty for long periods, perhaps resulting in the therapist feeling pressed to sustain any genuine interest in the patient. People can be dropped once the patient has made narcissistic use of him or her. For example, during vacations, the therapist is completely forgotten and there is no mourning. Again, the analyst will find it difficult to work with a patient who does not seem to care whether he/she is absent or present. Even after years of analysis, such patients will be willing to drop the analyst over the slightest frustration.

In the candidate's experience, disillusionment and burnout in treatment staff working in methadone units are
generally viewed as a normal reaction to working with low prognosis patients, or are attributed to lack of experience or training. The patient's attacks on staff are either viewed as "resistance" and the patient is labelled as unmotivated or non-compliant, or in other cases, are viewed as being justified because the patient is not improving. There is rarely any recognition that this situation may constitute an identifiable phenomenon, "negative therapeutic reaction", which is part of the course of therapy in cases of an identifiable syndrome, pathological narcissism.

In addition, Kernberg (1985) warns that unresolved narcissism in the therapist can lead to pathological reactions such as excessive rejection or acceptance of the patient's idealizations, the latter often rationalized as enjoyment of the sessions because the patient is so interesting, rather than insight into the fact that being idealized as a therapist is very gratifying. Narcissism in the therapist may also interfere with their ability to tolerate the patient's denial of them as a separate person or lead to grandiose moralizing and lecturing instead of empathic interpretation of the transference.

Identification of narcissistic pathology in drug abusers not only provides us with directions for treatment but also provides important prognostic information. The literature on methadone treatment concludes that the prognosis for drug dependent people with severe psychiatric problems is improved if they
receive treatment for these problems (Mattick & Hall, 1993). Patients who are older, are not polydrug abusers, have good work skills, more stable home lives and less psychopathology at admission tend to have better outcomes (Prescott, 1990). It could be argued that a high level of psychopathology would generally be associated with less interpersonal and vocational stability and increased drug abuse. Craig (1979a, 1979b, 1982) found that traits such as poor impulse control, low frustration tolerance, need for immediate gratification, and demandingness of attention did not respond to methadone treatment. This list of traits bears a striking resemblance to that comprising narcissistic pathology. Prescott (1990) concludes that "...investigations of the relationship between treatment outcome and personality variables are at an early stage. There is a need to relate personality factors to treatment outcomes..." (p.18).

Kernberg (1985) lists nine important prognostic indicators for therapeutic success with pathologically narcissistic patients. Motivation for participating in treatment is the first indicator. If they are in treatment in order to "learn" psychoanalysis and thereby gain power and knowledge, this secondary gain will tend to block any potential therapeutic gains. Similarly, if the motivation for treatment is to become perfect or superior rather than to address pathology, the prognosis will be poor. Unless the patient can tolerate feelings of depression and mourning that will accompany the loss of their grandiose ideal, they will be unable to relinquish
their narcissistic view of themselves. Similarly, the capacity to experience guilt rather than rage will be important if they are to appraise their own demandingness and aggression realistically. Then the potential for sublimation rather than acting out of aggressive tendencies will become important. Regression towards primary-process thinking will undermine progress. These capacities will largely be determined by the degree of superego integration, impulse control and anxiety tolerance. In addition to internal factors, the patient's external world can also influence prognosis. For example, if there are opportunities for unusual gratification of narcissistic needs for power, importance or admiration, such as would be afforded to movie stars or politicians, then chronic acting out will continue under the guise of normal behaviour. According to Kernberg, therapy has been successful when the patient can feel guilt and despair about the way they have devalued the therapist, who is now appreciated as a good and important person in the patient's life. If this can progress into feelings of love and gratitude, the patient can start to acknowledge the independence of others and this will produce vital changes in his or her internal representational world, so that the person's objects, and therefore his or her object relationships, become more normal.

10.10 The Potential Role of Psychoanalysis and Psychoanalytic Theory in the Addiction Field
The results of the present study showed that the majority of patients on a methadone programme suffered from a moderate to high level of narcissistic disturbance. The results also provided support for Wurmser's theory of the central role of narcissistic disturbance in the psychodynamics of compulsive substance use. This would imply that psychoanalytic theory and treatment provide important contributions to the field of the addictions. However, this result is not generally reflected in the literature, research or clinical practice in the field. Mattick and Hall (1993) go so far as to say that "there is no basis for the use of interpretative psychotherapies for opiate dependence. Their use is not advocated" (p.131). The same conclusions have been reached in the treatment of alcoholism (Matick & Jarvis, 1993). However, they do qualify their conclusions by suggesting that in cases of moderately severe psychopathology, "such an approach may have some value" (p.131). Such pessimism seems to be premature when studies investigating the efficacy of adjunct psychotherapy for methadone patients have been fraught with methodological problems such as small sample sizes, high drop-out rates and doubtful outcome measures, and have produced equivocal results. Rounsaville, Glasser, Wilber, Weissman and Kleber (1983) randomly allocated 72 patients to either a low contact group or short term interpersonal psychotherapy and found no evidence of a better outcome from the therapy group. However, there was a high dropout rate and the patients were already
attending group therapy. Two studies have produced more encouraging results. Willet (1973) randomly allocated patients to methadone alone, adjunct analytic psychotherapy and adjunct group therapy and found that the two treatment groups produced greater change over eight weeks on the Interpersonal Checklist. Again, dropout was high. Woody, McLellan, Luborsky and O'Brien (1995) studied methadone patients participating in either counselling plus drug counselling or supportive-expressive psychotherapy plus drug counselling and found that while both groups showed gains, the patients receiving psychotherapy showed superior outcomes. During the study, the psychotherapy patients required lower doses of methadone and had fewer urines containing cocaine than the counselling group. Further, at 6-month follow-up, many of the gains made by the counselling group had diminished whereas most of the gains made by the psychotherapy group had been maintained. Woody, Luborsky, McLellan, O'Brien, Beck, Blaine, Herman and Hole (1983) randomly allocated 110 methadone patients to counselling, counselling plus supportive expressive therapy, and counselling plus cognitive behavioural therapy. The dropout rate was low. At 12 month follow-up both therapy groups had better outcomes, were on lower doses and used less ancillary medication. The most interesting results were obtained when patients with low severity psychiatric problems were compared to those with high severity psychiatric problems. While low severity patients benefited from any of the three intervention
regimes, patients with high levels of psychiatric problems constituted the group which benefited most from psychotherapy. In a review of the literature, Rounsaville and Kleber (1985) conclude that psychotherapy is best for methadone patients with high severity psychiatric problems. Mattick and Hall (1993) conclude that:

the evidence for the use of psychotherapy as a general adjunct to methadone maintenance treatment is equivocal. For patients who choose to become involved in some form of psychotherapy, it may be of benefit. Until better evidence of efficacy is provided, psychotherapy should only be provided as an option for those patients who have serious psychiatric problems and wish to be involved in this form of treatment (p.36).

In this way, psychoanalytic psychotherapy and, by association, psychoanalytic theory, have been pronounced almost "irrelevant" to methadone treatment and often to the drug and alcohol field in general. This seems premature and unjustified. The kind of psychotherapy required for methadone patients with narcissistic disturbances is long, specific and intensive, and cannot be equated with the brief trials of interventions described as "psychotherapy" included in outcome studies to date. The usual outcome measures employed in drug and alcohol research do not tap the kinds of characterological changes that psychoanalytic therapy is designed to produce. For example, measuring changes in object relationship patterns would be more relevant than
measuring changes in level of depression or drug use. Also, while psychotherapy has been deemed only appropriate for those with high severity psychiatric problems, patients with high levels of narcissistic pathology are not generally identified or considered to be part of this group. As discussed previously in this paper, the literature tends to focus on psychosis, major depression and Antisocial Personality Disorder as the important high severity psychiatric problems.

Given that the present study has found a relationship between narcissistic pathology and extracurricular drug use in methadone patients, future research should investigate the possible relationship between narcissism and other outcome measures in methadone treatment such as level of criminal behaviour, general level of interpersonal and vocational functioning, depression and anxiety. Studies could also investigate the efficacy of interpretative psychotherapy for patients identified as suffering high levels of narcissistic pathology. With regard to methodology, four factors would be of importance. First, the psychotherapy offered should conform to recommendations in the literature from Kernberg and Wurmser, for example, concerning the length, frequency and specific characteristics of the therapy required for patients with severe narcissistic disturbance. Second, random allocation to psychotherapy and control groups should only occur after patients have been assessed as being suitable candidates for such therapy. This would entail
assessment of strength and nature of motivation plus the other prognostic factors discussed previously. Third, given the complexity of the therapy, therapists should be experienced analysts or psychoanalytic therapists. Fourth, outcome measures should tap the specific kinds of changes this type of therapy is designed to produce, that is, changes in object representations and relations and changes in the transference and countertransference therapeutic patterns in addition to the traditional behavioural outcome measures. As with any kind of intensive long term psychotherapy, initial regression, decompensation and disintegration should be acknowledged as a predictable phase of treatment rather than evidence of a failed intervention. Of course, the type of research described here would be an enormous undertaking fraught with many difficulties and it is not surprising that such research has not yet been undertaken. However, until this kind of research is done, it is premature to pronounce psychoanalysis as being irrelevant to the drug and alcohol field. Kernberg (1994) has developed a procedure for measuring structural change in borderline personalities. Verbatim records of therapy sessions over years of therapy were analysed to determine the patient's predominant mode of object relationships and transference patterns across each year of treatment. A similar model could be formulated for measuring structural change in narcissistic personalities in methadone units.

It could be argued that, even if narcissistic personality disturbance is at the core of many addiction
problems, and even if psychoanalysis is the only form of treatment known to address this psychopathology, it is not feasible to provide patients with such a long-term, expensive form of treatment, and psychoanalytic interventions will never become part of mainstream treatment in the addiction field, particularly in the public sector. As Kaplan (1977) points out, the number of heroin addicts who have been analyzed is very small. While this may be true, some important points need to be made about the place of psychodynamic theory and practice in the addiction field. First, psychodynamic considerations have not been largely excluded from the treatment of addictions because they are irrelevant but because they cannot be incorporated into the rigid constraints and narrow focus often designated as the realm of drug and alcohol professionals. An example of this trend is the way the public health system divides addiction problems and mental health problems into separate services. The recent acknowledgement of the special needs of dual diagnosis patients is still largely restricted to the area of "major" mental illness, that is schizophrenia and manic depressive psychosis. In terms of the rationale behind provision of treatment services, there is still little recognition of the high incidence of childhood abuse and related mental health problems in drug and alcohol patients (Bammer, 1993). The majority of drug and alcohol patients, that is, those with personality disorders, are still often not identified as a group with special needs requiring specialized
interventions. The traditional focus is to help them cease or reduce substance abuse and associated harmful behaviour while their pervasive chronic psychopathology is farmed out, according to the individual presenting symptoms, to any number of "relevant" treatment, correctional or welfare agencies. In this way splitting and denial of the underlying problem in the individual is mirrored by the health system. Each agency can record impressive statistics to show that minimal, brief, cost-effective interventions are provided, thereby optimizing client numbers. However, this is a false economy when a long-term intervention by one professional in one agency might produce changes that would obviate the need for life-long support and continual acute crisis interventions. Although patients with addiction problems in psychotherapy may also require ancillary services and treatment, the goal is still one of supporting the person while the underlying problem is being treated, rather than indefinitely supporting the person as a substitute for treatment. In a review of the literature, Khantzian and Treece (1977) conclude that all prominent authors in the field recommend bi-phasic treatment involving initial measures to stabilize patients followed by modified long-term psychotherapy. Methadone maintenance treatment provides an ideal opportunity and limit-setting environment for the provision of psychotherapy, but this is generally not offered by methadone programmes in Australia. Psychoanalytic treatment addresses the psychic whole and this has traditionally been and continues to be
at odds with mainstream treatment of drug and alcohol problems. The absence of psychoanalysis from mainstream treatment has come to be mistakenly viewed as reflecting its irrelevance or lack of efficacy.

The second issue concerning the place of psychoanalysis in mainstream treatment of addiction problems involves the utilization of psychoanalytic knowledge in a general approach to working with patients, even if psychoanalysis proper is not a feasible form of treatment for many patients. For example, within a methadone clinic, many facets of the patients' experience and the staff's experience could be better understood and managed utilizing a psychodynamic framework. The programme structure with regard to issues such as programme rules, policy on takeaway doses, transfers, contact, dose, urines, extracurricular drug use, violence and aggression etc could incorporate an understanding of the central role of providing clear and consistent limits and boundaries for patients who lack sufficient internal structure to provide a safe environment. Clinical supervision sessions could focus on identification and resolution of transference and countertransference problems. Staff meetings could utilize a psychodynamic model for resolving case management problems rather than adopting a correctional or parental approach.

Ultimately, more research is needed to provide convincing evidence of the role of psychological factors in drug use. A recent study (Howard, 1993) found that only 17% of methadone patients reported that negative
emotional states led them to use heroin, stating that availability of the drug was the main precipitant. The author suggests that this stands in contradiction to any self-medication hypothesis of drug use and concludes: "it is one of the continuing paradoxes of methadone treatment that addicts do not see their problems in psychological terms, but staff treating them frequently see their clients as having psychological problems" (p36). This self-report material obtained from one-off interviews contrasts with the narratives previously discussed, in which patients in psychotherapy reveal detailed accounts of their search for drugs in order to alleviate aversive emotional states. Psychodynamic theory provides an important avenue for examining narcissistic personality structures which preclude insight and therefore reliable self-report in addicts, and for the modification of these structures through intensive psychotherapy.

10.11 Summary and Concluding Remarks

The present studies suggest that psychoanalytic theories and concepts can be tested and utilized in the assessment and treatment of methadone patients and in the training and supervision of methadone clinic staff. Future efforts should be directed towards the development of a research methodology and tradition in this area to promote the testing and application of current psychoanalytic knowledge in the field of the addictions.
The results of the present study provide initial support for a possible relationship between narcissistic character pathology and compulsive drug use and methadone treatment outcome. Further research is necessary to determine the specific nature and direction of this relationship.
REFERENCES


APPENDIX 1

LETTER TO PSYCHOANALYSTS AND PSYCHOTHERAPISTS
TO INVESTIGATE FACE VALIDITY
FOR THE PILOT NARCISSISTIC RAGE SCALE

Michelle Epstein
Psychologist
5/267 Carrington Rd
Coogee 2034.
Ph (BH) 4140243
(AH) 6650488

Dear

I am currently working on a thesis as part of a Masters of Clinical Psychology course at the University of Wollongong. My university supervisor is Rachel Henry. I work full-time at Chatswood Drug and Alcohol Service, where I receive clinical supervision from Dr Ron Spielman.

My research thesis involves investigation of a psychodynamic phenomenon in a specific patient population. As am I requesting your contribution to the study, I cannot explain to you the exact nature of the project; all contributors at this stage must be "blind". However, if you would like to be involved, a full description of the project will be provided to you once your contribution has been completed.

As part of my research, I have designed a rating scale which, it is hoped, is a clinically accurate measure of "X". It is therefore necessary to validate the scale, ie to provide sufficient evidence to suggest that the scale does in fact tap or measure "X". To provide this validation, I am seeking the assistance of clinicians such as yourself who would have a sophisticated understanding of, and much experience with "X".

Enclosed is a copy of the rating scale. Clinicians tick those characteristics exhibited by the patient, and the total number of ticks becomes the patient’s score. A high score indicates the patient has a high level of "X" and a low score indicates a low level of "X". If you would like to help, all you have to do is examine the scale and answer the following question:
WHAT DO YOU THINK THE SCALE IS MEASURING?

I would greatly appreciate your contribution. If you require any further information about me or my research, please call me on the numbers above. I am contacting a large number of people and will be validating the scale in different ways; some people will be told what it is measuring and others will not. It is therefore very important that you do not discuss with colleagues what you have been asked to do. When the validation stage is complete, all contributors will be fully informed as to the nature of the study.
I hope you will help and I look forward to your response.

Yours Sincerely,

Michelle Epstein
APPENDIX 2

LETTER TO PSYCHOANALYSTS AND PSYCHOTHERAPISTS TO INVESTIGATE CONTENT VALIDITY FOR THE PILOT NARCISSISTIC RAGE SCALE

Michelle Epstein,
Psychologist.
5/267 Carrington Rd
Coogee 2034.
Ph (BH) 4140243
(AH) 6650488

Dear

I am currently working on a thesis as part of a Masters of Clinical Psychology course at the University of Wollongong. My university supervisor is Rachel Henry. I work full-time at Chatswood Drug and Alcohol Service where I receive clinical supervision from Dr Ron Spielman.

As part of my research thesis, I have designed a rating scale that measures the level of Narcissistic Rage exhibited by a patient. It is therefore necessary to validate the scale, that is, to provide sufficient evidence to suggest that the scale does in fact provide an accurate measure of Narcissistic Rage. To provide this validation, I am seeking the assistance of clinicians such as yourself who would have a sophisticated understanding of, and experience with Narcissistic Rage in patients.

NB This scale is NOT designed to tap diagnostic criteria for Narcissistic Personality Disorder. Patients diagnosed as having a variety of personality disorders may also display and experience varying degrees of narcissistic rage.

** Narcissistic Rage refers to responses that follow narcissistic injury, or to responses that are designed to avoid / limit narcissistic injury
Your contribution to the study would involve the following:

**Step 1**
From your understanding of Narcissistic Rage in both the transference and as an experience reported by patients in their daily lives,

a) think of a patient whom you assess as exhibiting a high level of narcissistic rage
b) think of a patient whom you assess as exhibiting no (or the lowest level of) narcissistic rage.

**Step 2**
Now open the envelope containing the Narcissistic Rage Rating Scale. Two copies are provided.

a) Use the scale marked "HIGH NR" to rate the patient you have identified as exhibiting a high level of Narcissistic Rage.

b) Use the scale marked "LOW NR" to rate the patient you have identified as exhibiting no (or a low level of) Narcissistic Rage.

**Step 3**

a) Think of a patient whom you diagnose as having antisocial personality disorder.

b) Use the scale marked "APD" to rate this patient.

I would greatly appreciate your contribution. If you require any further information about me or my research, please call me on the numbers above. I am contacting a large number of people and will be validating the scale in different ways; some people will be told what it is measuring and others will not. It is therefore very important that you do not discuss with colleagues what you have been asked to do. When the validation stage is complete, all contributors will be fully informed as to the nature of the study.

I hope you will help and I look forward to your response.

Yours Sincerely,

Michelle Epstein
APPENDIX 3.

RAW DATA: SCORES ON THE PILOT NARCISSISTIC RAGE SCALE ALLOTTED BY CLINICIANS IN THE CONTENT VALIDITY STUDY, FOR PATIENTS SEEN IN PRIVATE PRACTICE ASSESSED AS DISPLAYING HIGH NARCISSISTIC RAGE, LOW NARCISSISTIC RAGE AND ANTISOCIAL PERSONALITY DISORDER

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APPENDIX 4.

RAW DATA: PATTERN OF SCORING FOR HIGH NARCISSISTIC RAGE, AND ANTISOCIAL PERSONALITY DISORDER PATIENTS ON THE 13 ITEMS OF THE PILOT NARCISSISTIC RAGE SCALE IN THE CONTENT VALIDITY STUDY

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## APPENDIX 6

**RAW DATA: URINALYSIS RESULTS FOR THE MAIN STUDY**

**EXPRESSED AS NUMBER OF POSITIVE URINE SAMPLES OUT OF TOTAL NUMBER OF URINE SAMPLES FOR EACH PATIENT**

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APPENDIX 7.
ALCOHOL CONSUMPTION SURVEY

Please tick the box to indicate your answer

Gender: Male [ ] Female [ ]

Description of alcohol use that is closest to my situation (you can tick more than one box)

I don't drink alcohol [ ]

I drink only moderate amounts of alcohol [ ]

I am a fairly heavy drinker but I don't get drunk [ ]

I get drunk often [ ]

I have periods where I binge drink [ ]

I like being drunk as much as I like being stoned [ ]

I tend to use alcohol instead of drugs now [ ]
APPENDIX 8.

INFORMATION SHEET FOR METHADONE PATIENTS EXPLAINING THE ALCOHOL CONSUMPTION SURVEY

This is a voluntary, anonymous survey conducted as part of a research project at the University of Wollongong.

The research is NOT part of this methadone clinic. The staff here have merely agreed to ask you to participate. The staff will not have access to raw data. As you will see, there is no way to identify who has filled in the survey.

The aim of the survey is to get an idea of the degree to which people on methadone use alcohol.

If you fill out the survey, just place it in the box provided, which will be removed at the end of dispensing today.

Your help would be appreciated,

Thank you,

MICHelle Epstein
VIGNETTE 1

When Rob decided he wanted to be on methadone, he turned up at the unit and demanded to be put on methadone there and then. He was very angry when he was told he would have to be assessed. Since then, Rob has been convinced that the methadone staff are "on a power trip".

Many staff meetings have centred around discussions on how best to deal with the verbal threats that Rob makes when his demands are not met. When Rob realised that verbal threats would no longer be tolerated, he began using his pregnant girlfriend as a lever; saying he needed to be exempt from rules so that he could care for her. This often put staff in a real bind, even though they knew they were being manipulated.

Another problem has been Rob's expectations of his case manager, whom he feels should be at his beck and call because "she is a public servant". He often asks for lifts and is furious when the answer is "no". Consequently, he is rude and hostile towards his case manager.

Rob has been disappointed with the methadone programme and feels he should have been off methadone by now. He blames the methadone staff for this and is also convinced that the staff have made life difficult for him, thereby preventing him from getting a job and leading a normal life.
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Another problem has been Rob's expectations of his case manager, whom he feels should be at his beck and call because "she is a public servant". He often asks for lifts and is furious when the answer is "no". Consequently, he is rude and hostile towards his case manager.

Even though Rob's urine results have been good, he has been disappointed with the methadone programme and feels he should have been off methadone by now. He blames the methadone staff for this and is also convinced that the staff have made life difficult for him, thereby preventing him from getting a job and leading a normal life.

VIGNETTE 1

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Another problem has been Rob's expectations of his case manager, whom he feels should be at his beck and call because "she is a public servant". He often asks for lifts and is furious when the answer is "no". Consequently, he is rude and hostile towards his case manager.

Rob's urines are often dirty and he has been disappointed with the methadone programme: he feels he should have been off methadone by now. He blames the methadone staff for this and is also convinced that the staff have made life difficult for him, thereby preventing him from getting a job and leading a normal life.
Sarah had always struck the staff as a very insightful client. At assessment, she was very open to any recommendations made, and clearly saw methadone as a stepping stone to becoming drug-free so that she could start to work on other problems that were not drug related, eg incest issues. She was very aware that her way of coping with her past, ie drugs, was destructive and prevented her from leading a normal life.

Sarah generally abided by the treatment contract, was punctual for appointments and cooperated with staff requests. She was generally polite and friendly, but when depressed would tend to be shy and withdrawn. She shows consideration for the needs of other clients.

Sarah seems to trust her case manager and seems to really appreciate having someone she can talk to. She has a friend who is on another methadone programme where there is no extra assistance offered to clients. She has often commented that her friend has no-one she can talk to and she has tried to convince her friend to transfer to this methadone programme.

Sarah has been very happy with the methadone programme and she hopes that she can be strong enough to come off methadone one day.

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to and she has tried to convince her friend to transfer to this methadone programme.

Sarah has been very happy with the methadone programme, even though her urines are often dirty. She hopes that she can be strong enough to come off methadone one day.

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Sarah has been very happy with the methadone programme, and her urine results have been good. She hopes that she can be strong enough to come off methadone one day.
Phil was very cooperative and motivated at assessment but had some unrealistic expectations. He thought that all his problems were due to his drug use and thought that when he stopped using heroin, everything would be ok.

In general, Phil has adapted well to being on methadone and is polite and friendly to staff. He is punctual for dispensing and appointments. He is usually considerate towards other clients, unless he has a lot on his mind; then he can be a bit pushy.

There was one occasion, however, where he wanted to go overseas to visit his mother, and he was very angry when he was told that he could not take methadone out of the country. He felt that he should be given special consideration because his mother was ill. The unit manager suggested that he could gradually reduce off methadone so that he would be free to travel. Phil didn't want to. Consequently, Phil didn't get to see his mother before she died, and he blames the unit manager, to whom he is civil but no longer friendly.

Apart from this episode, Phil has been happy with the methadone programme and he hopes to come off methadone one day.
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VIGNETTE 3

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Apart from this episode, Phil has been happy with the methadone programme. Although his urines are often dirty, he hopes to come off methadone one day.
When Peter was assessed for methadone, it became obvious that he was a polydrug abuser, and the staff were dubious about his suitability for methadone treatment. Although other forms of treatment were suggested, Peter insisted that he would only try methadone.

Peter is extremely friendly and often brings gifts for the dispensers, particularly lovely cakes and buns in the mornings. He likes to be very chatty and is quite entertaining because he is a bit melodramatic. From his behaviour, you would think he was a socialite in a chic cafe, not a heroin addict attending a methadone unit.

At times, the staff have had difficulty bringing Peter back down to reality. This has become necessary when he gets hurt at being treated "like a patient, not a friend". For example, he likes to ask staff members out socially, or gets upset when a staff member has to discuss some aspect of his treatment with him (instead of just social chit chat).

The staff often get the feeling that Peter would be happy to stay on methadone forever, without really giving it much thought. For him, coming to the unit is more a social event than a chore. His addiction does not seem to concern him.
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Peter's urine results have been unsatisfactory. The staff often get the feeling that Peter would be happy to stay on methadone forever, without really giving it much thought. For him, coming to the unit is more a social event than a chore. His addiction does not seem to concern him.
Liz had a heroin and alcohol problem when she came for assessment. She realized that methadone would not stop her from drinking. It was recommended that she attend AA but after feeling very judged by other AA members for being on methadone, she became a bit more secretive about her drinking and the staff were not sure if she was still going to AA or how heavy her current alcohol consumption might be.

The staff suspect that Liz may be quite secretive about other things as well. She can be evasive when asked questions. At times she has been caught out in a lie. On two occasions she "lost" her takeaway doses under suspicious circumstances.

Male staff have found Liz to be quite seductive, particularly when she is being confronted with something. Her clothes are usually very revealing and she is flirtatious. She is constantly borrowing money from other male clients on the programme, who then often complain to the staff that they have been "ripped off" by Liz.

The extent of Liz's drinking is a bit of a mystery. She says she is happy to stay on methadone for the moment but doesn't want to be on methadone forever.

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Liz's urines have mainly been clean but the extent of her drinking is a bit of a mystery. She says she is happy to stay on methadone for the moment but doesn't want to be on methadone forever.

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Liz's urines have mainly been dirty and the extent of her drinking is a bit of a mystery. She says she is happy to stay on methadone for the moment but doesn't want to be on methadone forever.
Tracey wanted to come onto the methadone programme because she was pregnant. Apart from her concern for her baby, she was fairly unmotivated and the staff doubted that she would have sought treatment if not for the pregnancy.

Tracey seemed to hold the methadone team responsible for the welfare of her baby, taking little responsibility herself. For example, she would often arrive late for methadone and when told that the dispensary was closed, she accused the staff of not caring enough about her baby. Tracey's boyfriend beat her violently on two occasions and Tracey was angry because the staff did not "do something to protect the baby". Tracey ignored staff recommendations to take out a restraining order.

More and more the staff became concerned about Tracey's ability to provide a safe home for a baby, and it was finally decided that DOCs would be notified when the baby was born. When Tracey was informed of this she stormed out and never came back.

The staff don't know what became of Tracey and they worried about her going into withdrawal, and the effect on the baby. Consequently some staff felt guilty about the decision to inform DOCs and the whole episode has been very traumatic for the team.
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VIGNETTE 6

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APPENDIX 10:

RAW DATA: SCORES ALLOTED ON THE NARCISSISTIC RAGE SCALE FOR METHADONE PATIENTS BY THE 4 RATERS IN THE MAIN STUDY AND IN THE RETEST RELIABILITY STUDY

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### Appendix 11

**Raw Data: Methadone Dose and Sex of Patients in the Main Study**

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## APPENDIX 12

**SCORING Obtained On The Narcissistic Rage Scale For Methadone Patients, For Hypothetical Patients Described In Case Vignettes.**

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