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## The Relationship of Relapse Into Alcohol and Drug Use and Emphatic Needs in the Dual Diagnosed Client

Jeanne M. Engel  
*Loyola University Chicago*

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LOYOLA UNIVERSITY CHICAGO

THE RELATIONSHIP OF RELAPSE INTO ALCOHOL AND DRUG USE

AND EMPATHIC NEEDS IN THE DUAL DIAGNOSED CLIENT

A DISSERTATION SUBMITTED TO THE  
LOYOLA UNIVERSITY CHICAGO  
SCHOOL OF SOCIAL WORK  
IN CANDIDACY FOR THE DEGREE OF  
DOCTORATE IN CLINICAL SOCIAL WORK

BY

JEANNE M. ENGEL  
CHICAGO, ILLINOIS

MAY, 1996

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I hereby recommend that the dissertation prepared under my supervision by JEANNE M. ENGEL entitled The Relationship of Relapse into Alcohol and Drug Use and Empathic Needs in the Direct Diagnosed Client be accepted in partial fulfillment of the requirements for the degree of Doctor of Social Work

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THE RELATIONSHIP OF RELAPSE INTO ALCOHOL AND DRUG USE  
AND EMPATHIC NEEDS IN THE DUAL DIAGNOSED CLIENT

This study explored the relationship between relapse into alcohol and drug use and the empathic needs of mirroring, idealizing, and twinship, as defined in the theory of self psychology. The presence or absence of these selfobject needs were identified through the subject's perception of events which precipitated relapse, using methodology of both quantitative and qualitative design. A purposive sample of 24 subjects were interviewed from 1993 to 1995, drawn from two chemical dependency treatment centers. The study is exploratory and descriptive. Instruments were designed to include: a relapse history, checklist of drug(s) used and feelings, researcher's comment sheet, and 25 question structured interview. Findings indicated: that pathology increased as addictive use increased; over 50% of subjects had symptoms of dual diagnosis; deficits existed in the needs of mirroring, idealizing, and twinship, reflecting a lack of cohesion in the self structure, which related to precipitants of relapse.

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I wish to acknowledge the two chemical dependency treatment facilities which extended their staff and support for this endeavor. For the sake of patient confidentiality the facilities must remain anonymous, yet their counsel will remain an inspiration to hundreds of patients and their families. The patients who volunteered to share their own stories, insights, and expertise in relapse will be long remembered. I am very appreciative for their honesty and trust.

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Jill Smith assisted in the computer analysis using SPSS-PC+ and brought technical knowledge and expertise to the project. The late Gene Smith was a consultant on frequency and correlation analyses, and assisted with many ideas and thoughts.

The late Joan Greenstone gave many hours of guidance,

as the chairperson of this study. Her knowledge and constant support will live on as a tribute to her thoughtful and compassionate inspiration to many. Dr. Joseph Walsh deserves special thanks for his unique talents of motivation, instruction and direction. He has earned the high respect awarded him by many.

To Joan Greenstone, Edward Engel,  
Jack Rodgers, Gene Smith, and  
Maria and Joseph Kawecki



We're not human beings that have occasional spiritual experiences--it's the other way around: we're spiritual beings that have occasional human experiences.

Deepak Chopra - The Seven Spiritual Laws of Success

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## CHAPTER 1

### INTRODUCTION TO THE PROBLEM

#### Introduction and General Statement of Purpose

This study evolves from the author's interest in addictions and relapse prevention, and investigates the relationship of relapse to three types of needs in human relationship, the needs to be mirrored, to idealize, and to form a twinship. These needs were identified by Heinz Kohut in the theory of self psychology (Kohut, 1971, 1984). The study examines both the desire for these qualities in relationships, and the experience of their withdrawal or absence.

Kohut identified the addictions as frequently seeded in the trauma of early empathic disappointments, wherein the parent "did not appropriately fulfill the functions (as a stimulus barrier; as an optimal provider of needed stimuli; as a supplier of tension-relieving gratification, etc), which the mature psychic apparatus should later be able to perform (or initiate) predominantly on its own" (Kohut, 1971, p. 46). Early trauma prohibits the internalization of self soothing functions, which are later found through the use of drugs. Kohut notes that the drugs or alcohol do not serve as a "substitute for loved or loving objects or for a relationship with them, but as a replacement for a deficit



in the psychological structure" (Kohut, 1971, p. 46). He also stated that addictions, perversions and delinquency demonstrate the relationship between "(a) the circumscribed primary narcissistic disturbance; (b) an early ego deficit which is correlated to it; and (c) the sexualization (in perversions) of the narcissistic disturbance" (Kohut, 1971, p. 69). Thus, Kohut linked addictions with narcissistic personality disorder, and to deficits in the psychological structure of the self due to empathic failures.

This investigation explores how inadequate responses of empathy, or failures in empathy, associated with the three needs of mirroring, idealizing and twinship, are perceived by those individuals prone toward addictive alcohol or drug use. This study defines empathy as the experience of comfort, compassion, sensitivity or understanding that occurs with a person or thing, and which has provided a needed meaning to a person. This inquiry defines relapse as the return to the use of alcohol or drugs, after a period of sobriety by the addicted person. Mirroring, idealizing, and twinship are defined in depth later in this report. The research will investigate how relapse may be a reaction to the perception of failure in needed responses, from significant persons or things, to the desire for mirroring, idealizing or twinship.

The study is qualitative in design, in that it investigates and describes the experience and meaning of

relapse to the individual. The study considers the effects of thought and emotion in the creation of meaning when empathy has failed, and the constructs of created reality which may be involved in the process of alcohol and drug relapse. The area of the inner subjective experience of the individual has been selected for examination.

The study is qualitative in using the method of content analysis in coding and analyzing the collected data. This will include summation of key phrases or patterns of responses in the interviews, and may reflect the desire for or absence of empathy.

The study also includes a comparison of data, contrasting the frequency and experiences of relapse, with reported experiences of failures in empathy associated to mirroring, idealizing and twinship needs. The contrasting data encompasses quantitative components, which were gained through data gathered on written forms, designed by the researcher.

The study is concerned with a population of chemically dependent (addicted) individuals who have experienced in-patient or intensive out-patient treatment for addiction, and who have relapsed.

### Theoretical Considerations

Questions regarding the purpose of chronic self-defeating drug and alcohol use have interested authors of many theoretical positions. Kohut's theory of self psychology has been selected for consideration in this study because of its unique focus on the narcissistic personality disorder, which is defined as a personality disorder reflective of a lack of cohesion of the self. The lack of cohesion is brought about through early traumatic disturbances in the relationship with significant others, usually parents, due to a deprivation of empathy, or disappointments in the idealized parent. These traumas interfere with the development of self regulation of the psyche, and result in fixation on aspects of the earlier objects (Kohut, 1971, p. 46). Recent theoretical notions of the self have suggested that addictions, perversions and delinquency may be behaviors indicative of psychological structures that lack cohesion. Thus narcissistic personality disorders may specifically lead to addictive behaviors through developmental failures in the building of psychological structures of the self.

Kohut differentiated between two forms of self disturbance. Narcissistic personality disorder was defined as a "temporary breakup, enfeeblement, or serious distortion of the self, manifested predominantly by symptoms [Ferenczi, 1930], such as hypersensitivity to slights, hypochondria, or

depression" (Kohut, 1977, p. 193). Narcissistic behavior disorders were defined as "temporary breakup, enfeeblement, or serious distortion of the self, manifested predominantly by symptoms [Ferenczi, 1930], such as perversion, delinquency, or addictions" (Kohut, 1977, p. 193). Kohut saw narcissistic personality disorder (NPD) as a compensatory self structure, which had internalized a minimum of the idealized self-objects; narcissistic behavior disorder (NBD) reflects a defensive response due to the need for mirroring self-objects. The two categories of narcissism have many overlapping symptoms and are generally referred to by self psychology authors as narcissistic personality disorder. This study takes note of Kohut's differentiation, but will use NPD to cover both definitions.

Self psychology suggests that the individual lacking a cohesive self experiences life with a distorted perception or belief, which leaves the individual with deficits that are notable in human relationships. Psychological self structure deficiencies result in repetitious social failures, and often lead to addictions. Kohut indicated that this was particularly true for individuals diagnosed with NPD. Thus, individuals with narcissistic personality disorder are often experiencing life with a dual-diagnosis, including chemical dependency and a coexisting psychiatric disorder (Kohut, 1977, p. 193).

### Need for Selfobjects

Most theories of human development consider the need for significant human bonding and empathy, which is begun in infancy with the primary caretaker, usually the mother. The primary caretaker becomes the first "selfobject," or person who conveys empathy in various ways to the infant. Self psychology is useful to this study as this theory considers the human need for selfobjects throughout the lifetime. In this study, selfobjects are defined as persons, symbols, or things which influence the emergence or maintenance of the self, and bring affirmation, meaning and coherence to the psychological structure of the self. When selfobjects fulfill the needs for affirmation, admiration and kinship, an individual is able to develop and maintain a sense of internal cohesion, stability, self-worth and self-esteem. The process of incorporating meaning and self-worth is first achieved through the bonding with a primary caretaker in infancy, and is later integrated into the self as a self function. This is coupled with self calming strategies, which later provide self restorative balance when an individual is under stress.

The individual who has not adequately experienced empathy in early relationships is left without a cohesive self structure, and is unable to self-right in the face of stress due to a lack of understanding of how or what to do to calm themselves, when anxiety and depression become

overwhelming. Kohut spoke of either "disintegration anxiety," associated with the specter of self-fragmentation, or "depletion anxiety," connected with the dread of self-collapse, related to these states (Kohut, 1977, p. 97).

The individual who suffers with the dual diagnosis of narcissistic personality disorder and chemical dependency may have a higher likelihood of using alcohol or drugs as a self-medication to calm these emotional states than other populations without narcissistic personality disorder. In sobriety, these persons may experience an emotional crisis of extreme moods. Depending on their state of internal crisis, and the accessibility of externally calming others or things, they may be at higher risk to relapse into drug/alcohol use. This potential is likely if they have not yet internalized the ability to affirm, soothe, and protect themselves. Unlike many other clinical populations, who are able to self-right under stress and avoid states of fragmentation of the self, they reach anxiety states rapidly and with pronounced terror.

### Three Types of Selfobject Needs

This study explores three types of selfobject needs which are (1) mirroring, (2) idealizing, and (3) twinship, and responses to failures in empathy in relation to these needs. The types of selfobject needs which predominate in a person's life can vary, and can also be experienced in

tandem. These needs for responses from others, or the need to respond to others in certain ways, are important in the development of a cohesive self structure. Their relationship to relapse is investigated in this study.

Mirroring selfobject needs are defined in this study as needs which affirm, confirm, recognize or accept the person. Idealizing needs are defined as the need to experience oneself as being a part of an admired or respected selfobject. Twinship needs, also called alterego needs, are those internal demands which reflect the craving to experience an essential likeness with the selfobject (Wolf, 1988, p. 55). Twinship needs provide a sense of sameness and kinship.

This study considers that issues related to selfobject transference are present and underlie all intimate relationships, not only therapeutic relationships (McMahon, 1991).

### Limits of Current Theory

Present theory is inadequate in explaining the precipitating factors which lead to relapse in individuals who desire sobriety. There is a deficiency in knowledge about how a failure in empathy, in specific kinds of relationship needs, may create an emotional fragmentation of self structure for addicts who are vulnerable to relapse experiences. Research into relapse prevention is a new

field of inquiry, with little investigation of this clinical profile. This study addresses two areas of inquiry: the dual diagnosed individual, who may experience narcissistic personality disorder and is chemically dependent, and the relationship of relapse to a failure in empathic response to the selfobject needs of mirroring, idealizing and twinship.

The study asks the question: What is the meaning of perceived failures in empathy in significant human relationships for dual diagnosed addicts, and how does this relate to relapse into alcohol or drug use? It is conceivable that individuals who lack a cohesive self structure may turn to alcohol and drugs, when a human relationship has created emotional pain through empathic failure.

### **Statement of the Research Problem and Specific Objectives**

Individuals suffering from narcissistic personality disorder have been identified as experiencing feelings of emptiness, depression, worthlessness or anxiety. In states of stress they may agonize in much discomfort, feeling a lack of self cohesion, the inability to be objective, a sense of panic, diminished energy and vitality, and disturbed emotional balance. These deficits result in self-regulation disturbances involving affect, self-esteem maintenance, the capacity for self care, and self-other relations (Khantzian, 1986). The dysfunctional states which



follow abstinence from alcohol or drugs, for persons diagnosed with narcissistic personality disorder, may far exceed the average expectation of adjustment to sobriety which is seen in other populations. The individual who has not incorporated coping strategies that soothe or calm the self cannot readily achieve a self-restorative process, since these were lacking in early relationships in infancy and childhood and were not integrated into the self structure (Ulman & Paul, 1989, p. 133). Feeling out of control, such individuals may resort to drug-of-choice use as an attempt to correct or modify an internally disruptive experience. The movement from an unempathic response from significant persons or things, to relapse may be rapid, preventing the person from having any cognitive understanding of the relationship of drug-of-choice use to the avoidance of associated states of pain or fragmentation.

### **Research Questions**

Since this study is exploratory and descriptive in nature, it attempts to discover what might be plausible causes of relapse into drug and alcohol use. The nature of the study is to define further hypotheses.

The purpose of the study is to examine these factors:

- A. the perception of failure in the empathic responses of significant others, things or symbols to the needs for (1) mirroring, (2) idealizing, or (3) twinship, and
- B. relapse into alcohol/drug use.

### Research Questions

This study is designed to explore the following questions: What experiences precipitate relapse? What does the experience mean to the relapsing person? Does the experience reflect a perceived failure in the need to respond or be responded to in certain ways? How does the person perceive the use of the drug? What comfort might be sought through the use of the drug? Is there any relationship between an individual's need for empathic responses (mirroring, idealizing, twinship) and relapse? What is experienced when empathic needs are met? What is experienced when empathic needs are not met? The questions selected for study are:

- (a) What kind of relationship exists between relapse and the perception of empathic failure of response to significant emotional needs in mirroring?
- (b) What kind of relationship exists between relapse and the perception of empathic failure of response to significant emotional needs in idealizing?
- (c) What kind of relationship exists between relapse

and the perception of empathic failure of response to significant emotional needs in twinship?

(d) In what other ways does the presence, or absence, of empathy affect the perceived desire for the drug-of-choice?

### Definition of Terms

In addition to aforementioned definitions for relapse, mirroring, idealizing, twinship, the following definitions are submitted:

Addiction "is a condition in which a person develops a biological, psychological and/or social dependence on any mood altering substance; it is accompanied by obsession, compulsion, and loss of control" (Gorski & Miller, 1986, p. 39).

Empathy is the experience of comfort, compassion, sensitivity or understanding that occurs with a person or thing, and which has provided a needed meaning to a person; empathic failure or loss can facilitate a sense of emptiness and fragmentation of the self.

Narcissistic Behavior Disorders (are a) "temporary breakup, enfeeblement, or serious distortion of the self, manifested predominantly by symptoms [Ferenczi, 1930] such

as perversion, delinquency, or addictions" (Kohut, 1977, p. 193).

Narcissistic Personality Disorders "are those selfobject disorders where damage to the self is temporary and restorable ... and where symptoms express an attempt to force the environment to yield needed selfobject experiences via behavioral maneuvers (e.g., soothing responses in interpersonal relationships) or to yield perceptions of restored selfobject functioning (e.g., addiction, perversion, delinquency)" (Wolf, 1988, p. 185).

Relapse is the return to the use of alcohol or drugs, after a period of sobriety by the addicted person. In this study, any use of alcohol or non-prescription drugs, following a period of hospitalization for treatment of chemical dependency, will constitute relapse, and will be accepted as reported by participants in the research study.

Selfobjects are the presence of persons, symbols, or things which provide experiences that create or maintain a psychological self structure. Selfobjects can enhance the sense of well being, or can diminish the sense of self cohesion, because of insufficient selfobject responses (Wolf, 1983, pp. 27-28).

### Selfobject Functions

In this study, we consider three types of selfobjects: mirroring, idealizing and twinship. The definitions are taken from the work of Mary McMahon (1991), who investigated the selfobject functions of couples in her dissertation. Her study focused on the selfobject functions of mirroring and idealizing, with minimal consideration to twinship. McMahon pointed out the need to capture words that represent both the presence of the transference-like reaction of mirroring or idealizing, and the need to find words representing the deficit of these experiences. The experience and the deficit of the experience of selfobject functions are important in the organization of the self. The definitions of selfobject functions are followed by words which are chosen to reflect two indices of measurement of transference-like reactions in terms of (1) the experience of them, and (2) the deficit of experience when they are lacking. These words were considered in the development of written forms, described later in this study.

Because of the socialization process associated with drug and alcohol use, where kinship is valued, twinship has been included as a variable in this study. The words selected for operationalized definition are developed from readings on the topic of twinship functions selected by the researcher. The following definitions of the mirroring, idealizing, and twinship selfobject functions are quoted

from the work of Mary McMahon (1991, p. 100-103):

### Mirroring Selfobject Functions

Referred to by Kohut as the functions of the 'grandiose self,' these include: the experiences of being affirmed and acknowledged by another who mirrors one's internal state, resulting in a sense of worth and positive self regard; the experience of being respected and approved by another who praises and compliments in authentic ways, resulting in a sense of dignity and self respect; the experience of admiration and feeling lovable, which results in the sense of poise, self confidence, and self assurance; the experience of being cheered on and encouraged in the mastery of challenges, resulting in a sense of firmness in the sense of self and the self-assertive pursuit of new activities.

Some of the ways in which a person might experience withdrawing or withholding of selfobject functions from the mirroring object could be described as follows: deficient feelings of affirmation, such as betrayal, denial, or refusal; deficient feelings of self esteem, such as feeling demeaned, disgraced or dismissed; deficient feelings of self-confidence, such as feeling guilty, uncertain, or self-doubt; deficient feelings of self-determination, such as ambivalence, dependence, or over involvement; a deficient sense of firmness and internal cohesiveness, such as confusion, disorganization, or lability. Such deficits often lead to a chronic sense of inadequacy and worthlessness, feeling blamed, criticized or humiliated, resulting in anger toward the significant other (McMahon, 1991, pp. 100-101).

### Idealizing Selfobject Functions

Referred to by Kohut as the functions of the 'idealized parent imago,' these include: the experience of safety that results from the faith in the strength and omnipotence of another, and the sharing in that strength and protectiveness which results in feeling powerful and effective as a human being; the experience of having one's excitement and overstimulating affects modulated by another, resulting in the sense of self-control, self-discipline, and self-regulation; the experience of being soothed, comforted, and calmed by another who provides solace as well as joyous vitality, resulting in the capacity for enthusiasm and

equanimity; the experience of learning rules of conduct that represent the content of the culture's values and ideals, which become consolidated into a value system, and a set of ideals that serve as guides in one's life and which supply a sense of purpose in the pursuit of a life's goal.

Some of the ways in which a person might experience the withdrawing or withholding of selfobject functions from the idealized object could be described as follows: feelings of deficient physical and emotional protection, such as feeling endangered, exposed or threatened; a feeling of being deficiently soothed and comforted, such as being aggravated, frustrated or provoked; having a deficient model of inner strength with feelings of being demoralized, depleted, or let down; having a deficient model of self-control with feelings of being indecisive, hesitant, or overstimulated. Such deficits often lead to a sense of insecurity, vulnerability and uncertainty, feeling unsafe, ignored, neglected or undermined, resulting in disillusionment toward the significant other (McMahon, 1991, pp. 102-103).

#### Twinship (Alterego) Selfobject Functions

Referred to by Kohut as the functions of 'twinship,' these include: the experience of a common bond with others that leads to the feeling of kinship; the experience of intactness of one's inborn givens and natural endowments that provide the sense of well being and wholesomeness without which one can feel dehumanized. Deficits in alterego functions lead to a sense of alienation and a lack of connectedness, with major differences in values, interests and activities, resulting in confusion and discomfort toward the significant other (McMahon, 1991, p. 103).

#### Significance to Clinical Social Work

This study is considered significant to the field of clinical social work for five reasons. First, the therapist may be used by the client as a selfobject substitute for the drug-of-choice. Thus, an understanding of the functions and importance of empathy associated with selfobjects is

critical to clients in the early months of living sober, when the therapist may be a "human bridge" for the client's continued sobriety. Predictable losses, such as breaks in treatment, may be especially disruptive for recovering individuals.

Social workers are commonly a part of the in-patient treatment team, often serving as the primary therapist of the client in chemical dependency treatment. The second reason why this study is significant to clinical social work is that it will enhance the knowledge base for the social worker committed to in-patient treatment settings. She is responsible for the addict and his/her family in early recovery, and assists in the discernment of many kinds of loss. This will include the client's loss of the social worker upon discharge from the treatment center. The relationship of empathic response to relapse may be critical for diagnosis, treatment, and educational components of in-patient treatment.

A striking feature of counseling clients involved in substance abuse is the chaos that pervades their lives. Even dysfunctional attachments or dependencies have meaning to the addict, and may be important to their structural cohesiveness. To remove them will require a thorough understanding of the symbolic meaning to the client, which reflects the values of social work in preserving client dignity and self determination. This study explores the



understanding of these functions for the relapsing person, a third component of enhancing the knowledge base of clinical social work.

A fourth issue is the fact that little research has been done on individuals who return to treatment centers due to relapse a second or third time. Miller and Hester (1980), in their review of over five hundred alcoholism treatment outcome studies, determined that over 74% of those treated for alcoholism relapsed within the first year of treatment. The most popular of treatment models in the chemical dependency field is the disease model, defined by Jellinek in his book, The Disease Concept of Alcoholism (Jellinek, 1960). Jellinek developed a stage of progression schedule for the disease. However, the disease model, and other models that focus on the behavioral aspects of working with addicts, do not serve individuals well when their initial success with sobriety is followed by experiences of psychological fragmentation. For them the experience of sobriety is one which may bring an internal emptiness, depression and a sense of anxiety that was served by the drug-of-choice. These treatment needs are unique and demand research into theoretical and treatment concerns that attend to the developmental problems of the self. Social workers are minimally represented in this field of research.

Fifth, the study of addiction theory and treatment has a new scope of interest, that of relapse prevention. There

is a need for social work research in this field. Relapse prevention is discussed by Dennis Daley, MSW, as a field presenting the need for clarity in issues of definition, knowledge, research and treatment methodologies (Daley, 1989). The CENAPS (Center for Applied Sciences) Model of Treatment identifies many phases and warning signs of relapse, which occur prior to actual use of alcohol/drugs (Gorski & Miller, 1986, pp. 139-155). These include many symptoms related to depression, anxiety and loneliness. Programs of relapse prevention such as the CENAPS Model are helpful in early intervention in the relapse cycle; we no longer have to wait for actual chemical use to identify relapse symptoms. There are many needs to be studied in the field of relapse prevention. This study responds to the investigation of selfobjects needs in the relapsing individual.

#### **Assumptions of the Study**

(1) An assumption is made that the relapse process can be adequately studied by utilization of research interviews and client perceptions of the process. (2) It is assumed that the identification of some disorders of the self can be measured through the presence of addictive behaviors. (3) It is assumed that addicts dealing with multiple experiences of relapse have a higher possibility of behaviors associated with narcissistic personality disorder,

and may have unique needs relative to the functions of mirroring, idealizing and twinship. (4) An assumption is made that selfobjects can be identified and measured, through the presence of persons or things which provide experiences which create or maintain a psychological self structure. (5) It is assumed that experiences of perceived selfobject failures of empathy will be reported by the subject, concerning his/her past, including the meanings that this holds for them in the present. This study has no prediction intended regarding the differences in selfobject or relapse experiences for men and women. If there are differences, they should be defined in a future study. It is speculated that they will be similar. (6) The study assumes no differentiation between the use of alcohol or other drugs in the addiction process, since both are substances which can result in psychological dependency, for purposes of this study's design and interest.

This study explores the process of relapse from the theoretical perspective of self psychology. There are various other hypothetical frameworks through which to consider the study's findings. Psychoanalytic theorists might deliberate the use of the drug-of-choice as manifestations of oral needs or intrapsychic conflicts. Carl Jung suggested another theoretical position when he stated that the "craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for

wholeness, expressed in medieval language: the union with God." (Levin, 1987, p. 82) Thus, the perspective of self psychology is acknowledged as one theoretical alternative among many potential viewpoints, which is particularly suited to the study of empathy, and selfobject needs.

### Limitations of the Study

#### Literature Review

The review of the literature is limited to the categories of psychological theory and empirical research, each as applied to clinical social work, and to the components of this study. Topics have been confined to self psychology, selfobjects, narcissistic personality disorder, addiction, dual diagnosis, and relapse prevention.

The review of literature does not demonstrate an exhaustive evaluation of the integration between empirical research and psychological theory related to the topics addressed in this study. Nor does the literature attempt to review all existing theories regarding addictions, relapse prevention, narcissistic personality disorder, dual diagnosis, selfobjects, and self psychology.

### The Written Forms

Since the researcher designed all the forms that she used in this study, the written forms have not been tested for validity or reliability in past research studies. The language and understanding of the words chosen to represent various feelings may be unreliable. Since subjects represented various races and cultures, it is possible that some of the chosen words in the forms were mistaken, or misunderstood by subjects. Although the checklists provided a uniform response format for a given set of stimuli, they are subject to invalidities and a lack of reliability due to biases of acquiescence, social acceptance, extreme responding, cautiousness and evasiveness (Polansky, 1975, p. 262). However, "Self reports have been shown to be valid indicators of verifiable information concerning the person" (Polansky, 1975, p. 259).

### Data Related to SPSS-PC+

Although the data gained through the written forms and their statistical manipulation on the SPSS-PC+ are insightful, there is no intent by the researcher to suggest internal validity. The data does not meet criteria of inferential statistics and is not generalizable due to the small population of the subjects. The intent of this study is exploratory and descriptive in nature and is the forerunner of potential other research studies in the

future.

### The Structured Interview

The standardized open ended interview has exact wording and sequence of questions, which were determined in advance. Thus, each subject was asked the same questions. This strategy reduced interviewer effects and bias and permitted decision makers to see and review the instrumentation used in the evaluation. However, little flexibility in relating the interview to particular circumstances existed. The wording of questions was the same in each interview and this limited the naturalness of questions and possible answers (Polansky, 1975, p. 117).

The limitations of the self-report interviews between the researcher and the subjects included: (1) the fact that many subjects were limited in verbal facility; (2) the fact that the researcher's background was as a clinician, which may have biased some interview exchanges, in that she did not ask for further clarity from the subject on matters of retrospective interest; (3) the researcher's focus on empathic attunement with the subject may have biased her ability to see other kinds of data which emerged in observation; (4) the time pressures of interviews may have prevented some subjects from being able to expand on their thoughts about relapse; and, (5) financial limitations influenced the extent to which the researcher could travel

to treatment sites and therefore limited the population size and diversity.

The determinates of dual diagnosis, which are reflective in both quantitative and qualitative data, are considered subjective in nature. No instruments or measures were used to verify levels of emotional states of the subjects, other than those suggested in the body of the study.

### Observation

In observing the subjects, the researcher was biased by her own racial, cultural, gender, and professional perspectives. The researcher was also observed by the subjects, which may have influenced subjects due to her sex, race, or perceived status as a doctoral student. Reactivity of the subjects to these issues may have been present, and may have influenced their behaviors or responses to the questions.

The subjects in this study were recently detoxified from substances, and were undergoing treatment in in-patient and intensive outpatient chemical dependency treatment centers. As such, they were in medical transition, and were sometimes experiencing acute levels of emotional pain. Thus, their observations, and biases, may be particular to this period of their recovery and may not represent the views of other relapsing individuals further along in their

sobriety. The respondent's history of chronic self anesthetizing through the use of alcohol and drugs may have influenced the accuracy of their memories in self reports to the researcher.

Other limitations of this study are considered in Chapter 4, data analysis of the written forms, and Chapter 5, data analysis of the structured interviews.

The literature review follows in Chapter 2, addressing more specific areas of psychological theory and empirical research.



## CHAPTER 2

### REVIEW OF THE LITERATURE

#### Introduction

The available literature of chemical dependency related to relapse and narcissistic personality disorder is rather limited since the field of relapse is fairly new. For this study the literature has been divided into two categories of psychological theory and empirical research, each as applied to clinical social work. It will cover the topics of self psychology, selfobjects, narcissistic personality disorder, addiction, dual diagnosis and relapse prevention.

#### Psychological Theory

##### Self Psychology

In order to understand the underpinnings of self psychological views regarding the narcissistic addict, we must first review the conceptualizations of that theory. To do so will set the stage for the additional theoretical considerations that must be added to the factors involved in this dual diagnosis.

Heinz Kohut, in his book, The Restoration of the Self (1988, pp. 70-72), took exception to drive theory and

classic metapsychology in his concern for the narcissistic personality disorder. Kohut's belief was that the central focus of the psychopathology of the narcissistic personality disorder was in the self of the child. Responding to unempathic communication and attunement of the primary caretaker, the child's self is "enfeebled and fragmentation-prone" (Kohut, 1977 p. 74). It is in the child's longing for the mother, for her visual gaze, touch, affirmation, admiration, idealization, that a cohesive self is developed. The process of trauma that the infant experiences, when these needs are denied, can result in a lack of self cohesion.

As the infant is deprived of the needed attunement with the mother, the process of structure building of the self is inhibited. The cohesion of the child's self is frail. In a struggle to feel alive, to feel a movement toward pleasure aims, the child defensively moves toward the stimulation of erogenic zones and later to oral and anal pleasures. It is in this process that Kohut saw the beginnings of addiction processes to selfobjects other than the human link with persons.

Kohut indicated that in it was in the psychological state of a self that was fragile in its development that the psychology of the self was most relevant (p. 94). This was most pertinent where "experiences of disturbed self-acceptance and/or of the fragmentation of the self occupy

the center of the psychological stage (as is the case par excellence with the narcissistic personality disorders)" (p. 94). He elaborated on the inefficiency of defensive maneuvers, such as promiscuity and oral ingestion, in a person's raising their self-esteem, in the following way:

... It is the structural void in the self that the addict tries to fill--whether by sexual activity or by oral ingestion. And the structural void cannot be filled any better by oral ingestion than by other forms of addictive behavior. It is the lack of self-esteem of the unmirrored self, the uncertainty about the very existence of the self, the dreadful feeling of the fragmentation of the self that the addict tries to counteract by his addictive behavior. There is no pleasure in addictive eating and drinking--the stimulation of the erogenous zones does not satisfy. To sum up: the problems of the self cannot be adequately formulated in terms of drive psychology (1977, p. 197).

Self Psychology emerged through Kohut's writings in the early 1970's and resulted in an energetic conceptual dispute between traditional psychoanalytic and self psychological theorists (Balter & Spencer, 1991; Chessick, 1980; Cooper, 1990; Etchegoyen, 1991; Ostow, 1979; Patton, 1980; Sauberman, 1989; Segel, 1981; Tobin, 1991; White, 1980).

Self Psychology represents a paradigm shift from the classical analytic paradigm to a new one. Grotstein (1983) noted this paradigm shift as the most important shift in psychoanalytic theory and psycho-dynamic practice in decades. Self Psychology uses empathy as a method of observation and it uses the narcissistic transferences of mirroring, idealizing, and twinship to transform therapeutically a patient's archaic narcissism into a new

personality structure. The change is possible because the self-selfobject relationship is reenacted in treatment. Thus, Self Psychology might be described as a theory of selfobject psychology (Lee & Martin, 1991, p. 100).

Kohut redefined narcissism, believing that narcissistic libido developed separately from object libido in a parallel process, not at opposite ends of the same continuum as Freud had postulated (Lee & Martin, p. 119). Kohut felt narcissism had adaptive value and should not be eradicated, but understood in terms of its constructive purposes. He was interested in the "transformation of archaic narcissism to mature forms" (Lee & Martin, 1991, p. 120). He saw this potential of transformation, if not traumatized in infancy or childhood, as developing from archaic to more mature forms of development. These forms were: creative activity, empathy, the acceptance of transience (finiteness/death), capacity for humor and wisdom, or the acceptance of limitations in one's physical, intellectual and emotional powers.

D. W. Winnicott's writings from 1951 to 1971, had remarkable similarity to Kohut's concepts. Winnicott was associated to the British object relations theorists. He wrote about the significance of the environmental factors on the infant, and of the mothering figure as central in the development of the self (Bacal, 1989, p. 260).

The application of Self Psychology theory to work in

the addictions has interested many recent writers due interest in the application of selfobject theory to the treatment of alcohol and drugs (Berger, 1991; Dodes & Khantzian, 1991; Levin, 1991; Ulman & Paul, 1989; Wolf, 1988).

### Selfobjects

Winnicott's views of the infant and mother being an inseparable "unit" has been considered to resemble the archaic self-selfobject unit later elaborated by Kohut (1971, 1977). Winnicott and Kohut had comparable ideas on selfobject functioning, but Kohut was more precise in his organization of ideas. Winnicott described the infant's need for a holding environment, which suggests a merger, and is analogous to Kohut's archaic self-selfobject relationship (Bacal, 1989, p. 269). Winnicott's considerations of "good-enough mothering", the mother's ability to meet the young infant's needs in a state of "primary maternal preoccupation" (1956a), are most reflective of Kohut's descriptions of the selfobject function of the primary caretaker.

The psychological survival of an infant is dependent on various environmental supports, including the presence of responsive-empathic selfobjects. A distinctive part of the structure formation necessary in psychological growth is called transmuting internalization, in which the nuclear

self of the child will slowly and incrementally take in the functions once performed by others. The structure building process requires, (a) that the child's needs for mirroring or idealizing have been responded to, (b) that timeliness of non-traumatic failures have been met with appropriate selfobject experiences, and (c), that failures lead to the gradual replacement of selfobjects and their functions with the internalization of the individual's own self structure. Problems in the structure building process result in personalities lacking vitality, and the ability to self soothe, and having low self esteem, stifled creativity, and high levels of anxiety.

Pathology occurs "when parents or parenting figures are unresponsive, cold, humiliating, rejecting, hostile, abusive, angry, unempathic, demanding, perfectionistic, and unavailable; when the child does not experience the external admiration it requires during the grandiose phase. Depression, emptiness, and feelings of badness and incompleteness are experienced instead" (Freed, 1984, p. 397).

Kohut was able to profile the development of the self from states of initial fragmentation, to an archaic or primitive cohesive self, to a mature self. He believed that narcissistic patients were fixated at the developmental stage of the archaic self, and that these fixations resulted from failures in the empathic communication (mirroring) with

primary caretakers very early in life. Kohut (1977b) wrote about addiction, suggesting that it was a futile attempt to repair developmental deficits in the self structure (Levin, 1987, p. 13).

The healthy person will seek selfobjects that are pleasurable and which preserve a cohesive self. The unhealthy person chooses selfobjects that deter the maintenance of health and lack the ability to soothe. The loss of control that exists in addiction is frequently indicative of a selfobject suicide, wherein the addict repeatedly returns to a selfobject that is destructive and potentially life threatening.

Bacal (1989) notes that self psychological notions regarding enfeeblement or fragmentation of the self, due to selfobject failure, would be strengthened by Winnicott's concepts about the false self. The false self is a reaction to environmental failure. The false self responds to selfobject shortfalls through compromising its genuineness, rather than being weak or fragmented.

The compromise of genuineness, through the self soothing mechanism of alcohol/drug use, could be considered an environmental adaptation for the dually diagnosed substance abuser, and narcissistic personality disorder. Winnicott's concepts of "transitional objects" (1971d) are also consistent with the use of a drug-of-choice as a selfobject, an object that is experienced as an extension of

the self. Although Winnicott described many of the concepts later elaborated by Kohut, it is Kohut's systematic theoretical model that led to a greater understanding of the narcissistic personality.

### Types of Selfobjects

The idea of a selfobject function was derived by Kohut through an understanding of the narcissistic transference.

In the neurotic transference, the therapist becomes a screen for displacements and projections of actual past experiences with parents or significant others. In the narcissistic transference, the longing for missed experiences is relived with the therapist. In other words, neurotic transferees involve experiences that have taken place; narcissistic transferees, those which have not. Some patients present with both types of transferees; nonetheless, the distinction...is useful. (Lee & Martin, 1991, p. 127)

Kohut initially referred to two types of transferees, mirroring and idealizing. He later added twinship. The term narcissistic transference began to be replaced by the term selfobject function.

The major part of the working-through process in the analysis of narcissistic personality disturbances does not concern the overcoming of ego and superego resistances against the undoing of repressions ... the essential part of the working-through process concerns here the ego's reaction to the loss of the narcissistically experienced object. (Kohut, 1987, p. 95)

Kohut saw mirroring, idealizing and twinship as specific ways to describe the needs of narcissistic transference. (Lee & Martin, 1991, p. 127).



### Mirroring Transference

Kohut defined the mirroring transference as

the therapeutic reinstatement of that normal phase of the development of the grandiose self in which the gleam in the mother's eye, which mirrors the child's exhibitionistic display, and other forms of maternal participation in and response to the child's narcissistic-exhibitionistic enjoyment confirm the child's self-esteem and, by gradually increasing selectivity of these responses, begin to channel it into realistic directions. (Kohut, 1971).

Kohut considered the alter-ego or twinship transference a part of the mirroring transference in his early writings. However, in 1984 he conceived of the twinship transference as separate and different from the mirroring transference.

The mirroring transference can be viewed as a revival of the grandiose self (Chessick, 1985). Basch refers to mirroring as a demand for validation, wherein selfobjects "show attitudes, words and/or actions that resonate with one's own experiences" (Basch, 1992, p. 18). Unlike Kohut, Basch sees kinship, idealizing and mirroring on a continuum in which kinship (twinship) is a basis for idealizing and then for validation (mirroring). Kohut did not view this hierarchy of selfobject experiences as Basch, but saw them as presenting selfobject needs separately or in tandem with each other.

With the mirroring transference, the patient seeks a responsive selfobject who recognizes, admires and praises the patient in the transformation from a primitive archaic grandiosity to a wholesome pride in performance (Goldberg,

1988). Once transformed, self regulation and self discipline are better internalized. Significant to this study is the impact of a lack of mirroring by selfobjects and the relationship of the potential loss or failure of this selfobject need to alcohol and drug use.

### Idealizing Transference

The idealizing transference is seen by Kohut as a way a patient attempts to "overcome arrested (and) unmet developmental needs" (Kohut in Lee & Martin, 1991, p. 140). It is an attempt to save "a part of the lost experience of global narcissistic perfection by assigning to an archaic rudimentary (transitional) selfobject, the idealized parent imago" (Kohut, 1971, p. 37).

This need is based in the foundation of optimal development wherein the child idealizes the father, or other person, and slowly, through minor disappointments experienced, accepts the imperfection and humanity of the idealized person. When a child is traumatized in the idealization needs, through abrupt devaluation of the idealized selfobject, the self structure is not transformed into a tension regulating structure. Rather, the selfobject is retained unaltered in form, leaving the person to continually seek an approving relationship with someone they look up to, and without having the gratified phase-appropriate needs to idealize a selfobject.

Idealization transferences may be noted in silence, open admiration of the therapist, depreciation of the therapist through resistance to idealization, and in defensive idealization of oedipal rivalries based on hostility (Kohut, 1971, p. 75). These may reflect archaic or more mature developmental lines (Lee & Martin, 1991, p. 143-145).

Idealizing transferences suggest a longing to be strengthened and protected when necessary by association with an admired, powerful figure. Basch (in Detrick and Detrick, 1989, p. 15) suggests that the basis for this reaction stems from the childhood need to be held, protected and comforted. "It is a need to be united with someone one looks up to and who can lend one the inspiration, strength, and whatever else it takes to maintain the stability of the self-system when one is endangered, frustrated, or in search of meaning."

The idealizing transference is important to this study as drugs and alcohol can be sought to comfort or soothe the self, and may relate to relapse in this way. Ulman and Paul point out three basic types of addictive self disorders or self-disordered addicts. These are the manic addict, the depressed addict and the manic-depressed addict. They suggest that the manic-depressed addict may vacillate between the idealizing selfobject merger and the mirroring merger of grandiosity to create the illusion of well being

and self regulation (Ulman & Paul, 1989, p. 132).

Mary McMahon (1991) recently completed a study regarding the selfobject transference-like needs in couples which focused on the mirroring and idealizing transferences. This study attempted to address how a partner is chosen to confirm certain gender attributes, and found that both men and women want a partner who mirrors and idealizes them. McMahon found that mirroring and idealizing selfobject needs could be defined separately in terms of directionality, but the findings were unclear regarding the separation of mirroring and idealizing as discrete phenomena. "It would seem then that these two selfobject functions build on each other: being mirrored by the idealized other, and idealizing the one who provides mirroring, together providing the essential ingredients for self structure" (McMahon, 1991, pp. 213-214).

### Twinship Transference

Kohut saw the twinship transference as the third chance to acquire skills and tools for a cohesive nuclear self through likeness, kinship or sameness in relationship with other selfobjects (Lee & Martin, 1991). The first two chances occurred in infancy and the latency period. In 1984, Kohut wrote, "Within the context of the transference, an outline will gradually come to light of a person for whom the patient's early existence and actions were a source of

genuine joy; the significance of this person as a silent presence, as an alter ego or twin next to whom the child felt alive will gradually become clear" (Kohut, 1984, p. 204).

Detrick notes that in discussion with Kohut, Kohut said that "The relationship to a twin is that of an alterego," not delineating the twin from the alterego. Detrick did define the terms separately indicating that twinship is a "phenomena ... in which an experience of sameness or likeness serves the central function of the acquisition of skills and tools; alterego phenomena are those experiences of sameness or likeness that anchor the individual in a group process" (Detrick, 1986, p. 300). Detrick was one of very few writers in the 1980's that wrote about the twinship and alterego functions of selfobject transferences. Detrick suggests that mirroring and idealizing transferences are appropriately dealt with in the working through process of individual psychotherapy, while twinship and alterego transferences can best be met in group psychotherapy in the context of an interpretation that evokes an experience of twinship.

Basch identifies the need for kinship (twinship) to proceed to idealizing and mirroring transferences. He referred to "kinship experiences" as the most basic of the three transferences because it asserts and strengthens the sense of being a member of a group--the acceptance that

comes from being like the other. It is the appreciation of and the resonance with another's affect that is probably the most important factor, according to Basch (Basch, 1991, p. 19), in promoting "kinship experience."

Twinship experiences are important to this study as they are pertinent to social, cultural and psychological aspects of the self and the self cohesion, and are significant in many areas of alcohol and drug relapse.

#### Other Transferences

The merger transference involves transformation of the mergers of the archaic dimension of all three narcissistic transferences (i.e. mirroring, idealizing and twinship). A merger experience can occur when empathic failure with the therapist or selfobject is precipitated, and is seen as a type of regression. Wolf notes that a therapist's sleepiness or boredom in therapy may suggest the presence of a merger through the therapist's defensive withdrawal (Wolf, in Lee & Martin, 1991, p. 158). Wolf has identified several other types of transferences, such as adversarial needs, and efficacy needs (Wolf, 1988, p. 55). This study, however, will be limited to the transferences of mirroring, idealizing and twinship.

## Empirical Research

### Narcissistic Personality Disorder and Addictions

Narcissistic Personality Disorder. Along with the controversy regarding the new theory of self psychology came confusion regarding the definition of narcissistic personality disorder (NPD) as an independent diagnostic entity (Ronningstam, 1988). Kohut's work (1966, 1968, 1971, 1972) rarely focused on diagnostic issues, and was heavily reliant on transference material and information about past history. This was noted in the attempts by Forman (1976) and Goldstein (1985) to identify NPD diagnostic criteria from Kohut's work (Ronningstam, 1988).

Forman (1975) identified criteria for NPD which he derived from Kohut's descriptions, the most prominent of which are: (1) low self-esteem, (2) tendencies toward periodic hypochondriasis, and (3) feelings of emptiness or deadness (Millon, 1981, p. 165).

An attempt was made by Robert Stolorow to develop a functional definition of narcissism, as follows: "Mental activity is narcissistic to the degree that its function is to maintain the structural cohesiveness, temporal stability and positive affective coloring of the self-representation" (Stolorow, 1986, p. 198). He went on to identify several forms of healthy and unhealthy narcissism and described how this definition fit each category; the categories are (1)

Narcissism as a sexual perversion, (2) Narcissism as a mode of relating to objects, (3) Narcissism as a developmental stage, (4) Narcissism as self-esteem, and (5) Healthy versus unhealthy narcissism (cited in Morrison, 1986, p. 197-209).

Elsa Ronningstam notes that a low concordance of specific criteria exists among diagnostic categories, but that there is consensus about the conceptual themes describing self-experience, and interpersonal relations in NPD (Ronningstam, 1988). She compared three NPD diagnostic systems, with a descriptive, psychodynamic and psychoanalytic frame of reference. The systems included DSM-III-Axis II (1980), Akhtar and Thomson's system (1982) and Kernberg's system (1983). The core features of NPD appear to be mutually shared. These include: grandiosity, grandiose fantasies, and feelings of inferiority; idealization, devaluation and contempt of others, exhibitionism, and a requirement of admiration from others, entitlement, exploitative behavior, envy, lack of empathy, learning difficulties, and reactivity and instability. It was noted that NPD is often found in clusters of other personality disorders which share narcissistic traits, such as borderline and hysterical personalities. This is significant to consider in this study. However, this is true in many diagnostic categories. For example, dependency is often associated to the avoidant personality disorder. For purposes of this study, it is the narcissistic personality



disorder as the primary personality disorder that is of significance, rather than a clinical symptom that is in consort to other diagnoses.

Svrakic (1990) developed his own table of clinical features and structural elements of narcissistic emotions. He included primary emotions: envy, unprovoked rage, emptiness and boredom; secondary emotions included both positive (hypomanic exaltation) and negative emotions, (provoked rage, emptiness and boredom, pessimism). The introduction of the idea of pessimistic mood as characteristic of decompensated narcissistic traits was a unique aspect of this study. The pessimism may reflect the deficit in the psychic structure and the hopelessness experienced in maintaining sustaining self objects. Svrakic notes the duality of the narcissist: grandiosity vs inferiority. Much of the discussion of narcissistic personality traits discussed by Svrakic can be applied to the predictable behavior of addicts. These observations give reason to further consider the possibility of the dual diagnosis of NPD and addictions constituting a major portion of the populations at chemical dependency treatment centers.

The puzzlement regarding NPD diagnostic criteria remains, and presents some confusion for the interplay of theoretical, treatment and research interests. It becomes necessary to know the theoretical underpinnings of authors, since identical terms may have disparate meanings. For

example, it is agreed that altered self-esteem is a diagnostic criterion in NPD. Kohut indicates that the narcissist has low self-esteem, while criteria in DSM-IV suggests that a narcissist has an inflated sense of self-esteem. Although there is some agreement on the diagnostic components of narcissism, there is also dissension. Kohut's descriptions are not in full consensus with the DSM-IV criteria. A clinician may determine a client to be diagnosed as NPD within Kohut's descriptions and will find the diagnostic criteria in DSM-IV inapplicable.

Research has focused on comparisons of various schools of thought regarding narcissistic criteria (Adler, 1986; Bernstein, 1981; Detrick & Detrick, 1989; Freed, 1984; Jacoby, 1990; Kernberg, 1984; Philipson, 1981; Siomopoulos, 1988). Ronningstam's observation that at least three diagnostic systems of NPD, descriptive, psychodynamic and psychoanalytic frames of reference, still pervade the literature and continue to raise questions regarding a "common, distinct and coherent cluster of diagnostic features that are distinguishable from features in other personality disorders" (1988, p. 300). This suggests a need for continued research in the subject, and especially points to the need for further research that is focused on the theoretical posits of self psychology, where the symptomatology and treatment issues of NPD are in evolution.

Addiction. Jerome Levin identifies alcoholism as a "disorder of the self" (1987, p. 3). He notes that the definition of alcoholism is self-destruction by self-poisoning, of suicide on the installment plan. This suggests the self-pathology in addictions. Levin noted that the theories of self psychology were pertinent to his work with alcoholism. He used the Minnesota Multiaxial Personality Inventory as an instrument of research to identify elevated scores reflective of a "devil-may-care [mildly sociopathic] attitude...." He linked the identification of these raised scores to the diagnosis of narcissism, specifically the fixation/regression of the archaic grandiose self in alcoholism. His work reflects a sensitive understanding of the issues of psychotherapy with the narcissistic addict, and of the transference and countertransference issues that are involved.

Ulman and Paul use self psychology to understand and treat substance abuse disorders. They define substance abuse disorder as "the compulsive and habitual use (or, in the case of anorexia, the disuse) of a substance or substances, for the purpose of altering, either psychopharmacologically or biochemically and physiologically, the sense of subjective self. Such abuse is characterized by dependence, addiction, tolerance, and withdrawal" (Ulman & Paul, 1989, p. 122). They have three propositions in their approach: (1) all substance abuse disorders are

manifestations of a subjective disturbance in the unconscious organization of experiences of self in relation to selfobject; (2) the addictive person fantasizes a particular substance as imbued with unconscious meaning and it is subjectively experienced as providing selfobject functions; and, (3) self-psychological treatment is effective because the selfobject functions of substances become intersubjectively absorbed within the context of the therapeutic relationship in the form of "selfobject transference fantasies" (p. 122).

Ulman and Paul posit that the addict is compelled to depend upon inanimate substances in order to deal with the inadequately internalized self structures. The alcohol/drug is a "remedial stimulant" (Geist, 1984; Kohut, 1972, p. 626) which serves as a substitute selfobject and defends against the fragmentation of the self (Ulman & Paul, 1989, p. 123).

Weiss, Griffin and Mirin studied the self-medication hypothesis of drug abuse by examining drug effects and motivation for drug use in 494 hospitalized drug abusers. Most patients reported that they used drugs in response to depressive symptoms and experienced mood elevation, regardless of their drug choice. This study neither confirms nor negates the self-medication hypothesis of drug abuse, but found that most of the patients used drugs for medication even when they were not diagnosed as having major depression, and found the drug(s) improved their mood.

Women appeared particularly inclined toward medication for depressive symptoms (Weiss, Griffin & Mirin, 1992).

A recent exploratory analysis of social support and outcome of alcohol treatment was completed by Booth, Russell, Soucek and Laughlin (1992). They found that when family and friends were supportive and affirming of the alcoholic's competence, through statements regarding the reassurance of worth or esteem of the alcoholic, it resulted in significantly lengthening the time between readmissions for treatment. Being perceived by others outside the treatment environment as capable or "worthy" may enhance the self-confidence of the alcoholic so that he or she can overcome their drinking problem.

There is a need for more subjective data, based on the experiences of the narcissistic addict, to advance these formulations toward treatment models that are effective.

### Dual-Diagnosis

The dual diagnosis client meets the criteria for both chemical abuse or dependency and a coexisting psychiatric disorder. Why are professionals becoming increasingly interested in this population? The epidemic of drug use in America has existed for several decades with increasing use of more and more drugs at younger and younger ages.

Berger (1991) reports his psychoanalytic viewpoint of substance abuse from a compelling cultural-psychological

perspective, and disputes present treatment modalities. He states, "My conviction is that at the root of the failures of the mainstream approaches is the fact (at least, the fact for psychoanalysis) that those who compulsively and heavily use drugs suffer from severe midrange psychopathology or worse" (Berger, 1991, p. 128). Berger's notions illuminate thought on the wide range psychological problems of the culture and society, and challenge traditional approaches in the treatment of substance abuse with the dually diagnosed individual.

Individuals with a psychiatric disorder are at increased risk for having a substance abuse disorder (Evans & Sullivan, 1990, p. 3). The general population has a reported prevalence rate for alcohol and substance abuse or dependency of around 7%. Individuals with major depression or an anxiety disorder have doubled that, 14%; a 20% alcohol abuse rate exists for persons with bipolar disorder (Schukit, 1986); young chronically mentally ill patients have a reported 50% chance of addiction (Bergman, 1985; Safer, 1987), a 70% rate of abuse or addiction applies to antisocial personality disorders (Schukit, 1986).

Evans and Sullivan (1990) note that the individual with a dual diagnosis

presents with especially severe distress and disability. The dual diagnosis person's situation is one where the whole problem is greater than the sum of the parts, since the two disorders inevitably exacerbate each other. The confused person becomes more confused, the hostile person more threatening and

assaultive, and the suicidal person more likely to engage in harmful activities ... Coexisting disorders are also more difficult to treat. (p. 3)

The dual diagnosed client becomes increasingly confused about the nature and solutions to their problems. With each hospitalization the sense of hopefulness diminishes, along with their sense of worth.

There are other problems associated to the special population of the dual diagnosed client. These clients lack social connections and social skills, have problems with family systems and jobs, are more unable or unwilling to comply with treatment, and often seriously frustrate the treatment providers who find them perplexing.

As the research increasingly focuses on the physiological basis of addiction, the treatment providers and programs have focused on these concepts (Evans & Sullivan, 1990, p. 6; Searles, 1988). Mental health issues are separated from issues of alcohol and drug dependence in treatment centers and in governmental offices. Few professionals have the cross-training that is necessary to provide the wide spectrum of knowledge that is necessary in a field of this complexity. As a result, the dual diagnosed client suffers with inadequate, if not inept, services. This study focuses on the individual with coexisting mental health and chemical dependency treatment needs toward furthering research knowledge in these shared professional fields.

Laura Schmidt (1991) reported on her observations of dual diagnosis clients living in half-way houses. She found that the treatment philosophies of addictions counselors and those of mental health workers had divergent goals and presented a confusing dilemma to the client and staff. Mental health workers tended to have professional degrees, while alcoholism programs hired paraprofessionals or individuals who themselves had recovered from alcoholism through Alcoholics Anonymous participation. Schmidt found that mental health workers encouraged clients to be compliant in taking medications; AA programs encouraged the clients to get off drugs--legal or otherwise. AA and alcohol treatment stressed that abstinence from psychoactive substances was a necessary prerequisite for recovery and a key marker of success in treatment. The dual diagnosis client was often found to not "meet criteria" in either alcohol treatment programs or in mental health facilities, and was deemed inappropriate to both (p. 865). These issues, common to the individual who faces a dual diagnosis, such as the narcissistic personality disordered addict, or the individual who is experiencing bi-polar depression and addiction, present a complex treatment problem.

Malvern Institute in Malvern, Pennsylvania, has attempted to approach the dual diagnosis problem with a progressive new program. The Malvern Institute had used the multidisciplinary treatment team model, common to many dual



diagnosis settings. In these facilities, addiction is seen as the end result of multiple etiologies. Malvern noticed the inconsistencies in treatment, due to the fact that the professionals came from various theoretical frameworks and the splitting within the staff on these issues. This splitting caused inconsistency in treatment and a poor quality of treatment to patients. Ron Rogers and Scot McMillin developed a treatment model which is focused on the treatment of addiction. The model focuses on goals of treatment, roles, therapeutic activities, community meetings, small groups, individual therapy, lectures, and diet. The concern expressed in overviewing other programs is that treatment providers often overlook the recovering patient's physiology and limitations. Many issues are deferred for aftercare treatment, when the patient is capable of integrating more cognitive material. The model puts boundaries on staff so that they do not act out their codependent or countertransference issues, but focuses them on the program itself (Johnson, 1992).

These issues reflect the fervent need for research in dual diagnosis and especially regarding the diagnosis of narcissistic personality disorder. They also highlight the need to understand the functions of selfobject choices for individuals who experience trauma not only in the internal experience of their maladies, but in the systems that offer treatment.

### Relapse Prevention Theory

In 1985, the book Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors was published. Marlatt and Gordon presented their classic book in the field, stating that the primary focus of their model is toward the crucial issue maintenance in the habit-change process. Their model is based on the theoretical orientation that addictive behaviors are conceptualized as overlearned, maladaptive habit patterns rather than addictive "diseases." The application of self-management or self-control procedures is addressed through a process of unlearning habits that have become destructive. Thus, the focus is on change theory, rather than the etiology of addiction, and stresses that attribution of the responsibility for the solution to the problem of addiction (who is to control future events) is distinct from the attribution of responsibility for the development of a problem (who is to blame for a past event) (p. 12).

In 1986, Gorski and Miller authored the book, Staying Sober: A Guide for Relapse Prevention. Gorski has noted that studies of lifelong patterns of recovery and relapse indicate that patients who relapse are not hopeless. One third achieve permanent abstinence from their first serious attempt at recovery. Another third have a period of brief relapse episodes that eventually result in long term abstinence. An additional third have chronic relapses that

end in death from chemical dependency (Gorski, 1986b). Gorski and Miller developed the CENAPS Model of Relapse Prevention, which stresses the biological, psychological and social elements of addiction and recovery. Like Marlatt and Gordon, their focus is on changing patterns of destructive behavior. However, Gorski and Miller pay particular attention to the stages of recovery in biopsychosocial realms, and have developed a treatment strategy that is extremely comprehensive and well organized.

Dennis Daley has reviewed several models of relapse prevention, including the CENAPS Model. He notes the cognitive-behavioral, psychoeducational, and cognitive-behavioral models, in addition to his review of various methodological and clinical perspectives. He also notes the variety of systems that interplay in the life of a chemically dependent person, including the addict, the family, the professional, the chemical dependency treatment system, and other systems in the addict's life. For purposes of this study, it is significant to consider that each of these systems are potential selfobject systems to the addict.

In the variety of methodological approaches to the work of relapse prevention, there are few that address the issues that are specific to the narcissistic personality disordered and chemically dependent person. This is an area research that is on the cutting edge; little has been done. Ulman

and Paul consider the narcissist's dilemma in addiction and raise important and pertinent questions regarding the subjective disturbance of the self. But their case studies are not complete or convincing in terms of the need for more exploration regarding the actual experience of selfobject meaning for this clinical profile.

The individual with a dual diagnosis is known to have unique treatment needs; we have not yet found the answers to those needs. This study addresses a portion of those needs, toward more comprehensive theoretical, treatment and relapse prevention perspectives.

The next chapter explores the methodology of this study, and the manner in which both qualitative and quantitative approaches to the research questions were designed.

**CHAPTER 3**  
**METHODOLOGY**

**Introduction**

The current study was designed to explore the relationship between chemical dependency relapse and experiences of empathic presence or absence. No previous reported clinical social work studies specifically addresses these issues from either a research or theoretical perspective. This study included quantitative aspects, including the data gained from selected forms, and qualitative data, gained through structured interviews with research subjects.

The quantitative components of the study allowed the researcher to investigate specific data on the subject's drug-of-choice, times in treatment, length of sobriety, and feelings, through use of correlation, frequency, and cross tabulation analysis. This enhanced the ability to identify symptoms of dual diagnosis in the sampled population, and to distinguish the presence or absence of comfort sought through alcohol and drug use. Since no standard data collection instruments existed, the researcher developed her own forms. This, along with pretests, strengthened the content validity for the study.

The qualitative components of the study allowed the researcher to enter the world of the subjects and to investigate their own perceptions of their feelings associated to relapse. Questions developed for the structured interview were designed to explore the selfobject needs for mirroring, idealizing, and twinship, from the subject's perspective. These questions probed the presence, and absence, of empathic bonds in the subject's life through a systematically designed framework. Questions were structured in a manner which began with a review of the reason the subject was in treatment, examination of the last relapse event, and a progression of questions which explored selfobject needs. This was consistent with self psychological theory in that the inquiry pursued the uncovering of the existence of past and present empathic bonds, or empathic ruptures that existed in past and present relationships. Likewise, the content analysis of the structured interviews allowed the researcher to identify themes and patterns related to empathic bonds, or the lack of empathic bonds, in the subject's life.

Recovery from an addiction is a process, not a single event. The exploration of precipitants contributing to relapse is paramount to this study, because little is known about the impact of empathic presence or absence for addicted persons. The flight toward relapse is frequently swift, and unexpected. Persons in relapse are often unaware

of their own emotional crisis, and seldom recognize emotional signals which may have predicted the vulnerability of oncoming relapse. They are habitually numbed of feeling, do not know how, or have minimal ways, to identify or cope with strong emotions, and remain oblivious to the circumstances which brought them to a self medicated aftermath. Therefore, the cycle is often repeated.

The presence of mental states which commonly coincide with addictive behaviors include dual-diagnosis, suicidality, and other conditions of intense human suffering, such as losses of many kinds. Individuals being treated for addictions are at high risk and have many treatment concerns. Thus, the examination of feeling states, both when using and not using the drug-of-choice, and the understanding of events related to relapse are important in building the knowledge base, practice skills, and methods of treatment interventions.

The social use of alcohol and drugs is accepted in our culture, and often presents stirring and difficult choices for an addicted individual desiring sobriety. Alcohol and drug use frequently involve time with friends, spouses, neighbors, work colleagues, and extended family. These empathic bonds are critically interwoven into the individual's identity, familial and social support system, and their understanding of their social environment. The traditions of alcohol and drug use encompass familiar

gathering places, networks of communication, many life roles, relationships, and meaning systems. One does not give up just the drug-of-choice in the choice to recover; many relationships, places, things, and commonalities are sacrificed toward the goal of sobriety. The consequential losses, or changes within these systems, which are necessary to sobriety, may contribute to relapse, and are significant to this study in that they may also interfere with the established needs of mirroring, idealizing, and twinship, within the subjects' world.

#### Components of the Study

To study relapse, some criteria for sample inclusion had to be established. First, the diagnosis of an addiction was required; second, the subjects in the study had to have participated in treatment at a qualified chemical dependency treatment facility; third, there had to be at least one subsequent relapse into drug-of-choice use, after a period of sobriety; and, fourth, a consequent request for treatment at a chemical dependency facility, toward the desire for recovery, had to have occurred.

In addition to the verification of these four criteria, the researcher had an interest in exploring several other components, which investigated the interaction of progressive and addictive alcohol and drug use with particular emotional states, which might verify the presence



of dual diagnosis. These components included: (1) the drug(s)-of-choice and prescription drugs used; (2) feelings commonly reported when not using the drug-of-choice; (3) feelings experienced before the first treatment intervention; and (4) feelings described as present during the last relapse.

These items considered the existence of dual diagnosis, and explored the potential that the drug-of-choice may have been used to self-medicate, or to produce feeling states that enhanced or detracted from the emotional experience of the subjects studied. The components of this data allowed a comparison of changes in emotional response to the drug(s)-of-choice from (a) the first treatment intervention; to (b) the last relapse event. These factors were pursued by the following questions:

How does the person perceive the use of the drug?

What comfort might be sought through the use of the drug?

The structured interview considered these factors of relapse and many questions developed from the theoretical constructs of self psychology (Kohut, 1977). The specific research questions are reviewed in the Research Questions section of this chapter, and further in the section on the Interview as an Instrument. The researcher had to reframe

these questions into a format which would be understandable within common language, and which could be presented as concisely as possible to subjects. The data related to verification of addiction, relapse, and feeling states, which were reduced to written forms. The interview portion was reduced to 25 questions which reviewed the relapse event, what events precipitated the relapse, questions exploring people or things contributing to relapse or sobriety, and how these persons might have influenced the subject's feelings about themselves. These questions were pertinent to mirroring aspects of human need, defining how significant others, or events, may have empathically affirmed or not affirmed the involved subjects. Other questions explored how the research participants comforted or soothed the self, how therapists or counselors understood, or misunderstood, them, and if those experiences reminded them of other significant relationships. These questions considered idealizing needs, which included feelings of having felt protected, comforted, or soothed in relationships. Finally, questions related to having experienced common bonds with others, explored the subjects' twinship needs, and pondered in what ways they felt a link, connection, or tie with others in their human experience.

The research instruments were designed for this study by the researcher. They are described in greater detail in the Research Instrument portion of this chapter. They

included: (1) a relapse history inventory form, which included demographic information (age and sex), four questions related to prior treatment, history of drug-of-choice use, longest period of sobriety, and a check list of feelings experienced when not using the drug-of-choice (Appendix A); (2) a form which gathered information regarding drug-of-choice before first treatment for chemical dependency, and feelings experienced when using the drug-of-choice at that time (Appendix B); and, (3) a form which gathered information regarding drug-of-choice during the last relapse event, feelings experienced when using the drug-of-choice at that time, and any prescription drugs used (Appendix C). A form was designed for the researcher's comments (4), which reviewed symptoms particularly associated with narcissistic personality disorder (Appendix D). A list of 25 questions was developed (5), which guided the interview portion of the study, and was designed to identify experiences of empathic presence or absence from a self psychology perspective (Appendix E).

### **The Research Questions**

The study is designed to explore the following questions: What experiences precipitate relapse? What does the experience of relapse mean to the relapsing person? Does the experience reflect a failure in the need to respond or be responded to in certain ways? How does the person

perceive the use of the drug? What comfort is sought through the use of the drug? What kind of relationship exists between relapse and the perception of failure of empathic response to significant emotional needs for mirroring, idealizing, and twinship? In what other ways does the presence, or absence, of empathy affect the perceived desire for the drug of choice?

### The Research Project

The research project used a purposive sampling. This intensity sampling allows for information-rich cases that manifest the phenomenon of the relapse experience (Kidder & Judd, 1986; Monnet, Sullivan, & DeJong, 1986). It was decided to survey one particular sample of individuals who were identified to be chemically dependent, and had relapsed into use of drugs or alcohol, following a period of sobriety. It was further decided to include in the sample only subjects involved in either inpatient, or intensive outpatient treatment programs for chemical dependency.

This sample of subjects would have a diagnosis of Substance Dependence Disorder, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R), prior to 1994, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), after 1994. Subjects for this study were interviewed during 1993 and 1994, which involved the transition from DSM-III-R to DSM-IV criteria. The

modifications of definitions of Substance Dependence Disorder, from DSM-III-R to DSM-IV, were minimal, for purposes of this study, or for criteria for chemical dependency treatment diagnosis issues as used in inpatient and outpatient settings. The use of criteria for Substance Dependence Disorder (DSM-IV) is used for definition in this study.

In addition, subjects were thoroughly detoxified from all mood-altering substances. The researcher also wished to be sure that this was a clearly defined sample of chemically dependent persons who were obtaining treatment due to a relapse into drug/alcohol use, and who had experienced at least two treatment interventions for chemical dependency. Treatment interventions were defined as in-patient, or intensive out-patient therapy in a center designed to treat chemical dependency. The sampling criteria specified that subjects had to be at least eighteen years of age. This limitation was set to ensure that programs would be consistent with chemical dependency treatment units serving an adult population.

### **Operational Definitions**

For purposes of this study, definitions of terms include: addiction, empathy, narcissistic behavior disorders, narcissistic personality disorders, relapse, selfobjects, selfobject functions, and chemical dependency.

All but chemical dependency have been defined earlier in this paper.

The definition of chemical dependency is as follows:

Chemical dependency is defined as the psychological and physical dependence on a chemical substance. It is characterized by compulsion(s), obsessive thinking, denial and usage even in adverse consequences. Chemical dependency is defined as Substance Dependence Disorder in DSM-IV (DSM-IV, 1994):

A. At least three of the following:

1. "tolerance, as defined by either of the following:
  - (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
  - (b) markedly diminished effect with continued use of the same amount of substance
2. withdrawal, as manifested by either of the following:
  - (a) the characteristic withdrawal syndrome for the substance
  - (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. substance often taken in larger amounts or over a longer period than the person intended
4. persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time spent in activities necessary to obtain the substance
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

### Sample Selection and Criteria for Inclusion

Subjects were selected from hospital based inpatient and intensive outpatient chemical-dependency programs in Illinois. The hospitals are private hospital settings with adult and adolescent chemical dependency units. All of the hospital unit programs have been in existence for more than 15 years. The researcher contacted program directors, who had clinical experience, as well as a research interest in the fields of chemical dependency and relapse prevention, to discuss the research study. The hospital administrators, and the program directors, granted permission under the condition that subjects were voluntary, and would not be interviewed during treatment program activities. The administrators expressed concerns that the confidentiality of all subjects must be strictly protected. They also expressed concern that there be interface between the researcher and counselors, who were primary therapists involved with treatment of the subjects, if significant data gained during relapse interviews revealed life threatening or pertinent treatment issues. They requested that subjects be advised that significant data of this type would be shared with counselors. An agreement was reached that any individual data gathered from subjects, such as emotional conflicts which hindered their continued sobriety, and which may relate to their treatment goals, would be conveyed by the researcher to the counselors. All subjects agreed to

the aforementioned conditions of the interviews. Some indicated a marked desire that any pertinent data shared during the interviews, regarding their relapse events, thoughts, and feelings, be conveyed to their primary therapists toward the subject's goal of continued sobriety.

The subjects for this study were patients who entered an inpatient or intensive outpatient chemical dependency treatment program, due to relapse into drug/alcohol use after a period of sobriety. The subjects were voluntary admissions to the hospitals and were either self-referred or referred by their physician, therapist, employer, family, employee assistance program, or insurance company. At admission, subjects were diagnosed with a DSM-III-R or DSM-IV diagnosis of Substance Dependence Disorder and had to meet the hospital admission criteria for inpatient treatment for chemical dependency. Some subjects were diagnosed with a dual-diagnosis, meeting criteria for both chemical dependency criteria and a co-existing psychiatric disorder (described in DSM-IV). Inpatient treatment consisted of two phases of treatment: detoxification and intensive rehabilitative treatment. Inpatient subjects in this study had completed the detoxification portion of their treatment and had begun rehabilitative treatment. Outpatient subjects did not require detoxification portions of treatment, and had begun intensive rehabilitative treatment.

On admission the subjects reported a history of chronic



usage of alcohol, sedatives, tranquilizers, amphetamines, narcotics, hallucinogens, phencyclidine, cannabis, cocaine, or crack cocaine. Many subjects were poly addicted to one or more chemical substances and required a medically supervised detoxification due to acute physical and psychological symptoms of post-withdrawal. Detoxification lasted from three to ten days. After detoxification was completed, patients who were inpatient subjects were medically approved to move to the rehabilitation portion of treatment. All subjects had two or more treatment experiences, and had relapsed one or more times. Subjects began intensive treatment which included some combinations of: individual, group, and family counseling, employer education, community meetings, occupational therapy (inpatient only), self-help meetings, educational seminars, medical supervision and medical seminars, relapse prevention techniques and aftercare planning. The rehabilitation phase varies and can be from 10 to 45 days; intensive outpatient programs usually included a four-six week commitment to treatment, four-five days per week for a period of four hours per day. Aftercare meetings, which followed both forms of treatment, were three hour meetings, one day per week.

### The Interview Instruments

The interview instruments included the Relapse History Inventory (RHI), the Drug-of-Choice/Feeling Checklist Before First Treatment (DFB), the Drug-of-Choice/Feeling Checklist During Last Treatment (DFL), the Researcher's Comment Sheet (RCS), and 25 questions regarding relapse experiences (RQ). All instruments were designed by the researcher and had no history of use prior to this study.

Prior to the design of the Interview Instruments by the researcher, significant investigation occurred to consider existing instruments, which might be used for this study. This portion of the research revealed that existing measures of diagnosis do not reflect the theoretical positions of self psychology, nor do they measure responses regarding the presence or absence of empathic bonds. Particularly in the measure of NPD, the existing psychological instruments of measure reflect a composite of various authors, from conflicting theoretical positions. Thus, one might measure the existence of "Narcissistic Personality Disorder" on an existing psychological scale, and use the same language or words regarding the disorder, but have very different meanings regarding the etiology, theoretical foundations, and treatment of the disorder. In order to avoid the confusion of these complex and contradictive theoretical issues, which are the infrastructure of existing measures, the researcher acknowledged the absence of measures

reflective of self psychological views, and designed her own instruments. Reliability is sacrificed in the design of new instrumentation, and becomes a limitation of the study. However, validity is more likely to occur, since the theoretical posits considered in this study and the designed instruments are congruent with each other.

### Relapse History Inventory

The Relapse History Inventory included data on the age and sex of each participant, along with the following questions:

1. When were you in the hospital or treatment center for treatment of chemical dependency, prior to this time?
2. How many times have you used alcohol or drugs since you were in treatment for chemical dependency the last time?
3. What is the longest period of time you have stayed sober since your first treatment?
4. How many times have you been in a treatment center program to get help for drinking alcohol or use of drugs?
5. Please check all of the feelings listed below that you experience when you are not using alcohol or drugs: (depression, emptiness, low energy, mood swings, anxiety, a sense of panic, inability to be

objective, feeling fragmented inside, worthlessness).

The Relapse History Inventory was designed to identify information regarding verification of the subject's meeting criteria for being a candidate in the sampling. The RHI also identified nine symptoms of Narcissistic Personality Disorder, which were designated as experienced only during periods of sobriety. These symptoms were included as indicators for the potential of dual diagnosis.

#### Drug(s)-of-Choice/Feeling Checklists

The Drug-of-Choice/Feeling Checklist - Before First Treatment form included a checklist of drugs used (alcohol, sleeping pills, tranquilizers, amphetamines, narcotics, hallucinogens, phencyclidine, cannabis, cocaine, or other; and also a checklist of feelings that were experienced when using drug(s), including 47 feelings (empty, depressed, low energy, anxious, hyperactive, lonely, elated, humiliated, fragmented, falling apart, appreciated, soothed, vulnerable, resentful, insecure, let down, betrayed, angry, valued, calmed, shamed, composed, serene, safe, happy, alone, outraged, mellow, loved, complete, loss, passion, esteem, worthlessness, distress, panic, paranoid, cheerful, hurt, afraid, courageous, shy, whole, outgoing, affectionate, needed, and, frightened). It also asks the questions: Did you often use more than one drug per week? If yes, what

other drug did you often use?

The Drug-of-Choice/Feeling Checklist - During Last Relapse is a form which includes a checklist of drugs used during the last relapse, and feelings when using the drug(s)-of-choice, which duplicated the data on the DFB. In addition to asking for drug-of-choice, and feelings experienced when using the drug(s), it includes the question: Are you on any prescription drugs at this time?

The drug-of-choice/feeling checklists (DFB and DFL) were designed to gather data on the subject's drug-of-choice in order to compare any differences in feelings, which might be altered due to the type of drug used. The forms showed changes in the type, or progression, of drugs used from the periods of time of before first treatment to during last relapse. The forms indicated the same 47 feelings, identical on both the DFB and DFL, and showed changes, or progressions, of feeling states between the two time periods, allowing the researcher to investigate the progression of pathological affective states. The forms enhanced the researchers considerations of the subject's perception of feeling states over the course of time, and the use, or absence of use, of drugs/alcohol as a comforting agent for the subject. The question related to prescription drug use allowed the researcher to investigate further indications of dual diagnosis, if the subject was placed on antidepressant drugs by the treatment center. The forms

also allowed the researcher to cross-check data on the written forms with data gained in structured interviews, increasing the validity and reliability of the study.

#### Researcher's Comment Sheet

The Researcher's Comment Sheet (RCS) is a form which is designed to note data for the researcher, which consist of: subject number, sex of subject, date of interview, facility where interview occurred, a checklist of symptoms which assess the affective state of the subject as noted by the interviewer, the researcher's response and empathic experience with this subject, and notation of any other features/thoughts to remember or return to later, regarding the interview. The checklist of symptoms was designed to consider a composite of symptoms commonly associated with narcissistic personality/behavior disorders, and represented many authors in this field of study (Akhtar & Thompson, 1982; Khantzian, 1986; Kohut, 1977; Svrakic, 1990; Wolf, 1988). The RCS was designed to note any considerations of dual-diagnosis for subjects interviewed, and to provide a structured manner in which the researcher could note her own empathic responses to the subjects interviewed. The RCS was designed for inclusion of data analysis that was qualitative in nature, as it represents subjective data gained from the researcher's direct observations and empathic experiences during the interview.

### Research Questions for the Structured Interview

The Research Questions (RQ) included 25 open ended questions which explore the experience of referral to the treatment center, relapse experience, drug of choice, feelings when using and not using drugs, people who support and do not support the experience of sobriety, and people or things present in the subject's life prior to the relapse event. The questions also investigate relationships and experiences of empathic presence or absence during the last relapse event, feelings before relapse, ways in which the subjects comforted themselves, experiences of being understood or not understood by therapists, ways of coping with feelings, and common bonds with other people. The last five questions involve feelings or thoughts regarding events discussed during the research interview, questions which might be added to the interview by participants, and items discussed which were troubling or helpful during the interview. These were included: (1) to identify areas important to the subject's future treatment, which were conveyed by the researcher to their primary therapist at the treatment center; (2) to allow a time to process any emotional issues which may have been perplexing for the subjects to reveal; and, (3) to bring a sense of closure to the interview, including the subject's ability to add ideas or thoughts that may be helpful to other future interviews (Appendix E).

The presence or absence of empathy in a person's life is not an easy subject to explore, especially with individuals one has just been introduced to for the first time. Thus, the structured interview was carefully designed to move from topics related to entering treatment, and relapse events, to topics that were more personal, and emotional for the subjects. Because the researcher's investigation of addiction included the theoretical knowledge that a structural deficiency of the self may exist for these subjects (Kohut, 1977), she was cognizant of the potential that there could be selfobject deficiencies. The questions were designed to uncover the presence, or absence, of mirroring, idealizing, and twinship bonds, including the existence of empathic attunement, or ruptures of empathic attunement in the subject's life. The perceptions of the subject's responses to these questions were directly linked to the research questions, and thus, allowed analysis of these topics.

The last five questions of the structured interview were designed to give the subject input into the process of the interview, as outlined. Because the interviews were emotionally draining, this also permitted a time period to disengage from the tension of sharing very personal data for some subjects.



### The Interview Process

The primary therapists approached potential subjects for the study to see if they were willing to participate in an interview about their relapse history. Subjects were informed that their voluntary agreement to participate in an interview could lead to: (a) understanding of their experience of relapse, (b) identification of their own relapse events, and (c) furthering research in the field of relapse prevention. The interview would be conducted during periods of time which would not involve the subjects' treatment activities, and would take from one to one-and-one half hours of their time, during which time they would complete forms and answer questions regarding their own experience of relapse. The confidentiality of the subjects and voluntary participation in the study was reinforced in discussion with subjects. All participating subjects signed a consent form (Appendix F).

Permission for the research study was requested, and granted, through the Institutional Review Board at Loyola University, and through patient hospital research review boards. The referring primary therapist read the consent form to each subject. In addition, the subjects read and signed the consent form before agreeing to participate in this study. The consent form included the agreement to tape the interview, for purposes of transcribing accurate data. Each subject included in the study agreed to the taping of

interviews. Agreement with each facility specified that tapes would be destroyed at the completion of the dissertation process, for purposes of confidentiality.

"Qualitative researchers are sensitive to their effects on the people they study" (Emerson, 1983; Taylor & Bogdan, 1984). The researcher herself became an instrument of the study process. This researcher has a background of fifteen years in private practice as Licensed Clinical Social Worker and clinician. She has been a Certified Addictions Counselor in the state of Illinois for ten years; she is certified as a Relapse Specialist I. Therefore, she brought to the interviews a fund of clinical knowledge and experience, which was sensitive to both mental health disorders and the processes of addiction and relapse. Since the researcher becomes part and parcel of the qualitative study, this is important in the understanding of herself as a qualified research instrument. This study explored not only aforementioned questions of empathic response with others significant to the subjects studied, but her own immediate observations and experiences of empathic response of subjects with her, during the interview portion of the study.

The researcher went to the treatment site, reviewed the consent form with each participant, and invited questions concerning the research interview. The subjects' willingness for the researcher to inform the primary

therapist of any significant data regarding threat to life, or treatment issues, followed. Twenty-five subjects agreed to be interviewed. Twenty-four of these subjects are included in the study. The one other subject, who is not included, had to leave early due to his transportation home from outpatient treatment, and did not return to complete his interview on a subsequently arranged date.

Subjects were interviewed in a private counseling office within the treatment facility. Subjects who agreed to participate were given the RHI, DFB, and DFL. The researcher remained in the office with subjects as they completed each form to assist the subject if needed. Some subjects needed assistance to clarify questions related to their personal history. The subjects' responses to the RHI were enthusiastic and serious. Some subjects revealed family history, or related data, when completing the RHI. Some subjects engaged the researcher in lengthy discussion of their personal histories, and needed to be guided back to the completion of the form, with the assurance that these details would be reviewed in the open question portion of the interview.

The subjects completed the RHI, DFB, and DFL in a period of approximately 15 minutes. The subjects often revealed that it was beneficial for them to review their drug-of-choice changes from before treatment to their last relapse. The subjects also often found it helpful to

consider the feelings that they had when not using drugs, and those they experienced before treatment, and during the last relapse. The subjects sometimes asked for definitions of specific feelings, when they were unsure of the meaning of a word.

The taped interview was then begun. The subjects were asked to consider that they were the "expert" in the field of relapse, and the researcher desired to learn from them. The subjects were told that none of their answers or questions would be considered irrelevant, and that any thoughts they had were important. Many subjects indicated that they were relieved to hear this, and that they were "an expert in relapse." Twenty-five questions were asked of each subject. Clarification of certain answers was made through additional probing by the researcher, when answers were vague, incomplete, or used jargon unfamiliar to the researcher. The interviews were approximately one and one-half hours in length.

When subjects revealed data that suggested a high level of emotion, or included information on suicidality, the researcher noted this. At the end of the interview the subject was asked if the researcher could convey this data to the primary therapist. All agreed that this would be helpful in order for the subject to work on the particular personal issue that created intense affective states, or had been noted as life threatening in nature. The researcher

followed up on each interview with a written note to the primary therapist, indicating the participation, nature of their patient's input during the interview, and important features of that interview's data regarding relapse or suicidality. Conveyance of this information was completed in each case within 24 hours of the interview process, to inform the primary therapist that their patient had completed the relapse interview, and alert them to any emotional issues that might have resulted from the relapse interview. The RQ, researcher's comment sheet, was completed directly following each interview.

The RHI, DfB, DFL, RCS, and taped interview of 25 questions was completed on 24 subjects. The data was collected over an 18 month period.

#### Content Analysis Codebook

A codebook was constructed for the content analysis of the taped interviews, the qualitative portion of data analysis. The codebook is included in Appendix G of this study. To protect the project from possible researcher bias, five of the interviews were reviewed with the chairperson of the dissertation committee. The chairperson was instructed to rate the interviews using the codebook criteria. Differences in coding were discussed and amended.

The "team research" approach is consistent with qualitative procedures and includes the input from several

individuals who are specialists in various fields of study, specifically related to this research project. To stress the validity of measures, multiple methods of inquiry were considered related to the research questions, and various individuals reviewed the structure of measurement tools toward a consensus of opinion on the basic constructs, coding categories, and themes of the data. The team research approach suggests a combination of methods, or the triangulation strategy of data analysis, to guard against researcher's bias. The input from other resources enhances research validity (Taylor & Bogdan, 1984).

The codebook and five example interviews were then submitted to two other dissertation committee members for review of coding criteria. After reviewing the five cases of data, those members substantiated the criteria of the codebook as consistent with their own observations of coding categories. The codebook and one interview was then submitted to a fourth person not on the dissertation committee. That person, an expert in qualitative methodology, reviewed the coding categories for thoroughness, consistency, and content. The codebook was then approved for a content analysis of the 24 interviews.

Qualitative methodology produces descriptive data, people's own written, spoken words, and observable data (Taylor & Bogdan, 1984). It is inductive, gathering patterns, themes, concepts and insights from the data,

rather than from preconceived theories. This study formulated research questions based on the constructs of self psychology, and allowed the answers to emerge from subject's own words, which were later defined through coding categories, patterns, and themes. It also considered data from social phenomena gathered during interviews, such as the subjects' acts, activities, meanings, participation, relationships, and settings (Lofland, 1971).

Qualitative research seeks an understanding of people from their own frame of reference, suspends the researcher's own beliefs, perspectives, and predispositions, and emphasizes validity (Taylor & Bogdan, 1984). This study approached research interviews with the desire to see things from the relapsing individual's point of view, and to "capture this process of interpretation" (Taylor & Bogdan, 1984) consistent with both phenomenological and qualitative methodology.

In this process of inquiry, the researcher and the subject may stray from specific questions to explore a perspective of insight or meaning. An example of this came up during an interview with a subject who digressed from the research question to comment on his experience in Alcoholics Anonymous. He conveyed a series of personal interpretations related to his struggle to understand what works for individuals he has witnessed in recovery at AA. He voiced his personal despair, that he could not quite grasp what he

was missing in the AA program. Despite his longing for sobriety and his attendance of several hundred meetings over a ten year time span, he felt an ineptness at integrating the 12-steps of AA. He believed these were his key to recovery. This example, and other interview experiences wherein the subject strayed from structured questions to share thoughts and meaning related to associated topics of their choice, were characteristic of the data available by the employment of qualitative methodology.

#### **Data Management**

The researcher conducted all of the interviews and retained all of the data collection instruments. The RHI, DFB, and DFL portions of data were separated from transcriptions of the taped interviews. These quantitative components were considered in data analysis which was performed using the Statistical Package for the Social Sciences (SPSS-PC+). Chi-square, t-test, Pearson's r and analysis of variance were statistical tests used to analyze the data, and verify its reliability.

The taped interviews which were conducted using the twenty five open ended questions were the qualitative portion of the research study. From these data, patterns and themes became evident and assisted the decision about the number of subjects needed. At the point of information saturation, i.e., when information gained in the process of



interviews became redundant in nature (Taylor & Bogdan, 1984), the data gathering had reached a point of saturation and interviewing ended.

As noted earlier, a code book for the content analysis of the taped interviews was constructed. Each subject's responses were scored in a line by line evaluation of the interview. This portion of data evaluation and scoring was completed by the researcher using the coding categories outlined in the coding book. This information was tabulated for each interview on a tally sheet which structured the coding categories. These later were tabulated on a master coding category sheet, which indicated the totals of each coding category theme for each subject.

### **Data Analysis**

Data analyzed in the SPSS-PC+ program forms the quantitative portion of this study and provides measures of frequency, cross-tabulation, and correlation studies. This portion of the study discusses demographic features, describes the sample population, treatment and relapse histories, drug(s)-of-choice use, and feeling checklists. Frequency statistics were used to categorize age, sex, race, times in treatment, longest periods of sobriety, and drug(s)-of-choice used.

Correlation and cross-tabulation statistics evaluated reported the information gathered on the 47 feelings listed

in the forms, DFB, and DFB (feelings when using alcohol/drugs), and feelings listed on the form RHI (feelings when not using alcohol/drugs). Three periods of time were considered. These included: (1) before first treatment (DFB); (2) during last relapse (DFL), and; (3) when not using alcohol/drugs. These data screened for significant findings in affective states of sobriety, and in data on affective states when using alcohol/drugs. Feelings most reported and having a significance level of .001 were selected to: (1) identify the emotional responses to drugs and alcohol, and (2) consider emotional states predictive of drug use, both before treatment and during last relapse events. To evaluate feelings reported when not using drugs and for dual diagnosis considerations, frequency and correlation analyses were conducted on the subject's responses to the checklist of feelings when not using the drug-of-choice.

Data analyzed in the qualitative portions of this study include subject's responses to the 25 open ended questions (RQ), the Researcher's Comment Sheet (RCS), and the Codebook of content analysis criteria used to categorize the data into patterns and themes. Consistent with qualitative methodology, several steps occurred in data analysis. These included multiple readings of interview transcripts, notation of themes, hunches, ideas and interpretations, sorting for pertinent themes, construction of coding

typologies, development of key concepts and theoretical propositions, and development of a story line (i.e., "What is this a study of?") (Taylor & Bogdan, 1984, pp. 130-136).

In coding data, each line of each interview transcription was coded and sorted into appropriate categories. Coding categories were refined through the use of four readers in order to develop consistent and valid categories and to minimize researcher bias. A final phase of qualitative analysis was "discounting data". This process reviewed data with an eye toward examination of the context in which the data were collected (Taylor & Bogdan, 1984). Issues such as the observer/researcher influence on the setting, sources of information, and the researcher's assumptions and presuppositions were considered.

Each research question was considered in data analysis with a view toward both the quantitative and qualitative validity. Where possible, these two sets of data were integrated to produce both quantitative and qualitative insights or observations on each research question.

The research questions and an analysis of patterns, themes and conceptual insights are presented in the following chapters of this study. The next chapter, Chapter 4, deals with the written forms and the data analysis of that portion of the study.

## CHAPTER 4

### FACTS AND FINDINGS: THE WRITTEN FORMS

#### Introduction

This chapter focuses on data gathered through use of the written forms, including:

RHI Relapse History Inventory

DFB Drug and Feeling Checklist (before first treatment)

DFL Drug and Feeling Checklist (during last relapse)

The chapter also considers demographics, and statistical analysis procedures done using the SPSS-PC+ program. The chapter analyzes the characteristics of the sample population and their reported feelings at three time periods. These include: (1) before first treatment, (2) during the last relapse, and (3) when not using the drug of choice.

#### Research Questions

Two research questions are considered in this chapter. The other research questions are reviewed in Chapter 5. This chapter concentrates on the following questions:

- (1) How do these respondents perceive the use of the drug(s)-of-choice?

- (2) What comfort might be sought through the use of the drug(s)-of-choice?

In the first question, the researcher was seeking to uncover the subject's past and present experiences of sensations or feelings regarding the use, and non-use, of anesthetizing substances. The researcher theorized that subjects may use drugs, including alcohol, in order to avoid a psychological state which was more onerous than addictive use, despite whatever problems that use created in their lives. Perceptions which were associated with these emotional states were considered a potential explanation of relapse. The researcher was questioning whether and how a drug might serve necessary selfobject functions for the individual.

If relapsing individuals were experiencing problems in empathic bonds, it would be likely that they would seek a substitute state, through which to comfort the self, and avoid the emptiness that a lack of intimacy with others represented in their emotional experience. This led to the second research question: What comfort might be sought through the use of the drug?

Although there are a host of social, familial, and physiological issues which relate to drug use, this study considers the subjective experience of the user. In considering the comfort of a drug, the researcher asked questions, such as: What feeling states might be present in

subjects, which demand comfort, despite the professed goal of sobriety? Why would a drug be used for comfort instead of a person? What other mechanisms or alternatives other than drugs did the person consider in their desire to comfort the self?

These two research questions, related to perception and comfort involved in the chronic use of drugs, were important to the understanding of relapse events and the study of empathy relative to relapse.

#### **Written Forms - DFB, DFL, RHI**

To gather data on perception and comfort issues of drug use and other interests of the study, the researcher compiled a check list of feeling states. This included feelings which often ascribe "positive" connotations (examples: calmed, serene, valued), or "negative" states (examples: depressed, angry, frightened). The subjects were asked to indicate their experience of feelings before treatment and during the last relapse event. These 47 feelings were identical on both forms (DFB and DFL). A separate list of nine feelings when not using drugs or alcohol related to symptoms of narcissistic personality disorder, was included on the Relapse History Inventory form. These nine symptoms were provided to screen for the potential of dual diagnosis, especially related to NPD.

The checklist of feelings is not considered

comprehensive of the range of all human feelings, but was chosen to reflect commonly used language about the expression of feeling states. Some feelings were chosen to distinguish among the selfobject needs of mirroring, idealizing, and twinship, in addition to the simple reflection of the range of human feelings. For example, anger is a feeling that may be represented as an outcome of a lack of mirroring, idealizing, or twinship needs being met. Calmed or safe, are feeling states representative of the positive experience of the need to idealize and also to feel some element of protection.

#### Use of SPSS-PC+

The concretization of words which captured feeling states allowed the researcher to gather data which could be analyzed through the SPSS-PC+ program of statistical analysis. This included issues of the subjects' demographics description, histories of treatment, length of sobriety, and drug(s)-of-choice.

SPSS-PC+ provided measures of frequency, cross-tabulation, and correlation regarding these data. This was utilized to strengthen the study's validity and reliability. The quantitative analysis included in this chapter relates to these portions of the research. The qualitative portion of the taped interviews is reviewed in Chapter 5.

### Description of the Sample

There were 24 subjects (N = 24) interviewed for this study (see Table 1). The subjects represented various socioeconomic characteristics including working and middle class backgrounds. The demographic data are limited to age, gender, and race.

The age of the subjects ranged from 23 to 56 years. The mean age was 38.8, the median age was 39; the mode was "under 35", represented by the largest category of nine subjects. The gender breakdown was 20 males and four females. The racial breakdown of the subjects identified 20 Caucasians, two African-Americans, and two Latinos (Table 1).

The lower percentage of women in the sample (four of 24) is characteristic of most chemical dependency units. Approximately 20% of the population seeking treatment for addictions are females (Beckman, 1975; Schuckit & Doby, 1983). Because of issues such as social stigma associated with women addicts, the tendency to drink alcohol alone at home or be polydrug users, and the special problems of child care, women tend not to seek treatment as frequently as men do (Fewell, 1985). Because of these issues there is some lack of clarity about actual number of women who are addicted to drugs and alcohol.



Table 1

Characteristics of the Subjects (N = 24)

	Number of Subjects	Percent of Subjects
<u>Age Groupings</u>		
Under 33 years old	7	29%
34 through 44 years old	10	42%
45 through 56 years old	7	29%
<u>Gender</u>		
Male	20	83%
Female	4	17%
<u>Race</u>		
Caucasian	20	84%
African-American	2	8%
Latino	2	8%
<u>Times in Treatment for Chemical Dependency</u>		
2 Times	12	50%
3 Times	6	25%
4 or More Times	6	25%
<u>Time Since Last Treatment</u>		
1 Year or less	13	54%
2-4 Years	6	25%
Over 4 years	5	21%
<u>Longest Period of Sobriety</u>		
5 Months or less	6	25%
6-10 Months	7	29%
11-24 Months	8	33%
Over 24 Months	3	13%
<u>More Than One Type of Drug Per Week</u>		
Before 1st treatment	10	42%
During Last Relapse	9	38%
<u>Alcohol/Drug Use Since Last Treatment</u>		
1-4 Times (Total)	4	17%
1-2 Times per week	0	--
3-4 Times per week	1	4%
Daily	15	62%
Binge use	4	17%

The characteristic of race represented a high number of Caucasians (84%) and the low number of minorities (16%). The researcher speculated that may have been due to the geographic location of the chemical dependency treatment centers which were situated in primarily Caucasian communities.

Most subjects showed anxiety regarding the interview. The researcher began each interview stating her appreciation for their personal contribution to the research on relapse. This effort at empathy helped many subjects to relax and to experience a sense of equality in the task of the interview.

The attempt to link empathically with subjects was also important to the research validity, because the researcher was requesting information from subjects that entailed their perceptions of personal failure. The researcher recognized that the more the subjects appreciated that their contributions were valued, the more factual and disclosing they likely would be.

Thus, the theory-based impression that unmet empathic needs characterized this population was considered by the researcher from the onset and attended to through empathic attunement from the beginning of contact with each person. The researcher realized that she herself was a "tool" of the research process, who could enhance or detract from the study.

### Treatment and Relapse Data

The identifying information regarding times in treatment for chemical dependency, time since last relapse, longest period of sobriety, more than one drug used per week, and alcohol/drug use since last treatment, was obtained in order to confirm that subjects were relapsing individuals. These data also were collected to identify trends in the time length of sobriety following treatment, in drug-of-choice use, and in the frequency of use during the relapse period.

#### Times in Treatment

The number of times in treatment for chemical dependency indicates that 50% of the subjects had been in treatment two times; 25% were in treatment three times; 25% were in treatment four or more times. These data confirm that 100% of this population was in treatment two or more times, which was a criterion for inclusion in the study. Of note, however, 75% of the subjects had been in treatment three times and 25% reported over four treatments for chemical dependency. This is a staggering figure in terms of the pursuit and financial costs of sobriety for this population.

### Time Since Last Treatment

Time since last treatment indicated that for 54% of the subjects one year or less elapsed since they were involved as a patient in a chemical dependency treatment center; for 25% two to four years elapsed without treatment intervention; for 21% four years or more elapsed since their last treatment. This suggests that in this population of relapsing individuals, over half of them relapsed within one year, and that multiple treatment interventions are common for some individuals who seek sobriety.

### Longest Period of Sobriety

The data regarding longest period of sobriety indicate that 87% of the subjects had relapsed within a two year period. Twenty-five percent relapsed within five months; 29% relapsed within six-ten months; 33% relapsed in an 11-24 month period; and 12% relapsed in a period exceeding 24 months. When viewed in combination with times in treatment, this indicates that 87% of the subjects relapsed within two years and 79% returned for treatment again within this time frame.

### Drug(s)-of-Choice

In this population, 42% of the subjects indicated that they used more than one drug per week before their first treatment; 38% indicated that they used more than one drug

per week during the last relapse. Subjects who used more than one drug before first treatment also used more than one drug during last relapse. Alcohol in combination with other controlled substances (usually cocaine) most commonly was used by these subjects. The remaining percent (58%) of the population of subjects used only alcohol before their first treatment and 62% used alcohol only during the last relapse time periods.

The subjects' reported their alcohol/drug use since their last treatment for chemical dependency as is indicated on Table 2. The majority of the relapsing subjects found that their relapse led to daily use of the drug(s)-of-choice.

Table 2

Alcohol/Drug Use Since Last Treatment for Chemical Dependency (N = 24)

Frequency of Use by Subjects	Percent of Subjects
1-4 Times (total use)	17%
3-4 Times per week	4%
Daily use	62%
Binge use	17%

The demographics and other supportive data are presented for purposes of describing the particular subjects of this study. They present descriptive trends which may be further investigated in future research studies and are not

presumed to be generalizable or representative of an entire population.

### Subject Responses to the Drug(s)-of-Choice

The following information is related to the subjects' responses to questions about their drug(s)-of-choice. Alcohol was the drug-of-choice most used by this population of individuals. In order of frequency it is followed by cocaine/crack, cannabis, heroin, speed, and various tranquilizers (see Table 3). Crack cocaine abuse in tandem with alcohol abuse frequently was reported by respondents. The alcohol consumption made them drowsy; the cocaine was reported to "bring them up again, so they did not sleep." The subjects stated these were used together so that they could drink more alcohol without losing consciousness. The following table reviews the drug(s)-of-choice:

Table 3

Drug(s)-of-Choice Before First Treatment and During Last Relapse (N = 24)

	Before Treatment		During Last Relapse		
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>	
Alcohol	21*	3	Alcohol	21*	3
Tranquilizers	0	24	Tranquilizers	2	22
Amphetamines	1	23	Amphetamines	0	24
Narcotics	2	22	Narcotics	2	22
LSD/PCP	0	24	LSD/PCP	0	24
Cannabis	3	21	Cannabis	1	23
Cocaine/Crack	8	16	Cocaine/Crack	9	15

\*Highest used drug

At the time of the interview prescription drug use was reported by ten subjects (41.7%). The specific type of prescription drugs was not a focus of this study and information about prescription drugs was not collected.

Correlation Studies on the Drug(s)-of-Choice

The statistical analysis used in this study has been limited to stringent alpha levels of significance (.001). The .001 level of statistical significance was selected due to its higher confidence level. However, this presents a limitation in the study. Alpha levels such as .001 make it so difficult to reject the null hypothesis that many false ones, which should be rejected, are not. Thus, in selecting suitable alpha levels the risk of inferential error (beta

error, which is the probability of failing to reject null hypotheses that are actually false) exists (Monette, Sullivan, & DeJong, 1986). The researcher decided to approach data from the conservative and higher levels of significance due to the purposive sample and small population size.

In analyzing the use of drugs during the period of time "before first treatment", alcohol use and heroin were found to have significant negative correlation, ( $r^2 = -.7977$ ,  $p < .001$ ), indicating that alcohol use and heroin use were inversely related. People who used alcohol did not use heroin. No other statistically significant data of relationships were found. No statistically significant data comparing the drugs used during the period "during last relapse" emerged from the information.

A correlation analysis on the period of time of "before first treatment" with "during last relapse" revealed that alcohol and heroin were negatively correlated ( $r^2 = -.7977$ ,  $p = <.001$ ) and were not used together. Subjects using heroin maintained narcotic use both before their first treatment and during the last relapse. Cannabis and tranquilizers showed a significant positive correlation of  $r^2 = .7977$  ( $p = <.001$ ), and were used together both before treatment and during the last relapse when these were the subjects' drug(s)-of-choice.



Feelings When Not Using the Drug(s) -of-Choice

The subjects were asked to identify the presence or absence of nine feelings when they were not using alcohol/drugs. These feelings are characteristic of the symptoms of narcissistic personality disorder, and were selected to identify the potential of dual-diagnosis in the population. Table 4 presents the data on these nine feelings:

Table 4

"Yes" Responses to Feelings When NOT Using the Drug(s) -of-Choice (N = 24)

Feeling	Number of Subjects	Percent of Subjects
Mood Swings	19	79%
Depression	16	67%
Anxiety	16	67%
Fragmentation	15	63%
Emptiness	15	63%
Low Energy	12	50%
Inability to be Objective	10	42%
Worthlessness	10	42%
Sense of Panic	7	29%

Symptoms of Dual Diagnosis

These data suggests that of the nine feelings listed which represent symptoms of narcissistic personality disorder (and experienced when not using alcohol or drugs), 50% or more of the total number of subjects reported the presence of several symptoms. This may demonstrate the high potential of dual diagnosis. These symptoms are

representative of symptoms which support the theoretical propositions of self psychology regarding deficits in the cohesion of these subjects' internalized self structure, especially related to NPD.

Referring to their times of sobriety, a high portion of these subjects described affective states which suggest the presence of psychological pathology. They expected sobriety to bring relief from symptoms of emotional trauma yet found themselves in a double-bind: their addiction was destroying them, but without the self medication of alcohol or drugs, they experienced intense emotional states of discomfort. This may be highly influential in their subsequent relapse(s), for some experienced more emotional pain in sobriety than in addictive use.

It is noteworthy that 42% of this population of relapsing subjects reported feelings (when sober) of the inability to be objective. Likewise, 42% of this population reported feelings of worthlessness. These may be secondary symptoms to be screened as indicators of dual diagnosis.

#### Correlation Analysis on the Feelings When **NOT** Using Alcohol/Drugs

The Pearson's  $r$  statistical test was used to analyze the correlation among the nine feelings when not using alcohol/drugs (mood swings, depression, anxiety, fragmentation, emptiness, low energy, inability to be

objective, worthlessness, and sense of panic). Alpha levels were set at .001 levels for all analyses.

Table 5 presents the significant correlations of feelings when not using alcohol/drugs as reported on the RHI form and which met the significance level of  $r_2 = .001$ .

Table 5

Correlation Analyses of Feelings When NOT Using the Drug(s) - of-Choice (N = 24)

Feelings When NOT Using Alcohol/Drugs			$r_2 = .001$
Depression	and	Emptiness	.92
Low Energy	and	Inability to be Objective	.75
Emptiness	and	Inability to be Objective	.73
Sense of Panic	and	Inability to be Objective	.70
Sense of Panic	and	Worthlessness	.70
Worthlessness	and	Inability to be Objective	.70
Depression	and	Inability to be Objective	.69
Anxiety	and	Emptiness	.63
Low Energy	and	Worthlessness	.63

This correlation study indicates that there was a significant positive association between the feeling of emptiness and the feeling of depression; where one existed, the other was likely to be present, ( $r^2 = .9293$ ,  $p < .001$ ). Likewise, other sets of feelings reported by subjects had  $r^2$  values reaching statistical levels of significance, indicating the predictability of these pairings of feelings. These were: low energy and the inability to be objective (.7575); emptiness and the inability to be objective (.7372); a sense of panic and the inability to be objective

(.7042); worthlessness and the sense of panic (.7042); worthlessness and the inability to be objective (.7042); depression and the inability to be objective (.6934); emptiness and anxiety (.6319); and, worthlessness and low energy (.6316).

The sets of feelings represented here substantiate the presence of dual diagnosis symptomatology, and that certain symptoms may predictably exist in tandem for the study subjects. The  $r^2$  values represented in Table 5 are high, indicating significance statistically. These symptoms are particularly representative of the narcissistic personality disorder and suggest the potential that these subjects may lack the psychological structure necessary to successfully complete traditional substance abuse treatment programs. In other words, in removing their drug-of-choice, they are predictably prone to experience feeling states of emptiness, depression, low energy, the inability to be objective, a sense of panic, anxiety, worthlessness, and without the internalized psychological structure through which to work through these emotions.

#### **Feelings When USING the Drug(s)-of-Choice**

The subjects completed a checklist of feelings related to their emotional response when using alcohol or drugs. The first of these forms listed 47 feelings and referred to the time period before first treatment (Drug and Feeling

Checklist - Before first treatment/DFB). The second form, also listing 47 feelings, referred to the time period during last relapse (Drug and Feeling Checklist - During Last Relapse/DFL) (Appendix B and C).

#### Table 6: Feelings Listed by Percentages

Table 6 depicts the total percent of subjects reporting each feeling (indicated on the written forms DFB/DFL), when subjects were using the drug(s)-of-choice. The percentages reported summarize the total population (N = 24), and are not suggestive of the same subject having each feeling.

There are several interesting points to be observed in Table 6, and in the clusters of percentage levels reflective of the feelings which are represented there. In both time periods, before first treatment, and during last relapse, the subjects' predominant recall of emotional states references moods that are psychologically painful.

#### Table 6: Before First Treatment

In the before first treatment profile (Table 6), a high percent of respondents felt resentful (79%), anger, depression, and hurt. Seventy-one percent of the subjects reported feelings of falling apart, of being hurt, lonely, paranoid, and feeling worthless. Sixty-seven percent reported feeling anxious, empty, frightened, insecure, outraged, and shamed. Fifty-eight percent reported feeling

afraid, distressed, and having low energy. Fifty percent or more of these subjects checked at least one "negative" feeling state. It would appear that the subjects' perception of feelings when using alcohol and drugs earlier in their addiction was problematic, in that it left them feeling many negative emotions.

Table 6

Response to Checklists DFB/DFL: When Using the Drug(s)-of-Choice (N = 24)

Before First Treatment (DFB)		During Last Relapse (DFL)	
Feelings	Percent of Subjects	Feelings	Percent of Subjects
Resentful	79%	Depressed	92%
Alone	75%	Low Energy	92%
Angry	75%	Worthlessness	92%
Depressed	75%	Alone	88%
Falling Apart	71%	Frightened	83%
Hurt	71%	Angry	79%
Lonely	71%	Lonely	79%
Paranoid	71%	Paranoid	79%
Worthlessness	71%	Falling Apart	75%
Anxious	67%	Insecure	75%
Empty	67%	Afraid	71%
Frightened	67%	Vulnerable	71%
Insecure	67%	Distress	63%
Outraged	67%	Empty	63%
Shamed	67%	Humiliated	63%
Afraid	58%	Hurt	63%
Distress	58%	Resentful	63%
Low Energy	58%	Shamed	63%
Fragmented	54%	Anxious	58%
Humiliated	54%	Loss	58%
Let Down	54%	Let Down	58%
Loss	54%	Outraged	58%
Mellow	50%	Fragmented	50%
Hyperactive	46%	Panic	50%

Table 6 (continued)

Before First Treatment (DFB)		During Last Relapse (DFL)	
Feelings	Percent of Subjects	Feelings	Percent of Subjects
Vulnerable	46%	Betrayed	38%
Betrayed	42%	Shy	38%
Outgoing	42%	Hyperactive	29%
Happy	41%	Mellow	29%
Panic	38%	Courageous	25%
Affectionate	33%	Outgoing	25%
Elated	33%	Elated	21%
Needed	33%	Happy	21%
Shy	33%	Loved	21%
Calmed	29%	Needed	21%
Cheerful	29%	Soothed	21%
Loved	29%	Affectionate	17%
Passion	25%	Calmed	17%
Whole	25%	Cheerful	17%
Esteem	21%	Complete	17%
Soothed	21%	Esteem	17%
Appreciated	17%	Serene	13%
Complete	17%	Appreciated	8%
Courageous	17%	Composed	8%
Safe	17%	Passion	8%
Valued	17%	Safe	8%
Composed	13%	Valued	8%
Serene	13%	Whole	8%

Table 7

Average Number of Positive and Negative Feeling Word Choices  
Indicated on the DFB/DFL Checklists (N = 24)

Before First Treatment (DFB)	During Last Relapse (DFL)
Positives = 5.29 per subject	Positives = 3 per subject
Negatives = 16.8 per subject	Negatives = 18 per subject

Table 6: During Last Relapse

In the during last relapse profile (Table 6), more subjects reported greater numbers of negative feelings than they did on the "before" profile. Ninety-two percent report depression, low energy, and a sense of worthlessness. Eighty-eight percent report feeling alone. Eighty-three percent report feeling frightened. Seventy-nine percent report feelings of anger, lonely, and paranoid. Seventy-five percent report falling apart, and insecure states. Seventy-one percent report feeling afraid, and vulnerable. Sixty-three percent report feeling distressed, empty, humiliated, hurt, resentful, and shamed. Fifty-eight percent report feeling anxious, loss, let down, and outraged. Fifty percent report feeling fragmented, and panicked. These perceptions suggest a relationship between an addictive use of alcohol and drugs and an increase of negative emotional states for these subjects. In this profile, 24 negative feeling states were reported by 50% or more of the total number of subjects. Positive feelings regarding their last relapse were noted by fewer than 50% of the respondents.

Before the subjects' first chemical dependency treatment, they reported a combination of both positive and negative feelings while using the drug(s)-of-choice. Their emotional worlds reflected a sense of balance, even though a predominance of negative feelings was indicated. For



example, positive feelings included: mellow (50% of subjects), outgoing (42%), happy (41%), affectionate (33%), elated (33%), and needed (33%).

However, during the last relapse time frame, positive feelings plummeted, for example: elated (21%), happy (21%), needed (21%), affectionate (17%), esteem (17%), dropped in percentages. In this time period, negative emotions increased dramatically. These appear to be important data regarding the psychological changes and therapeutic considerations for chronically relapsing individuals. The degree of depression, fear, worthlessness and insecurity reported here may have important implications for clinical practice.

Seven symptoms of narcissistic personality disorder, listed on Table 4 (Feelings When Not Using the Drug(s)-of-choice), are present in the during last relapse section of Table 6. These include feelings of depression, anxiety, fragmentation, emptiness, low energy, worthlessness, and sense of panic. These reports indicate that at least 50%, and often percentages in excess of 50%, of the total number of subjects experienced these symptoms at both time periods. Dual diagnosis is posited. This is a finding that warrants further research due to the clinical implications of dual diagnosis for chronically relapsing persons.

Table 7: Averages of Positive/Negative Word Choices

Averages were compiled on the total number of "yes" statements to both "positive", and "negative" feelings in order to look for trends or patterns in the time periods studied and to consider the differences in reported feelings as addiction progressed (Table 7).

On Table 7, the average number of "yes" statements to "positive" feelings, before first treatment, was 5.29 (of 127 total). The average number of "negative" feelings during this time period was 16.8 (of 404 total).

The average number of "yes" statements to "positive" feelings, during the last relapse, was 3 (of 71 total). The average number of "yes" statements to "negative" feelings, during last relapse, was 18 (of 432 total). Thus, there was a decrease in the average of positive feelings, from 5.29 to 3, and an increase in negative feelings, from 16.8 to 18 for these subjects as addictive use progressed from before first treatment to during last relapse.

This corroborates the progression of negative feelings as addiction advanced. It also suggests the frequency of certain feeling states which are particularly indicative of relapse events, for example: afraid, alone, angry, anxious, depressed, distressed, outraged, paranoid, resentful, shamed, vulnerable, and worthlessness. During the last relapse, negative word choices had a 6:1 ratio over positive word choices.

### Theoretical Considerations of Feeling Words/Responses

The clustering of these negative feelings suggests the profile of an individual experiencing a disintegration of their psychological stability, esteem, and cohesion. The profile is one reflective of narcissistic personality disorder and other profiles in mental health diagnosis. Many of these subjects experienced symptomatology both when using and not using their drug(s)-of-choice, which is critical to the issue of relapse prevention, as well as to dual diagnosis concerns.

### Frequency Distribution: Feelings When Using Alcohol/Drugs

In Tables 8 and 9, a frequency distribution of feelings is presented to illustrate: (1) the classification of feelings into positive and negative categories by the researcher, (2) the number of "yes" responses by the subjects (N = 24) to words on the feeling lists (DFB & DFL), and, (3) the levels of significance found in the chi-square analysis of nominal data.

Chi-square is a widely used inferential statistic suitable for nominal data, and was used in this study as a part of the SPSS-PC+ program of statistical measure. The more the sample diverges from the expected frequency, calculated by chi-square, the more it is likely that an association exists. In this study, chi-square indicates that the frequency of expectation on each word would be 12,

or 50% of the population of  $N = 24$ . Frequency distribution is used to rearrange the data from the lowest value to the highest, and to count the frequency of each value. Divergence above, or below, the frequency expectation level become significant.

The following two tables (Tables 8 and 9) reflect certain data which indicate divergence from frequency expectation levels in both positive and negative word choices. The frequency of choices for certain positive words was lower than would be expected; the frequency of choices for certain negative words was higher than would be expected. Thus both the choice to not select words indicative of positive feelings, and the choice to select words indicative of negative feelings, became significant findings in this population of subjects.

Table 8 and 9: Frequency Distribution of Feeling Word Choices

Table 8 represents responses in the time period before first treatment, and indicates the words that have statistical significance at three levels. The significance levels of  $< .05(*)$ ,  $< .01(**)$ , and,  $< .001(***)$ , are representative of the frequency of certain feelings indicated by these subjects, with  $< .001$  significance levels being the most statistically significant findings.

Table 9 represents responses for the time period during

last relapse, and also indicates significance levels of  $< .05(*)$ ,  $< .01(**)$ , and,  $< .001(***)$ , representative of the frequency of certain feelings indicated by these subjects.

Table 8 highlights the words, composed and serene, as having the highest significance, in the "before first treatment" phase of time. The high significance levels of these "positive" words are representative of their being rarely selected to describe the subject's feelings. The same is true, at lesser significance levels, for the words esteem, soothed, appreciate, complete, courageous, safe, and valued. Table 8 also identifies other "positive" words, representative of having decreasing significance levels, such as needed, elated, affectionate, happy, and mellow.

Table 9, identifies the time period of during last relapse in a frequency distribution table, which allows the reader to see the increase in negative words selected (Examples: depression, worthlessness, and alone). Table 9 also highlights the words with statistical significance, through use of the Chi-square test of nominal data.

The most interesting finding in this data is the change that can be witnessed in the two time periods "before/during" and how the words of negative/positive connotations are experienced by these subjects. Table 9 verifies the increase of negative word choices, and the decrease of positive word choices, which describe a range of emotions during the last relapse. In other words, pathology

increased as addictive use increased.

Table 8

Frequency Distribution of Feelings When Using the Drug(s) -  
of-Choice: Before First Treatment (N = 24)

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Chi-Square

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**Positive Words:**

Mellow	.0000
Happy	.6667
Affectionate	2.6667
Elated	2.6667
Needed	2.6667
Calmed	4.1667*
Cheerful	4.1667*
Loved	4.1667*
Passion	6.0000*
Whole	6.0000*
Esteem	8.1667**
Soothed	8.1667**
Appreciated	10.6667**
Complete	10.6667**
Courageous	10.6667**
Safe	10.6667**
Valued	10.6667**
Composed	13.5000***
Serene	13.5000***

**Negative Words:**

Resentful	8.1667**
Angry	6.0000*
Alone	6.0000*
Depressed	6.0000*
Falling apart	4.1667*
Hurt	4.1667*
Lonely	4.1667*
Paranoid	4.1667*
Worthlessness	4.1667*
Anxious	2.6667
Empty	2.6667
Insecure	2.6667
Outraged	2.6667
Shamed	2.6667
Shy	2.6667
Frightened	1.5000
Panic	1.5000

Table 8 (continued)

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 Chi-Square
 

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**Negative Words:** (continued)

Afraid	.6667
Betrayed	.6667
Distressed	.6667
Low Energy	.6667
Outgoing	.6667
Fragmented	.1667
Humiliated	.1667
Hyperactive	.1667
Let Down	.1667
Loss	.1667
Vulnerable	.1667

---

\* = significance levels at .05

\*\* = significance levels at .01

\*\*\* = significance levels at .001

Count on positive feelings: 127

Count on negative feelings: 404

Total count: 531

Table 9

Frequency Distribution of Feelings When Using the Drug(s) -  
of-Choice: During Last Relapse (N = 24)

---

	Chi-Square
<b>Positive Words:</b>	
Mellow	4.1667*
Courageous	6.0000*
Outgoing	6.0000*
Elated	8.1667**
Happy	8.1667**
Loved	8.1667**
Needed	8.1667**
Soothed	8.1667**
Affectionate	10.6667**
Calmed	10.6667**
Cheerful	10.6667**
Complete	10.6667**
Esteem	10.6667**
Serene	13.5000***
Appreciated	16.6667***
Composed	16.6667***
Passion	16.6667***
Safe	16.6667***
Valued	16.6667***
Whole	16.6667***
<b>Negative Words:</b>	
Depressed	16.6667***
Worthlessness	16.6667***
Alone	13.5000***
Angry	8.1667**
Lonely	8.1667**
Paranoid	8.1667**
Falling apart	6.0000*
Frightened	6.0000*
Insecure	6.0000*
Afraid	4.1667*
Hyperactive	4.1667*
Low Energy	4.1667*
Vulnerable	4.1667*
Betrayed	1.5000
Distressed	1.5000
Empty	1.5000
Humiliated	1.5000
Hurt	1.5000
Resentful	1.5000



Table 9 (continued)

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Chi-Square
<b>Negative Words:</b> (continued)
Shamed 1.5000
Shy 1.5000
Anxious .6667
Let Down .6667
Loss .6667
Outraged .6667
Fragmented .0000
Panic .0000

---

\* = significance level at .05

\*\* = significance level at .01

\*\*\* = significance level at .001

Count on positive feelings: 71

Count on negative feelings: 432

Total count: 503

### Correlation Analysis of Word Pairs/Clusters

Because the data on feelings imply a trend toward more negative word choices, particularly during the last relapse, the researcher questioned the potential that certain words could fall into sets or clusters (just as clinical symptoms do) having statistical significance. A correlation analysis of the words reported by subjects was used to investigate word pairing and to consider content validity in the study. For example, in pairing words, one would expect to find "depression and low energy" together, but not "depression and cheerful". The analysis of words through correlation studies explored these relationships, and the logic of word choices. The following portion of the study addresses that

correlation analysis.

### Correlation Analysis of Feeling Words

A correlation analysis was completed on the feeling words reported by subjects on the DFB and DFL, ( $p = .001$ ). The correlation coefficient, or Pearson's  $r$ , is the most widely used measure of association for interval data with ranges varying between -1.00 and 1.00. This data was compiled using SPSS-PC+, and is limited to word pairs with significance levels of  $r_2 = .001$ . A list of the data is included in Tables 10, 11, and 12. Correlations were completed which represented three views of this data, before first treatment, during last relapse, and before first treatment with during last relapse.

Unlike the percentage (see Table 6) and frequency tables (see Tables 8 and 9), which reflected how many subjects reported certain feelings, this correlation study considers which words, and how often those words, are related to each other. Each word was analyzed against all other words on the checklist, for each category of time, (before, during, and "with").

The clinician is sorely lacking concrete tools, which assess the emotional states of individuals using alcohol and drugs. Such individuals commonly deny their feelings or anesthetized them. The word pairs identified here demand further research, but represent certain predictable feeling

states which have high levels of statistical significance. Thus, the word pairings might be developed, through further research, into a meaningful clinical tool of assessment.

#### Word Pair Correlations: Before First Treatment

The correlation studies suggested that in the period before first treatment (see Table 10) word pairs fell into categories in an almost even split of twosomes, indicative of positive and negative feelings (20 positive; 23 negative; Total 43). The pairing of words appeared to be logical (i.e., pairing of words of so-called positive or negative connotations were linked with like words). For example, fragmented and insecure ( $r_2 = .7687$ ), serene and appreciated ( $r_2 = .8452$ ). The content validity of the feeling checklist portion of the written forms (DFB and DFL) appeared stable, in that certain words chosen by these subjects may have predicted the presence of closely associated feeling states.

The data on Table 10 simply reports the word pairs which met the  $r_2 = .001$  statistical significance levels. These range from highest (.8452) to lowest (.6325) levels of importance, suggesting how often these words are related to each other. The highest pairing of words during this time period were: appreciated and serene, happy and mellow, and let down and fragmentation, all having .8452 ratings of significance and predictability. All reported word pairs represented the  $p = <.001$  levels of significance.

Table 10

Feeling Word Pairs Having  $p \leq .001$  Levels of Significance:  
Before First Treatment (N = 24)

---

Word Pairs	$r_2$
Appreciated and Serene	.8452
Happy and Mellow	.8452
Let Down and Fragmentation	.8322
Hurt and Lonely	.7983
Worthlessness and Falling Apart	.7983
Fragmented and Insecure	.7687
Calm and Happy	.7593
Loved and Outgoing	.7593
Betrayed and Low Esteem	.7143
Worthlessness and Empty	.7130
Emptiness and Falling Apart	.7130
Falling apart and Insecure	.7130
Worthlessness and Insecure	.7130
Needed and Loved	.7130
Courage and Appreciated	.7000
Valued and Complete	.7000
Vulnerable and Distress	.7000
Fragmented and Loneliness	.6976
Loss and Lonely	.6976
Loss and Falling Apart	.6976
Hurt and Loss	.6976
Calm and Safe	.6969
Loved and Valued	.6969
Loved and Safe	.6969
Loved and Complete	.6969
Alone and Lonely	.6880
Anger and Falling Apart	.6880
Anger and Worthlessness	.6880
Depression and Low Esteem	.6831
Outgoing and Whole	.6831
Let Down and Frightened	.6693
Empty and Distress	.6574
Insecure and Distress	.6574
Affection and Outgoing	.6574
Needed and Outgoing	.6574
Happy and Outgoing	.6571
Passive and Serene	.6547
Complete and Whole	.6547
Resentful and Anger	.6516
Shy and Loss	.6504
Calm and Mellow	.6417

---

Table 10 (continued)

Word Pairs	$r_2$
Needed and Valued	.6325
Needed and Safe	.6325
Affection and Courage	.6325
Positive sets of feeling pairs:	20
Negative sets of feeling pairs:	23
Total sets of feeling pairs:	43

#### Word Pair Correlations: During Last Relapse

Table 11 explores the positive and negative word pairs as they are related to each other, in the later time frame of during the last relapse. All words were compared against all other words (total of 47), to see the frequency of choice of one word with another.

Table 11 reports word pairs in terms of the predictability of one word (of the pair) being chosen with the other word (of the pair) (e.g. worthlessness and depression). In the case of the pair, "worthlessness and depression" there is perfect correlation. One can expect that when the word worthlessness is chosen, depression will also be chosen.

The importance of Table 11 is as follows: (1) the correlation analysis revealed a logical matching of positive and negative terminology, appearing to verify content validity in word choices used to represent a range of

emotions, (2) the correlation analysis identified word pairs as they relate to each other in terms of statistical significance, and therefore, predictability (but not generalizable to other populations), and, (3) Table 11 identifies word pairs which potentially can be studied further as a research tool for measures of feelings associated to relapse. In the period of during last relapse, four sets of feelings had the highest correlations ( $r^2 = 1.0000$ ). These were: worthlessness and depression, safe and appreciated, whole and complete, and anxiety and worthlessness. Table 11 shows word pairings, and their significance levels ( $p = < .001$ ), ranging from 1.0000 (most significant) to .6391 (least significant) in terms of their relationship to each other.

Table 11

Feeling Word Pairs Having  $p \leq .001$  Levels of Significance:  
During Last Relapse (N = 24)

---

Word Pairs	$r_2$
Worthlessness and Depression	1.0000
Appreciated and Safe	1.0000
Whole and Complete	1.0000
Anxiety and Worthlessness	1.0000
Affection and Needed	.8718
Calm and Serene	.8452
Distress and Vulnerable	.8284
Elated and Hyperactive	.7994
Vulnerable and Lonely	.7994
Empty and Insecure	.7994
Happy and Mellow	.7994
Empty and Insecure	.7994
Alone and Depressed	.7977
Appreciated and Serene	.7977
Complete and Serene	.7977
Safe and Serene	.7977
Alone and Worthlessness	.7977
Serene and Whole	.7977
Courageous and Outgoing	.7778
Calm and Outgoing	.7746
Affection and Outgoing	.7742
Loved and Needed	.7474
Anxious and Humiliated	.7419
Alone and Lonely	.7368
Happy and Serene	.7368
Needed and Serene	.7368
Affection and Calm	.7000
Calm and Mellow	.6969
Mellow and Outgoing	.6880
Insecure and Let Down	.6831
Fragmented and Let Down	.6761
Anxiety and Panic	.6761
Affection and Appreciated	.6742
Appreciated and Calm	.6742
Calm and Complete	.6742
Calm and Safe	.6742
Composed and Complete	.6742
Esteem and Valued	.6742
Cheerful and Complete	.6742
Whole and Calm	.6742
Affection and Valued	.6742

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Table 11 (continued)

Word Pairs	$r_2$
Affection and Complete	.6742
Affection and Safe	.6742
Whole and Composed	.6742
Cheerful and Passive	.6742
Cheerful and Whole	.6742
Affection and Whole	.6742
Lonely and Shame	.6623
Distress and Lonely	.6623
Lonely and Resentful	.6623
Alone and Falling Apart	.6547
Betrayed and Let Down	.6547
Outgoing and Serene	.6547
Courageous and Soothed	.6516
Outgoing and Soothed	.6516
Happy and Outgoing	.6516
Needed and Outgoing	.6516
Distress and Empty	.6444
Humiliated and Resentful	.6444
Fragmented and Low Esteem	.6417
Empty and Vulnerable	.6391
Shame and Vulnerable	.6391
Positive sets of feeling pairs:	40
Negative sets of feeling pairs:	25
Total sets of feeling pairs:	65

Word Pair Correlations: Before First Treatment **WITH** During Last Relapse

Table 12 represents a correlation analysis comparing the word pairs of "before first treatment" WITH "during last relapse". A total of 19 word pairs emerged in this analysis (15 positive, 4 negative), within the statistically significant level of  $p = < .001$ . These data suggests ranges of significance from most significant (.7977) to least



significant (.6325). These pairings also reveals the use of language that is paired in logical trends, and is reflective of a range of human emotions.

The importance of the correlation studies in this comparison of word pairs (before first treatment **WITH** during last relapse) is not known. This a limitation of this study. It seems most relevant that the purpose of establishing content validity is secured. However, the fact that there is a higher ratio of correlation, with positive word pairs, may reflect more about the infrequency of positive reported feelings, than any more relevant finding in this matter.

Table 12

Correlation of Words Having  $p < .001$  Levels of Significance:  
Before WITH During Last Relapse (N = 24)

---

Word Pairs	$r_2$
Calmed and Safe	.7977
Composed and Appreciated	.7977
Composed and Safe	.7977
Serene and Appreciated	.7977
Serene and Safe	.7977
Appreciated and Safe	.6742
Complete and Valued	.6742
Safe and Composed	.6742
Safe and Whole	.6742
Loss and Hurt	.6693
Soothed and Courageous	.6591
Whole and Serene	.6547
Soothed and Outgoing	.6516
Whole and Happy	.6516
Whole and Needed	.6516
Hurt and Resentful	.6391
Hurt and Shamed	.6391
Lonely and Shamed	.6391
Needed and Affectionate	.6325
Positive sets of feeling pairs:	15
Negative sets of feeling pairs:	4
Total sets of feeling pairs:	19

---

### Summary

Chapter 4 has reviewed the demographics, substantiating issues of the subjects' drug(s)-of-choice, relapses, and treatment histories. These data were generated by the completion of written forms (RHI, DFB, and DFL), and statistical analyses performed using SPSS-PC+. Twenty-four subjects participated in the study.

In the opening of this chapter, two research questions pertinent to this study were considered. They were: "How does the person perceive the use of the drug?", and "What comfort might be sought through the use of the drug?". These questions form the foundation of this chapter's summary.

### Perception

Although all subjects professed the desire for sobriety. They returned to use the drug(s)-of-choice, despite severe costs to their lives. Many had returned three or four times, and some as many as six times, to chemical dependency treatment centers. In addition to actual hours at the treatment centers, all subjects discussed the need to attend 12-step self help meetings several times per week. Thus, they perceived their addiction, and its consequences in their lives, as important, serious, and costly in many ways.

These data indicates that the subjects' perception of their own feeling states were of ever increasing negative emotions, confusion, chaos, and destructive life experiences as addictive use of alcohol and drugs continued. During their last relapse, the average ratio of negative feelings reported by subjects was six times greater than the positive feelings, suggesting highly unstable psychological conditions. The drugs and alcohol served a purpose that

perception alone could not uncover, for the subjects acknowledged the damage of the losses that drugs and alcohol had caused in their lives. Most of the subjects admitted that they did not know why they continued in an addictive state, though they knew it was destroying them.

The subjects reported high degrees of depression (92%), low energy (92%), worthlessness (92%), and of feeling alone (88%), and frightened (83%), during their last relapse event. These emotional states did not appear to be dependent on any specific type of alcohol or drug, nor on any combinations of drugs, but cut across the entire population of subjects. Likewise, many symptoms of potential dual-diagnosis were observed in these respondents (54%). Subjects desired to end the cycle of their own self-medicated destruction but could not cope with the magnitude of negative feelings that entrenched their lives when sober.

Most importantly, subjects lacked empathy and objectivity in the understanding of their own needs, feelings, and behaviors. They minimized extremely complex treatment issues about themselves. Their perception of using alcohol/drugs was primarily one of an escape from reality, a reprieve from their inner worlds of pain. Relapse happened so quickly for some of them that they felt they had little or no time to "think things out". Others planned the relapse, without knowing why.

Comfort

Subjects indicated that drug/alcohol use usually began earlier in their lives, in the context of social settings, including family gatherings. From adolescent use, they progressed into social settings of drug use with friends, family, and neighbors. Many drank and/or did drugs with work colleagues and their spouses. This progressed into chronic and daily use for most. Seventeen percent reported binge use, with periods of sporadic sobriety. Comfort was sought from the culturally accepted norm of social interaction. Drug use chronicity became apparent through the symptoms of addiction (i.e., blackouts, increased tolerance, and loss of control over how much, and how often they used). These factors pertain to the entire population of subjects, regardless of age, sex, or race.

As life responsibilities increased, such as marriage, children, and financial pressures, many subjects were confronted with the problems of their addictive use. They dealt with these growing stressors by increased use of the drug(s)-of-choice. This was reinforced by their support systems of drinking/drugging colleagues, though with little verbal encouragement to use. They were simply invited to events where alcohol/drug use was common. Women tended to talk more often to subjects about the respondent's addictive use and its consequences. Subjects reported initial offense to these initiatives, but later acknowledged them as caring.

In the meantime, subject's stated that they ignored caring others who voiced concern for them, and used more frequently to "show that I was in control."

Subjects stated that they were vaguely aware that they were becoming dependent on alcohol/drugs, but that they wanted to escape from their own irresponsibility in other life areas, such as faltering marriages, jobs, guilt at faulty parenting, or financial strain. Subjects often reported increased drug/alcohol use in response to control issues, especially emanating from their parents, when parents provided any form of shelter care sustenance over them. In these cases, subjects were enraged with parents, but saw the financial sustenance of provision for their wives and children as essential to accept. They responded to this with withdrawal into silence, but the use of the drug(s)-of-choice increased.

As chronic use of alcohol/drugs increased, it appeared that the comfort sought, through the use of the drug(s)-of-choice, was to console or calm the degree of negative feelings experienced by these subjects. The facts presented in this study suggest that these persons experience progressive states of emotional pain, both when sober and when intoxicated. The loss of objectivity, reported by many (42%) when not using the drug(s)-of-choice, may have influenced the subjects' judgment when considering the decision to use, or not to use, alcohol/drugs. Also, the

degree of depression, mood swings, anxiety, and fragmentation, when sober may have made the decision to maintain sobriety a difficult one at best.

Comfort was a two edged sword for these subjects. They turned to self medication efforts as the means to maintain a sense of cohesion from a life experience that was chaotic, both internally and externally, i.e., out of this chronic use came addiction. Few subjects knew of any way other than drug and alcohol use to calm themselves when angry or depressed.

Subjects sometimes referred to their family, especially their children, as a source of comfort. But can an adult expect one's child to be their main source of comfort? It is more likely that the child expects to be calmed and protected by the adult. This may suggest that the comfort sought with the subjects' children was to need, and want, to be admired as a parent. Failing their children's trust brought these subjects a sense of shame and they reacted to this by withdrawing from their children. These selfobject functions of the needs to be mirrored, idealized, and form common bonds, or twinship, with significant others or things were somehow disabled in these subjects and frustrated their needs for comfort.

The subjects discussed feeling more psychologically whole when using alcohol/drugs and when using the experience of a momentary sense of cohesion. When soothed through the

self medication of addictive substances, subjects may have experienced the closest states of feeling whole they had known.

Some subjects referred to sports, especially fishing or bowling, as a means of comfort. More commonly, subjects acknowledged that self help members (usually Alcoholic Anonymous) were their main supports now, and that their past relapses related to not attending meetings anymore. Relationships with AA sponsors were particularly important to subjects, and in these they were highly surprised when "talking together helped in a moment of crisis". Clearly, sponsors were new selfobjects. Subjects sometimes anguished over topical issues at AA meetings, such as discussion of a family member's lost trust or dealing with conflict. Several subjects stated that after a meeting of this type they wanted to run away and drink. This underlines the issues of perplexity that these subjects encounter when faced with dealing with emotionally stressful topics. When anxious, they return to the single alternative they had found that comforted them: the drug(s)-of-choice.

Yet, as evidenced by the degree of negative feelings that these subjects have reported, there is little comfort derived in appropriating a depressant, when one is depressed. (Ninety-two percent of the subjects reported depression). The intellect alone provides rationale for ceasing the cycle. The pursuit of other drugs, such as



cocaine and alcohol used in tandem, may be an attempt to ward off the depressant effect of alcohol. Subjects indicated that they found this combination to enable them to drink longer, to stay awake at parties and gatherings with friends that they enjoyed. But they also noted that the exhaustion from the combination of drugs would last several days. Many tired of this outcome and the effects on their total life style.

There was an alarming starkness to the lack of calming resources and soothing mechanisms for this population of subjects. The idea of creative play, for example, art, music, dance, reading, nature, meditation, gardening, etc., was not mentioned. Subjects were shocked, and extremely shy, that they found they had to talk and to listen to others if they were to be successful in overcoming their addiction. This researcher speculates that this suggests the absence of understanding the intrasubjective world within them. Thus, they could not comfort themselves because they did not know the greater part of their own identity, their psychological self.

#### **Limitations Specific to These Findings**

Limitations representative of this portion of the study were partially indicated in Chapter 1. Further limitations regarding Chapter 4 findings include: (1) the lack of comprehensiveness of words chosen on the DFB/DFL written

checklists which reflect a range of positive and negative feelings; (2) the inexhaustive feeling list of words which represent NPD or dual diagnosis symptoms on the RHI form and selected by respondents regarding feelings when not using the drug(s)-of-choice; and, (3) the limitation of using significance levels of  $p \leq .001$  on correlation analyses due to the enormous amount of information gathered in these data which may influence the exclusion of some findings.

### Conclusion

The researcher analyzed the written forms in several ways. These included a study of demographics, drug(s)-of-choice, treatment and relapse histories, and feeling word choices. The RHI, DFB, and DFL forms were evaluated through frequency and percentage distributions, cross tabulations, and correlation analysis. The analyses reviewed three periods of time: (1) before first treatment, (2) during last relapse event and, (3) periods of sobriety.

This chapter has revealed several important points:

- \* Negative feelings increase as addictive use increases.
- \* Certain feeling states, the presence of negative emotions, and the absence of certain positive feeling states emerged as predictable, but not generalizable, beyond these subjects.
- \* Words, reflective of feeling states, were

identified with this population of subjects which may be further studied toward tools of research. These words, and word pairs, were found to have statistical significance in their representation of the presence, or absence of feeling states in these subjects.

- \* Comfort was sought through the use of alcohol/drugs to avoid negative feeling states.
- \* Over 50% of this population of subjects had symptoms of dual diagnosis, when using and when sober.
- \* Many symptoms of dual diagnosis included the symptoms of Narcissistic Personality Disorder, as defined in the theory of self psychology.
- \* Fifty-four percent of this population of subjects relapsed within a 10 month period following treatment; 87% relapsed within a 24 month period of time. Traditional methods of treatment for chemical dependency were insufficient for the needs of these subjects.

Content validity of the written forms, especially related to the "feeling words lists" (DFB and DFL), were analyzed through a correlation analysis to identify word pairs or word clusters.

The issues of relapse, and the function of alcohol and drug use related to mirroring, idealizing, and twinship, are

further investigated in the following chapter. Chapter 5 evaluates the material of the subjects' taped interviews, and considers a qualitative analysis of their drug use, treatment histories, and relapses. It reviews the particular events of each subjects' interview, personal narrative, and intrasubjective experience. These are analyzed through a coding system of content analysis.

## CHAPTER 5

### THE PERSONAL WORLD OF THE SUBJECTS:

#### THE STRUCTURED INTERVIEWS

##### Introduction

Having completed the written forms, interviews progressed to the personal stories of each subject, their relationships, and to the experience of relapse events in their own lives. The interviews took place in small offices at the chemical dependency treatment centers and each was tape recorded, following the written permission of each subject. Each interview took approximately one and one-half hours to complete. The subjects had begun to relax, but were serious in demeanor.

The "Questions for the Structured Interview" (see Appendix E) were used as the basic format of each interview. The 25 questions were constructed with the following goals:

(1) to review the events which brought the subjects to treatment, the last experience of drinking or using drugs, and to re-verify the drug(s)-of-choice;

(2) to identify feelings when using and not using the drug(s)-of-choice;

(3) to identify ways that their associates encouraged or discouraged relapse;

(4) to identify the types of things and the people that support alcohol/drug use or sobriety;

(5) to identify feelings and events that occurred just prior to the last relapse event;

(6) to identify individuals who have provided a sense of empathy, or a lack of empathy, to these subjects;

(7) to identify ways the subjects dispensed self calming mechanisms in their own life experiences;

(8) to identify common bonds with other people; and

(9) to identify important events or feelings not suggested through the research questions that the subject was able to identify and share.

Questions for the structured interview were developed with consideration to the selfobject needs of mirroring, idealizing, and twinship. The researcher was aware that the interview moved from general knowledge about treatment and relapse events to more sensitive data about the subject's personal relationships and feelings. The researcher attempted to attune herself to the pace and emotional needs of the participants, allowing subjects to describe events more fully, or to take the time to identify the emotions that emerged during the interviewing process.

For the researcher, this was a complex process, gathering data on the structured questions, differentiating between the role of the researcher and the clinician, and staying within the interview time allowance (often with

requirements that subjects be available for certain program requirements at the treatment center). There was a need to respect the process of the subjects' sharing very personal information, and associated feelings, in a manner that was efficient, but which did not pressure subjects to "move on." In spite of the fact that the researcher had spent 15 years as a private practice clinician, this balance was difficult due to the intensity and seriousness of data covered in these interviews.

The researcher was aware that each interview had the potential of enhancing or detracting from the subjects' recovery process, because the theoretical constructs of her study included the hypothesis of empathic ruptures in the past histories of the subjects. Within this view, each interview was approached with awareness of the need to be sensitive to empathic needs, that even one contact with the subject demanded the researcher's commitment to be part of the treatment center's philosophy and goals, and of the subject's recovery.

This chapter deals with the content analysis of the interviews, the identification of themes and patterns which emerged, and the relationship of these key issues to the three research questions listed below. The data identified in this portion of the research study are generally qualitative in nature.

### Research Questions

This chapter addresses the following research questions:

- (1) What experiences precipitate relapse?
- (2) What does the experience mean to the relapsing person?
- (3) Does the experience reflect a failure in the need to respond or be responded to in certain ways?

### Content Analysis

Each interview was read and assigned coding categories in a line-by-line content analysis. The 52 coding categories were designed from earlier readings of the first five interviews, in collaboration with the committee, and with input from an additional expert advisor, who was familiar with qualitative methodology. This was outlined in Chapter 3, Methodology. The Coding Book is available in Appendix G of this report.

## I. CODING CATEGORIES

### Data Gained in Coding

The researcher will review the coding categories, which have been assembled into groups, reflecting related topics.

The coding categories have been grouped as follows:

- (1) relapse events, drug(s)-of-choice (during last



relapse), and periods of sobriety;

(2) reference to physical complaints, or withdrawal symptoms;

(3) job related issues;

(4) issues of loss, including family, significant others, self respect, general loss, threat to subject's own survival, or social isolation;

(5) reference to specific feelings, or the non-existence of feelings;

(6) concerns of dual diagnosis;

(7) reference to suicide;

(8) reference to the need to talk, and to reflection on a personal insight about the subject's life;

(9) reference to empathic attunement, idealizing, mirroring, or twinship (selfobject) needs; and

(10) reference to comfort or protection, or sobriety support of various kinds.

Because of the enormous amount of data which were gathered in the course of these interviews, this chapter will focus mainly on information which is specifically pertinent to the research questions.

Relapse, Drug(s)-of-Choice and Periods of Sobriety

Relapse. Relapse events described in the structured interview reflected the period of time during the last relapse event, or revealed the subject's chronic state of alcohol/drug use. Relapse usually followed a life event which subjects perceived as troublesome. These occurrences often constituted a dispute, criticism, or threat of control over the subject's life. Such events were laden with a past history of similar patterns in the subject's life experience, but were not stated by the subjects as a source of risk to sobriety. Issues which troubled the subjects, such as dealing with conflict that was provocative in terms of anger, anxiety, or lowered self esteem, appeared to direct subjects quickly toward use of alcohol or drugs.

Dissention with a spouse, parent (especially a father for male subjects), child, employer, or legal authority, were high relapse precipitants. Losses, such as divorce, or marital separation/conflict, rejection by a lover, death of a loved one, or job threat also spearheaded relapse.

The swiftness of movement from sobriety to relapse events was emphasized as surprising to some subjects. It appeared as if the subjects were unaware of the impending risks to their sobriety. For example:

"If anything, I learned from the relapse how quick it snuck up on me ... It snuck up on me so fast I didn't know what was happening." (Interview 2)

"The place where I was really ignorant was how fast it could take place ... that's one thing they could stress in treatment ... how fast a relapse can occur. I thought I had years; I didn't realize it could happen so quick." (Interview 4)

"It pops in your head real fast ... and sometimes you find yourself looking for a drink, and you don't even want one. Its kind of scary." (Interview 5)

In other interviews, subjects appeared aware of an anticipated relapse. For example:

"The people that supported my sobriety ... I was seeing them regularly. I was at (AA) meetings. I was going fishing with them. It had dropped off quite a bit because of my girlfriend. The fellow at work (AA member) knew my girlfriend ... he knew who she was and kept telling me "You've got to stay away from her." I did it my way. I didn't follow anybody else's suggestions, which was a part of recovery." (Interview 15)

"I just went off because I was losing faith in the AA program, and losing faith in myself again. It wasn't certain people or family members this time. It was my own thinking about 'I'm never going to stay sober the rest of my life.' ...I could see a relapse coming up, but I was trying to see how long I could keep going to meetings." (Interview 16)

"I know in my heart and in my mind that sobriety is a way of living and a way of thinking and it takes time before a person is sober. I could be clean and dry for days and months, and it does not mean that I am sober. Knowing that I'm just dry and clean, the things that would make me want to relapse, would make me want to use, would be my behavior. The way I'm thinking. The types of things I'm doing." (Interview 14)

Drug(s)-of-Choice. Subjects began their interviews with general statements regarding alcohol/drug use, and then moved toward specific events about their relapse. Alcohol was the most common drug-of-choice.

In the coding of the data from transcribed interviews it was noted that twenty three of the subjects indicated alcohol use during their last relapse, making the percentage of alcohol use 95.8%. Of interest, only 21 of the subjects reported alcohol use on the written forms. This discrepancy is due to subject's unawareness about various forms of alcohol substances, indicated in statements like, "I don't drink alcohol, only beer." Thus, they reported alcohol use (on written forms) at 87.5%, but review of the verbal interview data confirm 95.8% of these subjects used alcohol.

The second most used drugs were a combination of cocaine/alcohol (see Table 13). Most cocaine users preferred the combination of alcohol and cocaine, because cocaine allowed the participants to drink alcohol longer without going to sleep, i.e., cocaine extended the state of consciousness.

Table 13

Drugs(s)-of-Choice (N = 24)

	Alcohol	Tranquilizers (Sleeping pills)	Narcotics (Heroin)	Cannabis	Cocaine
	21*	2	2	1	9
Sex:					
Males	17	2	2	1	8
Females	4	0	0	0	1
	—	—	—	—	—
<u>Totals:</u>	21	2	2	1	9

\*21 subjects reported alcohol use on written forms

23 subjects reported alcohol use during verbal interview

Periods of Sobriety. Periods of sobriety were time frames that subjects analyzed and pondered as a goal. Since relapse was viewed by subjects as a failure, obstructing their value of sobriety, periods of abstinence held answers for them about when and how they had wandered from their goal. The subjects who were unable to identify the transgressions that led from sobriety to relapse appeared to experience a state of emotional frustration.

Longest periods of sobriety and drug(s)-of-choice are outlined on Table 14, as follows:

Table 14

Longest Period of Sobriety by Drug(s) Used (N = 24)

	1-3 Weeks	1-4 Months	5-10 Months	11-24 Months	3-4 Years	7-8 Years
Alcohol	3	2	7	7	1	1
Tranquilizers			1	1		
Narcotics			1		1	
Cannabis			1			
Cocaine	1	2	2	3	1	
Totals:	4	4	12	11	3	1

Periods of sobriety were described in one of two ways: (1) feeling good with increased states of well being and self esteem, or (2) states of emotional conflict decidedly influenced by depression, anxiety, and mood swings.

Physical Complaints and Withdrawal Symptoms

Hospitalization, physical ailments, and medical complications of withdrawal symptoms were spontaneously mentioned by subjects, although this was not a research question in the study. Alcohol users noted physical consequences such as blackout, morning shaking, pancreatitis, liver damage, and maladies associated with withdrawal symptoms.

The symptoms of physical withdrawal were more

frequently mentioned by cocaine and heroin users, including various states of nausea, physical shaking, and exhaustion for 1-3 days following use. Concentration problems were common to all recently detoxified subjects. Overall, subjects minimized physical and withdrawal symptoms, stating they were a necessary evil of use. It appeared obvious that as the course of addictive use continued, symptoms of physical/withdrawal complaints increased (see Table 15).

Table 15

Physical Complaints and Withdrawal Symptoms (N = 24)

	Number of Subjects Reporting	Total Number of Times Reported
Physical Complaint:	18	93
Withdrawal Symptoms:	7	25

Job Related Issues

The importance of employment was stressed by a total of twenty subjects, in the categories of "job", and "loss of job" (see Table 16). Threat of job loss was often the motivation for treatment, demanded by the employer for return to the work place. Loss of job, when addressed by subjects, was presented as indicative of a loss of self respect and feelings of worthlessness. No questions in the interview addressed the employment of the subjects, but each volunteered information regarding his/her employment status.

The threatened status or the insecurity of a job was stressed by subjects with observable anxiety.

Even changes in status on a job, such as demotion due to irresponsibility on a job site, were perceived of as major losses to the integrity of the subject, due to their (1) diminished esteem, (2) loss of financial income, and (3) status with work colleagues. Thus, in spite of relapses, job responsibility appeared to be a high motivator in sobriety, regardless of the vocational or professional level of the subject. Even individuals lacking employment stressed the need to work and the interplay of self identity through employment with their desire for self esteem.

Table 16

Job Related Issues (N = 24)

	Number of Subjects Reporting	Total Number of Times Reported
Job:	18	85
Loss of Job:	18	41

This category captured the significance and importance of employer based referrals for chemical dependency treatment and the threat to, or loss of, identity that was experienced by these subjects, regarding their jobs. The following were examples of losses related to jobs:



"I was doing something I liked, and the (curse) drinking ruined it for me. I'll never be a supervisor anymore. That was painful to get told. It still hurts now a little as I think about it.... If I was a supervisor over me, at the time it happened, I'd (have) done the same thing. But, it hurts." (Interview 5)

"My biggest fear has always been that I will not be able to support myself, which again is a fear ... Financial pressures, difficulty finding jobs, although I'm very good at what I do ... I can never really be a real person ... to get up, and go to work, and do a good job ... that sort of thing, to behave like a person ought behave." (Interview 6)

"It (the job) is important to me. I don't feel like drinking with people at work, because they know my problem. They know I can't drink no more. I was doing it behind their backs ... I went to a family picnic and started shaking, because I needed a drink.... Somebody was praying for me, because the following day, I went into work, and asked for help." (Interview 12)

### Issues of Loss

Loss was identified as a main theme or pattern in the process of coding category identification. Themes were selected to describe various kinds of loss: (1) family member; (2) significant other; (3) self respect; (4) general statements of loss; (5) loss related to a threat to the subject's own life; and (6) loss related to the experience of social isolation or disconnection from people. Specific kinds of loss (i.e., divorce, separation, or death of a loved one), were not distinguished from other losses in the coding categories. Table 17 displays the data regarding these themes:

Table 17

Loss (N = 24)

Type of Loss	Number of Subjects Reporting	Total Number of Times Reported
General Statement of Loss	23	238
Loss of Self Respect	23	132
Loss of Family Member	22	188
Social Isolation	21	107
Loss of Significant Other	19	86
Loss: Threat to Life	17	63

General Statement of Loss. Issues of general loss were noted in most interviews, and encompassed specific losses as well as the general state of having experienced life circumstances with despair. For example:

"I had a particular job (train conductor) that I worked. I had an attempted suicide (someone jumped in front of his train), and I had to deal with that.... It was a tragic scene. And then to see them hanging around, (around to see it), I thought was more tragic. A man with his two children; it looked like they weren't over eight, or ten years old, maybe ... bringing them up to look at the engine to show them ... My step-mother ... with cancer; ... one of my best friends I was growing up with had a reoccurrence of his cancer. And I think that all played a role. I relapsed." (Interview 13)

"Mom keeps secrets; she had a DUI too. My brother got killed ... You ever have a sister you can't stand? My older sister is different. She's a jiving, conniving (one). My older sister I hate ... I miss my dad. I miss my dad so much, because I've never been separated from my dad. He lives in (another state). All our lives we tried to please him, because we were proud of

him. I didn't want to not please him. I don't want to say I could never do anything right, but I could never either satisfy my parents, or do so many things..." (Interview 17)

Loss of Self Respect. The loss of self respect was referred to with shame and often anger. Subjects particularly anguished when the loss of self respect was due to demeaning behaviors by their counselors at treatment centers. For example:

"When I relapse I'm totally useless to myself, and everybody else. I can never make it. I can never really be a real person ... to be responsible. To be confident. To, you know, not go on binges. To do things that I consider a person ought do. To be kind and loving and help other people. That sort of thing ... Sometimes I feel like, I'm not a strong enough person to be able to deal with these things and not relapse." (Interview 6)

"Him (counselor) and I never hit it off for some reason or another ... He's one of those guys I'd like to have his respect. He makes me feel less than, on purpose, you know? ... I don't know why. It seems he's defeating the purpose of treatment ... It was just that he was constantly trying to put me down all the time, and I don't understand why unless that's his job, and he's very good at it.... On the other hand, when I walked in there (to treatment the second time), she (a different counselor) was there, and she gave me a hug, you know? That meant so much to me. I was very emotional at the time, in fact, it was a day before I could go to any sessions, and talk without crying. I still get a little choked up ..." (Interview 4)

"Why did I ever leave recovery type feelings? Fear, because there's always that fear that you be doing it again. Pain, because I hurt because I think about it... Even though there is that feeling of hope, and I'm glad that I made it back to start over again, it's like, ... how many times are you going to start over? That hurts and not so much me just thinking about it, you get reminded that you're starting over. You get reminded by your loved ones. I heard you say that before ... your mother, your ... father, my sisters ... that hurts. The counselors say, "You're program wise, you already know. How many times have you relapsed?"

... and to hear that, I know they mean it in a way to motivate me, but you just don't want to hear that."  
(Interview 14)

Experiences of lost self respect, associated with past counselors at treatment centers, appeared to link subjects with past experiences of empathic ruptures, for example with parents, or other treatment experiences that lacked empathic attunement. Subjects were aware of a sense of injustice in this, a pervading sense of anger, and of the irony of desiring to relate honestly with therapists, but of feeling demoralized when not understood or believed. For example:

"Sometimes, when you're telling the truth, they don't want to believe you. They're maybe not trying to tell you (that) you're lying, but they feel that you are not capable of telling the truth. They're just trying to get it out of you any way they can ... Several times, in other detox programs, and with other counselors, they more or less did the same thing ... when you're trying to come clean with people, and be perfectly honest, and they don't believe you, well ... it really (curse) me off. It really does." (Interview 10)

The researcher thought that the selfobject need to idealize may be part of the role that subjects unconsciously required of treatment counselors. As a part of idealizing, the latent hope of the subject would be to be calmed and comforted as a part of the treatment environment. This need for idealized selfobjects, and the security of that provision, would make the counselor an especially important instrument of healing, or could be disruptive to recovery if empathic ruptures occurred. Many subjects reported traumatic family histories and may have not been able to idealize their parents. It follows that they would continue

to seek others to fulfill this need. This magnifies the necessity for treatment providers to be sensitive to the intricate impact incurred in their roles, and responsibilities therein.

The loss of self respect was reported by 23 of the subjects, indicating that a connection with the need for admiration, and a loss of admiration, existed in many areas of their lives. Due to the calamities which addiction caused in family matters, employment and social endeavors, the subjects experienced a chronic loss of self respect due to failures in traditionally esteemed endeavors.

Loss of Family Member. The importance of family loss, or disassociation from family members, was critical to subjects. This category often represented actual deaths of parents, siblings, or the subject's own children. The emotional disconnection with loved ones was reported as painful, especially with reference to divorce, rejection or criticism by a family member.

The loss of independence was resented by subjects who reported that control of their life was forfeited to their parents (who created or maintained situations wherein the subject was dependent financially). These deprivations were presented as intensely demoralizing by the subjects, who discussed their loss of identity, dignity, or state of increased hopelessness.

Loss of family or disconnection from a family member or

significant other often precipitated a relapse event. For example:

"I am kind of full of shame, you know? I am angry that my mom never likes anything I do, and always tries to control me ... I don't feel like a man. My old man (father) always said I'd be like him, a bum. I get to remembering being a kid, and him hitting on me ... I got really angry at them (mother and father), and their control. I just gave in, you know? I just didn't last too long." (Interview 9)

"Communication was still pretty bad with my folks ... I had a hard time with communications ... especially my father. I can't talk to him; I don't know why. They are always ready for me to relapse or use. They try to manage everything ... totally controlling. They try to take my keys, they try to lock me away. I look at it as a sentence ... It's not what they said, it's what they do. Financially I get paid from my father's company. Everything has been taken care of pretty much by my parents. I worked a while back, but its been years actually since I've worked. The amount of control gets so irritating. I resent the control..." (Interview 8)

The loss of association with family members created a sense of loneliness. The following category deals with an extension of this state of seclusion through social isolation.

Social Isolation. Social isolation came up often in the process of interviews with subjects. Subjects reported that they "felt like a loner all their lives," or were left after sobriety to feel alone and unable to return to old friends who routinely drank alcohol. Except for AA links, this left the entire population feeling lonely and represented a gap in treatment resources. For example:

"People that I used to drink with a long time ago, I don't associate with those no more. When I was at work the last time, I was drinking. Nobody pushed me to drink, I kept it from them. Nobody knew I was drinking. I don't feel like drinking with them because they know my problem. I was a loner." (Interview 12)

"Withdraw, that's what I do. I'll start to withdraw, stay home, watch TV, not do anything. And this invariably leads to a binge. The depression makes me want to become very introverted, which is not what I should be doing. Because, by nature I like to be with people, joke around, and have fun. I don't want to see anybody, or hear anybody, or anything else ... I wouldn't go to very many (AA) meetings, and when I did go, I'd sort of not do anything ... not socialize very much. Go home right after the meeting." (Interview 6)

"My life is messed up; I don't get along with a lot of people because of what I've been doing. I'm a loner anyway ... I use a lot alone. My friends are even more users than me; they don't push...they just like to party a lot. I guess I only use with them because they are there. They are maybe not really friends as much as someone to use with." (Interview 9)

"I feel uncomfortable if I'm around them (friends) and I'm not partying. I feel like I don't belong there. So, the best way for me to stay sober is to stay away from them. I need new friends, because when I'm with them there is no doubt I'll go right back to it ... no question about it. For me to not relapse again, I'll just have to stay away. I know that." (Interview 23)

Loss of Significant Other. Loss of a significant other, usually a spouse, lover or close old friend, represented both a divorce/separation from the actual person, and the feeling of rupture or prohibition from a relationship. The loss of a significant other raised pain levels of depression and anxiety which contributed to relapse events. Likewise, significant others were sometimes instrumental in motivating subjects to enter treatment. For example:

"My husband was constantly gone ... I was angry ... hurt and angry because ... he could do something to be around a little more ... When he came home, I would have to hide my drinking. But, I didn't want him to know how much I was drinking ... Cause, him not being there, it (alcohol) was a good substitute ... And then it even became that I liked it better than him. He wanted me to stop drinking, drinking so much."  
(Interview 7)

"After she was gone, (7 year old daughter died), my friends, even friends I partied with, didn't want to have anything to do with me. They were scared to be with me. Everybody was. I was like a walking time bomb ... I got in fights constantly, because I was drunk, mad, or both ... angry at them. Taking her from me (referring to her death), angry at my girlfriend leaving me.... I forgot that I wasn't the only one hurting. She loved my daughter, probably as much as I did. (I was angry) at everybody, and everything."  
(Interview 23)

Loss Threatening to Life. Loss which threatened the subject's life was mentioned in many cases. These losses are represented in the following examples:

"Yes, I'm very self destructive. Obviously, I'm a drug addict ... You can die from a relapse." (Interview 8)

"Loss of control; just a big binge drink. Found myself where that's all I wanted to do. I didn't really care about anything, or anybody ... Blew all my money, and stayed drunk for two days. Never called anybody, people that cared about me, family, and friends. Felt just kind of worthless, like I wasn't any good to anybody, the way I was ... Knowing that if I kept up this lifestyle, I wouldn't be around very long ... when you're partying this hard ... in a way it is kind of a suicide in itself." (Interview 23)

"And the difference is this time (in recovery) I don't have time to be playing games anymore. Because I made it through this time ... I lived to see this one ... I don't think I have one more recovery left in me. Because, at the rate I'm going, I'm surprised I'm not dead now." (Interview 20).

Thus, the influence of alcohol and drug use on various aspects of life became increasingly threatening to subjects.



In some cases the cycle of relapse produced legal, familial, vocational, and personal dilemmas for these subjects.

### Feeling States

Ten feeling states were identified in the themes of interviews. These feeling states are summarized in Table 18:

Table 18

#### Feeling States Identified (N = 24)

Feeling State	Number of Subjects Reporting	Total Number of Times Reported
Depression	22	269
Anger	24	246
Discouragement	23	170
Fear	22	113
Inability to Feel	20	111
Denial	21	98
Feeling Good	20	98
Anxiety	21	92
Worthlessness	16	59
Blame	7	7

Anger and Depression. Feelings of anger and depression were linked and were the most reported feelings. Subjects reported anger frequently as a means through which they kept

distance between themselves and others, projecting an image of threat that they might lose control and hurt someone. The choice to disconnect from others (friends, family) was reported as a sense of the subjects' defense, in that they felt out of emotional control.

There was an ambiguity reported regarding which persons were friends and which were acquaintances, some people only being present in the subject's life to join them in the use of alcohol or drugs. Subjects appeared to be asking themselves: "To whom do I matter; to whom am I significant?", but were insecure about their importance to others and to themselves.

Anger appeared to stem from three factors, all closely related to the feelings of depression. These were: (1) the inability to tolerate situations of controversy, (2) the lack of personal understanding of their psychological/emotional needs, and (3) the lack of verbal problem solving skills or personal familiarity with open and trusting communication. Added to these factors was the feeling of personal worthlessness. The response of anger appeared to serve the desire to avoid situations that subjects did not know how to handle, and derived from the incapacity to identify the inner components motivating their frustrations. Examples are:

"I just get to a certain point and something twists. Somebody says something, and I go bananas ... pretty soon I start hollering and raisin' hell about something not even relevant to anything. Angry ... Don't get violent, ... its just a lot of verbal, verbal stuff. It damages everybody." (Interview 5)

"(I feel) impatience. Intolerant kinds of feelings. I can be ornery." (Interview 8)

"I had a lot of trouble with my anger." (Interview 9)

"I don't give a damn for anyone. Alone, you know? Depressed all the time; like it's a lot of rage in there ... a lot of anger, a lot of resentment, at my mother, for one, and everyone I run across, basically." (Interview 20)

Depression. Responses to depression were often masked in anger. Subjects reported the retreat to being alone as a relief, due to their depression. Because alcohol, and other drugs, often resulted in depression, the intake of high levels of these drugs produced this outcome. But subjects were perplexed by earlier states of euphoria (early use), and continued to seek relief from depression through increased intake of these same drugs. This is known to be a cycle of futility, but was evidenced often in this population. Ultimately this ended in the subject's drive toward seeking a state of unconsciousness (intoxication) in order to avoid intense levels of feelings, be it depression or other emotions.

Many subjects reported the observation that they had been depressed or angry "all my life," and viewed their conflicts as a blur of past, present, and future states of hopelessness. Since these subjects avoided conflict (albeit

for some through an aggressive demeanor), they unknowingly kept the cycle of their depression alive through substance abuse, and through their fear or ignorance of disclosure to trusted others about their pain. Situational depression, a natural outcome of losses that would be critical periods for non-addicted persons, was unmanageable for these subjects. For some, this issue was complicated by the potential of dual diagnosis, wherein sobriety was as emotionally painful as was addiction.

Discouraged. Feelings of discouragement were expressed recurrently by these subjects and were linked with the feelings of fear, anger, and depression. For example:

"Well, I was feeling very frustrated, very angry at myself. I was depressed, and I was thinking about suicide ... It was very frustrating (relapses) and I was very disappointed in myself ... and that it was just no hope for me." (Interview 11)

"When I see someone who's drunk, I say, Wow, that's me ... I don't like to be like that. When I see an AA member, I say, Wow, that person looks successful, I don't think I can do that. That's the kind of feelings I get. Its hard to bring a drunk to an AA meeting ... Feelings of hopelessness; I can't quit anyway. It's bad now, I might as well make it worse." (Interview 16)

Discouragement was representative of both a sense of personal inability to adhere to the goal of sobriety, and the shame that the subjects had been irresponsible in wanting to have pleased others through their sobriety. They had a lost sense of accomplishment in meeting their own goals (of sobriety and responsibility), and were subject to the criticism and deflation of others who were important in

their lives. The cycle of relapse must be viewed in the context of individual, familial, and social interaction. The discouragement of relapse reflected several aspects of each subject's identity.

Fear. Fear appeared to be an emotion which was intensified during the course of addictive use. Subjects often relayed the knowledge that they must face their fears as a part of recovery. They sometimes used slang, or jargon from AA, related to fear (such as "Let go, and let God," the serenity prayer, and "Easy does it") meaning to release their fears to a higher power, instead of fighting for control of their fears. Examples are:

"One of my basic fears is of not being able to support myself. Fear of getting drunk, and oddly enough, fear of dying, although drunks are in effect, suicidal attempts. How can I meet my maker, (God) after a suicide attempt?" (Interview 6)

"I think (I have) a lot of fears. And if you don't face them ... you're going to use ... I have a hard time with fears ... fear of myself, I think. I go blank. Its hard to look at yourself, when you're really doing what I'm doing. It hurts. (Interview 8)

"I was scared of her (mother, after her mother's suicide attempt) ... really afraid of her, and ashamed of her ... I thought it was my fault; I thought I wasn't good enough ... I was kind of scared of Dad ... He would always yell. He still does it." (Interview 21)

"It's definitely different (to be sober), definitely more frightening ... It is a lot easier when the day went bad to go get a drink, a lot easier." (Interview 4)

Fears were also connected to other factors for these subjects, including: (1) a sense of worthlessness or low

self esteem; (2) a lack of calming from others or mechanisms through which they could achieve a sense of solitude; and (3) an avoidance of self disclosure to others, housed in the premise that they were basically inept. Subjects' fears were observable as they were exposed during the process of the interview with the researcher. Fears and anxiety were inseparable.

Fear of death drove many subjects into treatment, as did the fear of losing family support, or the support of significant others. In this context, their fears were mobilized toward healthy ends.

Inability to Feel. The disavowal of feelings, or inability to distinguish what the subjects were experiencing emotionally, was identified. These subjects were practiced at avoidance of their emotions. They had learned to numb their feelings, often converting certain emotions (like anger) into depression, through unconscious processes. The following examples are illustrative of this phenomena:

"(I was) paranoid, very paranoid, lonely ... very isolated. I used with a small group, or more often on my own, (with) depression, waking up with depression ... I've been told since I have been here (in treatment) that I'm an angry person. I haven't found anger yet. I can't honestly say I felt angry or any other emotions yet." (Interview 3)

"It's my feelings I have a hard time with ... even to know what they are a lot of times. It's something I'm trying to learn. It's very hard." (Interview 8)

"Most of the time I feel I escape reality. It's an escape from reality for me, because I can't deal with daily life on its terms. That way I was able to face things and have no feelings." (Interview 10)

To not consciously feel when overwhelmed with life chaos may seem unusual. However, this defense should be viewed as potentially directed toward protecting the survival of these subjects. Alone, they could not unravel their dilemmas and used drugs/alcohol as a sort of self medication. The disavowal of feelings was an unconscious fleeing mechanism, among many in their menu of avoidance.

Denial. Denial is a mental state which is identified as a symptom of addictive use in chemical dependency treatment. These subjects reported denial in an unusual manner. They disclosed their disavowal process openly. Subjects did not act out denial, as much as witness to their own past history of refusing to face their own needs. For example:

"About a year ago, I was checked into a psychiatric ward ... I kind of minimized my alcohol use, and drug use, and they said it wasn't a problem, and didn't pull my past records (he had been there repeatedly). I was lying to myself, and I was lying to them ... to avoid alcohol, and drug programs ... I thought it was more of a thinking, than a drinking, problem." (Interview 10)

"There was quite a few people attending (AA Meetings) and this one guy says, 'I've been sober for eight years, but I smoke pot.' I thought, I'll try that. I went back to drinking, and everything else ... I don't believe he's sober, if he's still using ... My chemistry wouldn't allow that (cannabis use) to be enough for me." (Interview 12)

"Most of the times I wasn't right about things, and I found out the hard way. Thinking back on that I should learn to listen more, not hear, but listen to what they

(at AA) are saying. If I was so right about things, I wouldn't be where I'm at. That's just being honest. I am not saying what I think you want to hear, I'm saying what's honest. I really should have listened."  
(Interview 11)

Subjects reported the recognition that they had experienced the process of denial in indirect ways, such as indicating their past state of refusing to believe they were alcoholic or drug addicted. They also acknowledged the resistance to seeking treatment, or the delay in seeking treatment, primarily due to the desire to maintain a sense of control over their own life.

Subjects were often dependent on other people to provide the motivation to seek treatment intervention and voiced relief that help was provided, regardless of how intense their reluctance had been. Subjects thus sometimes presented an external refusal regarding their treatment for relapse, while longing to be protected by others from the addiction that was out of control. While these issues could be construed as denial, the researcher believes that they are much more complex and represent many other emotional states and the needs for certain kinds of selfobjects.

Feeling Good. This coding category was added to elaborate the extent to which subjects referred to the use of the drug(s)-of-choice as providing a positive feeling. The term "feeling good" was an umbrella phrase, most often used to describe the euphoria of enhanced mood provided through the drug(s)-of-choice. However temporary, these



states of relief from the challenges or emotional conflicts of sobriety led subjects to relapse.

States of feeling good were also extended to include social contacts with others, wherein the subjects felt whole, accepted, and cared about. Examples of each of these experiences are as follows:

"(When I use alcohol) it gives me energy. It makes me happy. It takes away nervousness, shyness. It does nice things to me. It makes me feel happier all around." (Interview 7)

"Cocaine made me able to drink more. It kept me up where I would drink more, and I didn't get as intoxicated, it seemed. I could go out, and enjoy myself, and feel good, feel happy, and then boy! When you came down, it's a bad down.... (On cannabis) I just feel more normal. My feelings and my ambitions ... I feel level. I didn't have the ups and downs smoking pot." (Interview 10)

Anxiety. Twenty-one of the subjects reported feelings of anxiety. These feelings were associated to two main areas of their lives. One was anxiety regarding their jobs, or threat of the loss of job, and the other related to a fear of loss regarding close family members or significant others.

Anxiety was also mentioned by subjects regarding their discomfort about disclosure about themselves. While recognizing that it was imperative to their recovery to discuss their past, and present concerns, the desire to avoid dialogue regarding emotionally based data was clear. This was an area of clear vulnerability for subjects, and will be discussed later in this study under the coding

categories of fear and talk. An example of this is as follows:

"I am unable to express how I'm feeling, and I get so frustrated inside that I leave. I just can't express how I'm feeling. It gets overwhelming, so I leave. You're trying to do this, and it's not coming out. Sometimes I just cannot really express how I am feeling." (Interview 8)

Worthlessness. Feelings of worthlessness were reported by some subjects directly, yet were sometimes masked in the defenses of anger or depression. Although the feeling of shame was not considered in this study, the worthlessness expressed by these subjects is probably placed close to this emotion. This category was coded "worthless" because it was the most common term used in language by subjects to describe feelings of having repeatedly failed at their own goals (of sobriety) and values (of responsibility), or in the assessment of subjects by others important to them.

Feelings of worthlessness often resonated from earlier (childhood) experiences of feeling inadequately loved or affirmed by parents. Thus experiences with subsequent authority figures were vulnerable to the revisiting of feelings of rejection, or desiring to be accepted, as a worthwhile person.

Treatment counselors carried a great deal of power in their role as an authority for subjects, and were considered instruments of increasing esteem or lowering it, depending on their responses to subjects. Subjects were keenly aware of the difference between honest and constructive criticism

of their faults and feeling that the therapist misused their power to humiliate them. In fact, the subjects were intensely focused on their failures and sought methods to improve themselves. Close to the surface, subjects approached all relationships prepared for a lack of affirmation, but were particularly offended when this came from treatment center personnel. For example:

"I was feeling insecure (about returning for treatment), very insecure. I knew what I had to do. All I wanted was to stop shaking, get my blood pressure back down, and get, out, get back with the program (AA). I knew what I needed to do. I didn't need to be humiliated ... Deep down I wanted someone (on staff) to pat me on the back, and say, good job, you made the right choice. I wanted reassurance I had made the right decision, even though I knew I did." (Interview 4)

"The first counselor I had ... I didn't like her. She kept doubting me. I kept telling her I didn't have a (curse) problem. Then, if I proved I didn't have a problem, she'd be ... You don't have to drop (urine analysis) today. I said, No! I'm going to drop every time I come (in for treatment) because I'm tired of you. They didn't even know I did cocaine, until I told them. So, who cares?" (Interview 17)

"(This relapse) was about depression and fear; feelings of worthlessness ... fear, depression, worthlessness, and low self esteem." (Interview 6)

"I was very depressed. I was crying all the time. I just felt worthless ... that's when I feel worthless, when I'm not around people ... I feel I'm not doing anything to contribute, to help people." (Interview 7)

"I get tremendous anxiety, I want to hide ... My self esteem is very low. I tend to beat myself up over the same thing over and over and over and I'm learning now that I'm ok." (Interview 8)

Blame. These subjects did not tend to blame others for the states of internal or external conflict in their lives.

Blame was the least reported feeling by these subjects. Although they expressed emotions of hurt, disappointment, or anger regarding losses, they tended to identify with others in critical self analysis of their own failures. This was an unexpected outcome of the study, since blame of others is a symptom often linked with addiction. For example:

"My parents make me think. I'm causing all these problems myself. They try to straighten me out, because I always blame things on others, which the alcohol is causing." (Interview 14)

"Yeah, the only place I had problems (with my family) was my Dad ... he's always wanting ... something else he wants me to do. I can't put the blame on him, because he knows how important these meetings are to me (AA). It seems like whenever I thought we were caught up (in their business) he'd always find something else for me to do ... My way of dealing with stress is to hit the bottle; his way is doing something." (Interview 4)

"I jump to conclusions ... My mind's racing ahead of what (others) are saying, but I'm not ready to hear what they are saying ... Lately, I'm answering questions before they even get it out. One time in a bar, I thought that two guys were talking about me negative ... I jumped in and started a fight. They were discussing something (that) they both liked; I was not listening." (Interview 5)

Blame might be further studied as an emotion that is put forward impulsively. It might serve as a defense against anxiety which is converted to logic as the person analyzes the truth of their own behaviors. At the point of logic, blame appeared to be released in these subjects.

## Dual Diagnosis

Dual diagnosis represents the simultaneous existence of (1) a chemical dependency, and (2) a mental health condition, as elaborated in Chapter 3. The co-existence of these conditions in a person constitutes dual diagnosis. Approximately 70% of this population of subjects appeared to have symptoms of both chemical dependency and some other diagnosable mental health condition. Earlier in this study in Chapter 4, the degree of symptomatology was outlined for those subjects when using, and when not using, the drug(s)-of-choice.

In the content analysis represented in this portion of the study, we look more closely at the issues of dual diagnosis as experienced by the subjects and as observed by the researcher in the interviews. In other words, some subjects would report that they had been diagnosed as dual diagnosed. Others would report chronic symptoms of both chemical dependency, and simultaneous mental health conditions. Examples of dual diagnosis reference are as follows:

"I stayed in the detox room for seven days, and (then) ... I seen the psychiatrist. It was a chemical imbalance. He put me on drugs, and I'm just starting to bounce back now, to come back to normal ... My other (previous) doctor started me with Prozac (antidepressant drug); It was like speed for me." (Interview 2)

"I'm usually pretty happy, when I'm not using. I do a lot of active things, I'm around a lot of family, people, my girlfriend. But, also, again, sometimes there's the depression (and) anxiety." (Interview 3)

"I was diagnosed a manic depressed, or something ... I was trying to take this medication the doctor gave me. She said not to drink, or use anything with it, so maybe (I had) a month (of sobriety) that time."  
(Interview 10)

"(I had those) feelings every day (depressed, let down, and angry). It was like I just was floating along through life being sick ... I always hoped to just be happy. I hoped all the time ... I always feel shame; I feel ashamed of myself. Embarrassed. They (relatives) look down on me for what I did, and my relapses, and my suicide attempts. It's not the first time I attempted suicide." (Interview 18)

Table 19 represents the data gathered in the dual diagnosis category:

Table 19

Dual Diagnosis (N = 24)

	Number of Subjects Identified	Total Number of Times Indicated
Dual Diagnosis	17	50

These concerns, represented by the researchers observation of data presented by and observed about subjects in this study, underline the need for mental health and chemical dependency treatment providers to work as a team on issues of relapse intervention and prevention. Because this population is likely to have high ratios of dual diagnosed persons, it is imperative that treatment models and providers carefully interact in the development of treatment/discharge plans connected with both chemical dependency and mental health issues. To not do so is to

further exacerbate patients' sense of personal failure and hopelessness.

The complexity of dynamics in these individuals was minimized or not presented in their self reports. Subjects' description of their diagnosis suggested a feeble understanding of their past and present diagnoses. They were limited in an awareness of the overall treatment issues of their own hospitalization. Being ignorant of the various facets of their lives which constituted trigger mechanisms or threats to sobriety, they had a higher risk of relapse upon discharge. Some recently detoxified subjects may have represented patients who would later receive information on their total diagnosis. But even patients well into treatment, who appeared capable of cognitive understanding of their treatment needs, were often unaware of the resources necessary, and available to them, to enhance their recovery.

Significant to this population of subjects is the degree and intensity of feelings of depression, anxiety, anger, worthlessness, and of being isolated or alone. These symptoms represent a global assessment of the subjects' ability or inability to function at levels which markedly influence their quality of life. In other words, jobs, family, marital relations, parenting skills, social functioning, and interpersonal skills all were impacted. The subjects' quality of life was marginal, immobilizing,

and placed them at life risk in many instances.

Suicide (Ideation, Gestures and Deaths)

The coding categories on suicide were divided into three groups: (1) ideation (thoughts); (2) gestures (action against life); and, (3) suicide referred to, which ended in death (such as a friend or family member). The subject of suicide was not a question on the interview but came up spontaneously from some of the subjects. Table 20 reflects the data on suicidality collected from subjects in this study.

Table 20

Suicidality (N = 24)

	Number of Subjects Reporting	Total Number of Times Reported
Suicidal (Ideation)	* 9	21
Suicide (of another)	4	21
Suicidal (Gesture)	7	17

\*Some subjects mentioned ideation and gestures of suicide.

Seven subjects referred to alcoholism as a suicide attempt that was slow yet deliberate. Two reported fleeting thoughts of suicide which occurred chronically when the subjects were depressed. Although disclaiming the active desire to die, many subjects shared their awareness that drinking and drug use inevitably would threaten, or had



threatened, their lives. One subject interviewed has died following an alcoholic binge. It is not known if the cause was suicidal.

Intense gestures where subjects indicated attempts to kill themselves were reported seven times. These gestures, often ones of repeated attempts to die by suicide, were indicative of the behaviors which resulted in their hospitalization. One subject deliberately drank large amounts of alcohol, and used cocaine, prior to setting himself on fire, in a premeditated suicide attempt. Others subjects jumped in front of cars, took large doses of drugs, or attempted suicide through other means. Subjects reported the inability to deal with levels of emotional pain as the cause of their despair along with suicidal gestures.

Subjects also reported the death of family members or friends who died by suicide in four interviews. A unique characteristic of these self reports, and other references to a death of a loved one, was the lack of emotion which prevailed as they were reported. The researcher was initially stunned by the casual reference to a friend's death by subjects, often presented between other thoughts about other issues under discussion. The researcher would return to the issue of the death and the subjects would then convey the impact of that loss on them. It was as if subjects were hesitant to directly convey a major loss, but tested the empathic sensitivity of the researcher by

cautiously introducing a topic which represented significant pain to them.

At the end of one interview, after the tape recorder was shut off, a subject revealed that he had attempted suicide by taking pills and was rushed to the emergency room of the hospital. While he was in the waiting room, another patient was admitted with a gun shot wound; this patient was rushed into the inner emergency room. The subject's response to another patient being seen before him, with both at life risk, was that his life did not matter to the staff. He left the hospital enraged, but saying nothing to staff. He went home, expecting to die. This suggests the need for verbal communication, and for explanation to a patient regarding the nature, and priority, of medical emergencies, and their meaning within that precedence. In this circumstance of crisis intervention both lives represented equally urgent situations. For this subject, this was a painful empathic rupture.

### Talk and Reflections

Talk and reflections of personal insights were identified as themes of the data from interviews with subjects and became coding categories. Table 21 represents this grouping of categories.

Table 21

Talk and Reflections (N = 24)

	Number of Subjects Reporting	Total Number of Times Reported
Talk	24	224
Reflections	22	149

Talk. Talk is a coding category which represents the need to talk, to confide in another person, especially regarding information which communicates subjective feelings, conflicts, insights, and problems. This category was spontaneously raised by all subjects as the pivotal criteria upon which they felt their recovery would hinge. It was not a research question raised by the study, but was underscored by each subject as the foundation necessary to their recovery.

Subjects reported their need to talk about all aspects of their addictive use of alcohol/drugs, with various degrees of emotion. Some described being surprised that they experienced relief after sharing with fellow 12-step members at meetings. Others struggled with tears during the research interview but painfully conveyed that they must continue (to talk) despite the vulnerability of intimate sharing with another. All subjects indicated that talking about their lives, relapses, losses, and needs was crucial

to their continued sobriety, and helped them to remember daily what chaos addictive use had caused in their past experiences.

Talking about themselves appeared to represent a new meaning system to subjects, creating a bridge from the selfobjects of drugs to the selfobjects of persons. Through this form of communication, they confronted many emotional realizations about themselves and others. It appeared to be the opposite of, or counterpart to, their defense of avoidance and to represent the need for the establishing of empathic relationships.

Behaviorally, some subjects were clearly unfamiliar with talking about their subjective experiences. Several asked if they made any sense, needing feedback which affirmed their ability to convey the meaning they desired to share with the researcher. Several subjects indicated that talking to others had been a life long battle. They felt inept trying to find language which conveyed their feelings with clarity. The researcher speculated that for many subjects who had anesthetized feelings for lengthy periods of time it would be laborious to share matters of emotional intimacy. Examples are as follows:

"What I want to say don't always come out of my mouth right ... I tend to hurt people with what I say, without intent. It just comes out a little bit wrong, and it's not what I really meant to say in the first place ... It's just like sitting here talking to you (the researcher). Things can come out wrong."  
(Interview 19)

"The more I get out and talk to people, I feel a common bond. I feel I'm not the only one; I had that feeling. Going to AA meetings, and talking about what I feel helps. I've never talked about what I feel; I just kept it all inside. It's just finding the right support system." (Interview 21)

"Mostly, I keep my mouth shut. If I have something bothering me, I keep it to myself and let the other people talk. I only ask for what I want once. The first time my counselor would not give me a pass to go home; he said no. I told him right then, I won't ask again. I keep quiet, and I don't ask again. The following week he gave me a pass without my asking. I don't know why, I ask once." (Interview 22)

Talking is crucial to the establishing of selfobject needs and thus is important to empathic bonds. The prohibition, or reluctance to use verbal communication, no matter what the cause, will significantly impact selfobject needs being met. Thus, the self imposed silence of many subjects, due to various causes, had bearing on their fulfillment of selfobject needs. In a like manner, the decision to convey their thoughts, feelings, and desires, enhanced the probability of feeling a deeper sense of being understood, cared about, and protected.

Reflections. This coding category represents a subject's reflection on a particular situation with an insight into their own learning. "Reflections" often indicate a point of change, growth, or the birth of a new paradigm for the subject's life understanding. Examples are:

"Everybody can go to (AA) meetings. I can talk AA (jargon). I can tell you the ins and outs of AA. I never worked it, and it's all about working (a program). It's a lot of work, and it's not going to be

easy ... I have to pick a winner (for a sponsor; someone with a lot of sobriety, who works the program in his life). I think I picked a good guy. I need a hardnose. I don't need someone I can pull the wool over. I need someone to make me work, and learn, and not give me the edge. That's hard for me to do." (Interview 10)

"What I'm saying is that the minute they (staff at treatment center) confront me, and attack what they call ego, or self centeredness, they drag the self esteem further down, which makes the self centeredness, or ego, get worse ... To me, ego is simply a lack of self esteem. That's what it comes from. It's a cover up ... some kind of front. They don't understand they're dealing with a front, a facade so to speak, when ego is present." (Interview 6)

This last quote from a subject is a particularly pertinent one with reference to the Narcissistic Personality Disorder. This reflection appears to display the subject's self understanding of his vulnerability, a low sense of self esteem, which is protected from others through an attempt to defend against attack, criticism, or judgement. He is aware that it is a "facade", a role he plays, to protect himself from an internal deficit which he cannot quite grasp.

#### Empathic Attunement, Mirroring, Idealizing, and Twinship

These coding categories directly relate to the theoretical underpinnings of this study; the consideration of selfobject needs in each of these areas. Table 22 represents these coding categories, and their reported frequencies.

Table 22

Empathic Attunement, Mirroring, Idealizing, and Twinship(N = 24)

	Number of Subjects Reporting	Total Number of Times Reported
Presence of Empathic Attunement	24	197
Lack of Empathic Attunement	23	174
Twinship	22	165
Mirroring	20	157
Idealizing	21	59

Lack of Empathic Attunement. The experience of a lack of empathic attunement, absence or rupture of feeling understood, is represented in this coding category.

Examples are:

"I get frustrated sometimes when I'm talking to certain people here (in the treatment center). You tell them something, and they want to hear it again. I'm trying to figure out, why can't he (listen), wasn't that clear enough? Why (are) they asking me again? How can I say it differently? I get frustrated." (Interview 15)

"She (wife) tried Al-Anon once, and wouldn't go on with it. She didn't have no help for herself. She didn't understand the sickness I was going through. She'd say, 'You're probably just wasting your time; you're going to meetings to have fun.' All negatives; nothing positive. Nothing encouraging." (Interview 10)

"I haven't seen my Dad talk to me much since I've been home. My Mom tries.... We just don't have nothing to talk about. He watches TV, talks about golf. Sometimes we work together (and) then we talk. Otherwise, I only talk to him if I have a question." (Interview 14)

Presence of Empathic Attunement. Empathic attunement + is a coding category representing the subjects' report of an experience of emotional responsiveness to some feeling, by another person who hears and/or seems to understand their feelings, or is in "tune" with their feelings, and needs.

Examples are:

"When I start arguing with somebody, and see that no matter what I say ... they'd make me feel the winner, put me on the right side of that argument, I'd just stop. I'd say ok." (Interview 15)

"I was shaking and it wasn't cold, because I needed a drink. My brother ... realized something was wrong with me. He told my sister I ought to get some help. They realized something was wrong (with me). They realized I was drinking again. Someone was praying for me, because the next day I went into work, and I asked for help." (Interview 12)

"He would talk to me over the phone, and he'd say, 'I don't want you to get upset, I don't want you to get angry, but I know you've (been) drinking a lot again. And we talked about my drinking.'" (Interview 7)

Twinship. Twinship is a coding category which illustrates the selfobject need to find common bonds or kinship with others. Twinship delineates the need to find new friends, form new bonds, and to seek new places, and activities, wherein to socialize with people. This need was often illustrated by subjects in two distinct areas: (1) the need to give up friendships, which were drawn from social situations formed when the subjects used alcohol and drugs,



and (2) the kinship found in groups, such as AA, or in the desire to find groups, or people/friends, who would support the goal of sobriety. For most subjects, this was considered an important variable necessary to avoid relapse. Examples are:

"Being here, (in treatment) you form a bond with other people trying to recover. It's nice to go to (AA) meetings, and be welcomed back. It gives you a warm feeling inside ... We have all been as sick as each other. We're no different. We all hurt people, and we're all trying to work through to get ourselves well. We're not bad people. We are all working together to try and recover, and keep ourselves sober a day at a time." (Interview 10)

"A lot of people in recovery are dealing with the same issues I am, like feelings and emotions; and like building up these walls, and trying to let them down. So I feel very good in recovery, because I feel similar to other people here. Outside of recovery ... there's not much I have in common with people." (Interview 3)

Mirroring. Mirroring is a code category representative of the selfobject need for affirmation and approval. It suggests the need to be held in high esteem on one pole, and the sense of loss that occurs when one is criticized, put down, or judged negatively on the other pole. Mirroring is indicative of the building of a healthy self structure of identity. The lack of mirroring creates the unhealthy sense of being non-cohesive in self structure. Both are important in the impact of relapse, because mirroring appeared to provide hope in the process of recovery to subjects, while the lack of mirroring appeared to render discouragement to subjects. Examples of (1) mirroring in the need for affirmation, and (2) mirroring ruptures in selfobject needs,

are as follows:

"These relationships make me not only feel, but know I'm a strong woman. My mother always told me that I'm too strong. It's real hard to find a very strong minded young woman ... because women now-a-days, they (are) strong ... but we've got a bunch of weak ones too ... just let anything influence their decisions."  
(Interview 17)

"I'm the type of person, I like to dress. I like to wear silk and leather, and gold and snake skin shoes. I got people saying 'You look good.' I got women winking, and if I don't get them I get real frustrated, and I won't talk about it. I'm not having fun anymore (if the affirmation dwindles); I'm bored. I'm missing something." (Interview 11)

"I was supposed to be a man when I was five years old. I got beat when I cried (by father), and bawled when I was little. I still can't cry for some reason. ...I hate him for that ... (he) never supports me. Nothing in my whole life. I didn't turn out what he wanted me to be." (Interview 18)

Idealizing. Idealizing is a code category reflective of the selfobject need of holding another in high esteem, to see another as a paragon, or suitable model, from which one builds a sense of internal strength. Through idealizing the development of goals, aspirations, and creativity is born. The lack of goals, aspirations, and creativity can be witnessed in the sense of emptiness, depression, or boredom, often exhibited in these subjects.

This category includes an important component part of the selfobject need of idealizing, the need to be comforted, protected, soothed, and calmed. Without the ability to idealize, comfort and protection are disrupted in the self structure. An example is:

"My father's a closed person. He doesn't communicate very well with the family. His father was like that too. It was sort of passed down, and I'm like that. It's really hard to change. I've worked so hard at it ... to build this kind of self image. It's hard to let go of that. (Dad) he feels I should use will power, buckle down, and forget it. I would probably associate him more with my reasons for using. He told me what was going to be done. That really bothered me, but I didn't talk about it. I honestly believe that led to my last relapse." (Interview 3)

In this example, the subject felt demoralized because of the frustration of being unable to stay sober, within the constraints of the idealized image of manhood in his family, which included the rule of very little communication. In addition to this, his inability to control his recovery, using his father's directives, (which were in opposition to the treatment center's philosophy), left the subject feeling "bothered", perhaps his words to express the incapacity to idealize his father. His father's communication was critical of the subject's efforts toward recovery, and yet, the father's advice did not cultivate recovery. Alone, and unable to calm himself, he relapsed.

#### Comfort and Protection - People, Alcohol, and Drugs

Data collected in this category is displayed in Table 23.

Table 23

Comfort and Protection (N = 24)

	Number of Subjects Reporting	Total Number of Times Reported
Comfort/Protection: persons	23	200
Comfort/Protection: alcohol	16	47
Comfort/Protection: drugs	12	27

Comfort and Protection: Person. In the previous category the selfobject need of idealizing was described and linked with the capacity to calm oneself. Subjects used alcohol, drugs, and persons to provide self calming or comfort. In this coding category, the subjects describe a person from their own life experience as providing comfort and protection. Examples are as follows:

"They'd take me to go get whatever I needed, clothes, a bicycle ... They'd do almost anything for me, when I was in the half-way house. And, when I did relapse, and was gone from the half-way house, they still did too. They continued to ... my mother, and sister, ... no matter what happens, even though they may not be right ... but they do." (Interview 18)

"Certain church members (comfort me) that I can really talk to. My Godmother comforts me. She don't baby me, but she comforts me in such a way that she lets me know that Jesus loves me. She reminds me of that first, and foremost, all the time. That's the most comforting thing you can hear." (Interview 11)

Subjects' immediate response to questions regarding how they comfort themselves when let down, angry, or depressed was to refer to the alcohol and drug use. However, as they

deliberated the question they tended to consider three human sources of comfort, listed here in their order of priority:

- (1) Alcoholics Anonymous, including their sponsors;
- (2) their counselor at the treatment center; and
- (3) selective members of their family, often their children.

Their repertoire of comforting adults was new, recently developed as a part of their treatment plan, but not rooted in their daily life experience apart from treatment. Since many subjects would change counselors when they moved from in-patient or intensive out-patient programs to aftercare, the likelihood of experience a loss of their primary therapists was high. The loss of the primary therapist was a loss in terms of both mirroring and idealizing needs and may be a critical factor worthy of future research study regarding relapse risks. This natural attrition process left the subjects with the familiar resources of Alcoholics Anonymous, and their sponsors, at the time of discharge, and the expectation of new counselors, and groups, thereafter. This change of calming influences appeared problematic for these subjects, when viewed with the degree of losses they had reported in their lives.

Comfort and Protection: Alcohol and Drugs. These two coding categories depict the use of alcohol and drugs as substances used to soothe, calm, or comfort the subjects, especially following some emotional stress. These categories are directly related to idealizing, in that it is

the expectation that an idealized other (in childhood, the parent) will protect and comfort. When protection, comfort, and the knowledge of how to calm the self, is not internalized during development of a self structure, the result is often the need to find other calming mechanisms.

An important part of this study, discovered in the interviews with subjects, is that most subjects did not know how to calm themselves, when faced with feelings of being let down, angry, or depressed. They often stated that alcohol/drugs were their sole source of comfort in these moments. Examples of these choices to use substances to comfort the self are addressed in the following statements by subjects, responding to the researcher's question, "What people or things are in your life that comfort you or help you to feel protected, when you are depressed or angry?"

(Question #15, Appendix G):

"By using drugs and alcohol. Any kind of bad feeling, that's what I used. It's a lot easier on me when I don't feel. Doesn't hurt as much. It's easier on me."  
(Interview 18)

"I think the honest answer would be I use drugs. I never really feel safe, you know?" (Interview 3)

"I drink, I use cocaine, I smoke pot." (Interview 9)

Sobriety Supports - Persons, Groups, Religion, and Things

Sobriety supports are coding categories which were drawn from references to (1) persons who supported sobriety through encouragement of some kind; (2) groups (such as AA, NA, CA) supporting sobriety through a specific program; (3) spiritual, or religious sources of inspiration to adhere to sobriety; and (4) things which are helpful to sobriety (activities, which often comfort), such as fishing, and symbolic items (a hunting knife, to which the treatment center had adhered an identification label, symbolizing the first treatment episode for one subject, and which he always carried with him as a reminder of his sobriety goal). Table 24 represents the data on these coding categories.

Table 24

Sobriety Supports (N = 24)

Sobriety Support		Number of Subjects Reporting	Total Number of Times Reported
Persons	+ (positive)	21	218
Persons	- (negative)	19	107
Groups	+	21	144
Groups	-	10	39
Religion/Spiritual	+	12	42
Religion/Spiritual	-	8	16
Things	+	8	20
Things	-	1	1

There are two poles to these supports: (1) positive (+), which encourage sobriety, and (2) negative (-), which detract from or discourage sobriety. Due to the multitude of data gathered in this section of the study, examples will not be representative of both positive and negative experiences by the subjects. Examples are:

Persons.

"I go to meetings (AA), try to talk to people, pray. Many people at AA are comforting. My father is comforting. Two friends have become very supportive (of sobriety) and we have become a whole lot closer. "Now my (other) buddy has sort of gone the other way. He is certain he could fix me, which he can't."  
(Interview 6)

"A sponsor is very important. He's been where you've been, done what you've done, and he's working, and you see it. He guides me through the 12-steps."  
(Interview 11)

"(I need) people that are trying to work this program (AA), that are being honest with themselves. People that talk about how their ass got kicked, instead of glorifying, and pretending that they didn't have a problem. People that tell the truth in the raw."  
(Interview 11)

"(I feel more like using drugs) when I be around people that glorify (the drug use). Every time I got high wasn't miserable ... there were times I had fun. For me, as an addict, I forget pain real easy after a few months of being clean ... We tend to forget not paying the rent, people closing doors in my face, the nights I haven't had a bath, a shave, stealing, lying. If you go to meetings (AA) you'll hear that from newcomers. If you don't go, (and) listen to that, you'll forget."  
(Interview 11)

People were important supports to the subjects' sobriety and represented models of behaviors for them to feel strengthened in their own lives. These prototypes of behavior could promote recovery, such as in the case of a



sponsor from AA who was valued or could detract from recovery, such as individuals who modeled toxic demeanors which did not support recovery. This category suggested the importance of idealizing selfobject needs.

### Religion.

"I pray." (Interview 6)

"The first three steps (of the 12-step programs) are important to a person who's been in recovery for years, no matter how long. The first is: 'I Can't - He Can', the second is: 'I Can't'; the third is: 'He Can, I Can't, So I'll Let Him' ... That's what they mean to me, and that's the AA saying." (Interview 11)

"I have to say, Jesus Christ is my Savior, the most comforting being I know. I do know him. He works through people I've been with, including the staff (at the treatment center) this week." (Interview 11)

References by subjects to religion, or spirituality, were common. Some, like the examples from interview 11, were suggestive of a faith that was integrated into the subject's perspective of life. More often, subjects struggled with their understanding of spirituality, dealing with problems in the acceptance of a faith that made sense to them.

Because many subjects had difficulties with trust in human relationships, due to empathic ruptures, the concept of a Higher Power in AA was reminiscent of a relationship of trust, particularly with God. Although the AA philosophy of a Higher Power is more global or universal than any specific religious dogma, some subjects resisted the concept of a Higher Power because they had unresolved issues of justice

within their particular faith or perception of God. Additionally, some men subjects found the notion of submission to a Higher Power problematic, for they had been raised in a culture which esteemed dominance of the male over submission. This was perceived by subjects as a loss of control over their lives, the antithesis of masculinity, strength, and of feeling whole. Women subjects had less resistance to the submission of their lives to a philosophy of a Higher Power.

Groups. Groups supportive of sobriety tended to be limited to AA meetings, church related activities, and gatherings with AA friends. Groups not supportive of sobriety were identified as meetings with past friends who used alcohol/drugs, neighborhood parties, and traditional family gatherings (examples: weddings).

"Just going to AA meetings, you get friends. Friends, all kinds of friends. You can actually sit down and play a game of cards without taking up a drink ... You say something, and they'll tell you a story that's almost exactly like what you went through. (AA) That's where you don't get lonely, because you have someone to talk to, to understand. It keeps me straight. If you really want to get help, and if you listen, then you listen to yourself after you listen; you can put whatever you can get out of it into your system, even if you have to sit there and memorize some of those things. If you don't, you may as well talk to a brick wall. I found that out last time." (Interview 5)

"I never dream, and when I do I don't remember nothing. I dreamt I had a rope tied around me and way up in the air, there was a clip ... It was this time of relapse ... I started climbing that rope, until I got to the top, climbed to the edge of a cliff. Not a soul was up there. I couldn't get loose from my rope, like someone was holding it there. When I cut my rope, someone pushed me off the cliff, which seemed

bottomless. I retied my rope, and it caught a stump half way down the cliff, that far from the bottom. (He indicates inches from the bottom.) I looked up and see a whole bunch of people on top of the cliff ... I was hanging there, and they dropped me another rope. When I got (to the top of the cliff) I see a real big sign. It says AA. I just couldn't believe it! It blew my mind. I do believe there is something out there, greater than I am. Maybe it's not Jesus, but there is something out there. Anyway, they pulled me to the top again." (Interview 5)

The last quotation was reported by the subject during Interview Five and indicates the importance to him of both AA as a group support and spirituality. He blended these two themes together in a dream that symbolized his struggle and the rescue of himself through sobriety supports.

#### Things.

"A lot of times, I just went fishing." (Interview 5)

"Well, I fish (to comfort myself)." (Interview 9)

"Routine in my daily life means a lot to me, to keep me calm." (Interview 4)

"The first time I went into treatment I took off the stickers (treatment center identification tags that are put on personal items). I came home with my pocket knife, and my FM radio. I took them off because I didn't want to remember that place. I took it all off. This time (last relapse) I left all this stuff on (the ID tags). I use this pocket knife every day. Every time I use this pocket knife I see that (ID tag) and it tells me don't even think about it (drinking). Now I'm leaving it on because I don't want to go back to that place. It's a little reminder that says don't think about it. I thought you might enjoy that." (Interview 4)

Comfort and protection derived from "things" included symbolic items, which assisted subjects to remember their goal of sobriety and activities which included a comfort to subjects and did not include the use of alcohol or drugs.

### Other Coding Categories

Coding categories of secrets and motivation were identified in the data. However, information gained in these categories were not vital or were better represented in other parts of this report. Secrets tended to suggest the desire to prohibit certain relatives from knowing about the subject's relapse or their hospitalization. Fourteen subjects mentioned secrets. A total of 70 indications of secrets was found.

Motivation, or the lack of motivation, were categories of the content analysis coding book, but were illustrated in the categories of reflection, and in feeling states (which echoed feelings of a lack of motivation). Twenty-one subjects reported feeling motivated in a positive way. Eleven subjects reported feeling non-motivated (motivated -). The content analysis revealed a total of 130 mentions of motivation +, and a total of 20 mentions of motivated -.

Although not represented in coding categories, several subjects did identify boredom, loneliness, and guilt as issues which troubled them and played a part in their use of alcohol or drugs. Also, several subjects mentioned the importance of listening to others, meaning to attend to and heed what was said, especially referring to AA meetings. In a like manner, personal honesty was stressed by these subjects, suggesting that this was important to the process

of self understanding and change.

Having completed the review of coding categories, the next section will deal with a summary of patterns revealed in the data.

## II. THEMES OF THE INTERVIEWS WITH SUBJECTS

### Relapse Events, Drug(s)-of-choice and Periods of Sobriety

#### Relapse

- \* Relapses followed life events which subjects perceived as troublesome.
- \* Subjects were often surprised by their own relapse, but some subjects were aware of a process which slowly moved toward an expected relapse.
- \* Sixty-two percent of subjects relapsed after 5-24 months of sobriety; 87% relapsed in 0-24 months of treatment.
- \* Nineteen of 24 subjects relapsed within 24 months of treatment; 87.5% of these used alcohol during the last relapse.
- \* Alcohol was the most often used drug-of-choice; alcohol used with cocaine was the second most used drug-of-choice by the subjects.

#### Physical Complaints and Withdrawal

- \* Physical complaints and withdrawal symptoms were severe for some subjects, but were not noted as deterrents of use.

#### Job Related Issues

- \* Employment and non-employment were viewed as important factors of self esteem, and of identity, to subjects.
- \* The desire to keep one's job influenced subjects to seek treatment.
- \* Job related referral for treatment was considered helpful and was utilized by subjects.

### Job Related Issues (continued)

- \* Treatment intervention from the job site was influential in subjects' avoidance of drinking with work colleagues.

### Issues of Loss

- \* Loss of connection with family members, or death of a family member, promoted feelings which subjects avoided through the use of alcohol or drugs.
- \* Loss of significant others, such as spouses, lovers, and friends promoted feelings which subjects avoided through the use of alcohol or drugs.
- \* The encouragement by family, friends, and others, to seek help for addictive behavior had significant influence on subject's seeking intervention despite overt resistance to these people in their lives.
- \* When subjects lost self respect due to relapses and chaos in their lives they withdrew and isolated themselves from family, friends, and significant others out of feelings of worthlessness, anger and depression.
- \* Subjects perceived losses as a amalgam of old and new emotional ruptures which were futile to resolve. All losses which were left emotionally unattended promoted a feeling of hopelessness.
- \* Losses which threatened the subject's own life were particularly frightening to them, but were presented in a cautious, almost covert manner of disclosure.
- \* Social isolation appeared linked to the use of alcohol/drugs. Subjects were unfamiliar with finding "new" friends in a sober state.
- \* AA was a resource of social support. Subjects not aligned with AA were particularly lonely and depressed due to social isolation.

### Feeling States

- \* Anger and depression were directly linked to each other, and were a product of the inability, by these subjects, to deal with troublesome situations in their lives.
- \* Subjects disavowed feelings and had little introspective capacity to unravel the sources of their emotional pain.
- \* Blame was seldom reported by these subjects.

### Feeling States (continued)

- \* Denial was reported by these subjects through their own observations of past disavowal (i.e., they did not act out their denial, but reported their own past history of refusing to face their own needs). They disclosed their denial process openly.
- \* Discouragement was pervasive in these subjects as a cycle of relapse and feelings of hopelessness grew. Discouragement represented the combination of many other feelings, such as fear, anxiety, and depression.
- \* Fears grew as addictive use continued. Fears centered around hopelessness (inability to maintain sobriety), the loss of independence (job), and death.
- \* Feeling good represented the initial euphoria of drug use, and the use of drugs/alcohol as self medicating in order to obtain a reprieve from feeling emotional pain.
- \* Worthlessness appeared to be activated by the sense of ignorance (about the complexity of the subject's life circumstances, and/or how to manage these), failure of meeting the goal of sobriety, the loss of self respect produced due to relapse, and various life problems.
- \* Many subjects used alcohol/drugs in order to "not feel." Thus, encouraging the subject to deal with emotional pain also risks that they may "anesthetize," returning to relapse in order to not feel.

### Dual Diagnosis

- \* Dual diagnosis symptoms were common in subjects in this study, suggesting that chronically relapsing persons should be carefully screened by both chemical dependency and mental health treatment centers for dual diagnosis symptoms.
- \* The dually diagnosed subjects reported at least as much emotional pain when sober as when using drugs/alcohol.
- \* The dually diagnosed subjects reported a higher risk of life threat.

### Suicidality

- \* Suicidality was present in over half of these subjects and was provoked by the loss or death of family members or friends.

### Talk

- \* Talk was the most important instrument of change reported by subjects. They stated that their ability to talk about themselves and to learn to share thoughts and feelings, were the bridges to recovery.
- \* Subjects stated that talking (in contrast to the avoidance of feelings) was necessary to their building a new social support system which would support their recovery.
- \* Talking appeared to be the behavioral link with the need and desire for empathic attunement.
- \* Motivation toward recovery was encouraged by caring and vocal others, who voiced concern for the subjects, and supported their efforts of treatment. Motivation was reversed by vocalized criticism, judgment, and behaviors which were experienced as demeaning the worth of the subjects.

### Empathic Attunement, Mirroring, Idealizing, and Twinship

#### Empathy

- \* The experience of empathy with another was perceived by subjects as supportive of their sense of worth, and, therefore, the hope of recovery.
- \* The experiences of a lack of empathy with another detracted from the sense of worth and increased anger and depression in these subjects. As a consequence, the feelings of hopelessness about their recovery increased when empathic attunement was ruptured.

#### Mirroring

- \* Mirroring, or the affirmation and approval of worth in these subjects, was considered a positive source of meaning, hope, and a sobriety support.
- \* A lack of mirroring, which was presented as critical judgments of these subjects, deterred the sense that recovery from alcohol/drug use could prevail. Subjects were particularly sensitive to rejection and/or judgmental statements on the part of treatment providers.



### Idealizing (Includes comfort/protection)

- \* Idealizing needs, the ability to perceive others as models to esteem, were important. Figures such as parents, sponsors from AA or counselors were often used as guides and models of strength.
- \* The ability to comfort, calm or protect subjects from experiences of ruptured empathy (rejection by others, lack of understanding by others) appeared to be important. Subjects expected criticism but were sensitive to models who were not honest or were not constructive in their communications with them. Subjects became confused with models who did not support treatment philosophies (such as parents) and found themselves unable to idealize such figures. They related to the models who supported their growth toward sobriety.
- \* Subjects did not have an internalized sense of how to comfort, calm, soothe, or protect themselves.
- \* Subjects used alcohol/drugs as the chronic means of calming their anxieties, fears, depression and anger outside of treatment environments. Few experienced people as supportive selfobjects prior to inclusion in the treatment plan.

### Twinship

- \* Twinship, or the development of common bonds with others, was a source of anxiety to subjects, in that it represented giving up old friendships, neighbors, and family who used drugs/alcohol.
- \* Subjects saw AA as a single source of kinship with others and a very meaningful source of support to their self understanding and sobriety.

### Sobriety Supports

- \* Subjects used persons, groups, religion, spiritual values, and things (including symbolic items and certain activities) as sobriety supports.

### Persons

- \* Persons experienced as sobriety supports were individuals who accepted the subject during states of sobriety and who consistently desired the state of sobriety for subjects and said so.
- \* Persons who communicated the desire that subjects get help, due to addictive use of drugs/alcohol,

were consistently seen as caring, even if the subject reacted to them in anger when they attempted to voice their concerns.

- \* Persons who offered alcohol/drugs to recovering subjects, no matter how important to the subject, were viewed as a risk to sobriety and a non-supportive threat to recovery.

### Groups

- \* Groups, such as all 12-step programs, were highly significant to subjects, in that they felt a common bond with them, and knew that most members would support sobriety.
- \* Group members, such as other AA members who stated that they were sober but smoked marijuana, could influence subjects to relapse in a like manner and were poor models of sobriety support.
- \* Groups such as 12-step programs sometimes upset subjects, in that at meetings topics of conflict regarding family, friendships, etc. were overwhelming to subjects. Subjects reported relapsing following meetings which frightened them or left them feeling overwhelmed emotionally. This left them devoid of resources.

### Religion/Spirituality

- \* Religion was seen as a support to sobriety by some subjects. Other subjects were angry at God, usually due to a loss in their lives.
- \* Many subjects struggled with spiritual beliefs, especially trying to apply these themes to their AA membership.

### Things (Symbolic Items and Activities)

- \* Things, such as symbolic representations (an ID tag from past treatment affixed to a subject's knife, an experience of witnessing a death in an emergency room), were viewed as reflections/insights for the subjects which supported their sobriety. Such insights were very difficult for the subjects to share (seeming to fear ridicule), but were critical moments of change in their life view of recovery.
- \* Fishing was the most common satisfying sobriety support activity expressed by men and calmed inner conflict.

- \* Routine and structure in the daily life of subjects was viewed as important to sobriety. Some subjects found this difficult to achieve in their homes.

The researcher will now apply the findings, which emerged from the data gathered in personal interviews with each respondent, to the research questions of this portion of the study.

### III. RESEARCH QUESTIONS

The data gathered in personal interviews will now be considered as these pertain to the research questions in the study.

Question: (1) What experiences precipitate relapse?

Relapse is a process of many events rather than a single incident. The precipitant of friction in some life area, resulting in the desire to avoid feelings of emotional conflict, appears to be an important influence on relapse into alcohol or drug use. Subjects anesthetized their feelings through the use of alcohol and drugs and reported the awareness that the avoidance of feeling was their specific goal in using the drug(s)-of-choice. Thus, alcohol and drug use followed troubling life events which were barely consciously noticed by these subjects, due to their proficiency with their acquired habit of numbing feelings.

The experiences precipitating relapse varied and at first glance, did not reveal a commonality. Further

analysis of the subjects' reports revealed the duplication of incidents of unaddressed frustration, usually in their most significant relationships. These events most often included dissension with family or friends. Many retreated into a quiet response of progressive isolation from relationships of meaning.

Just as anesthetizing oneself, through self medication, can be viewed as a certain form of fleeing from life, subjects had developed other mechanisms of avoidance. They not only withdrew from others; they withdrew from themselves. They avoided issues of conflict through defensive strategies such as social withdrawal, lack of communication, avoidance of 12-step meetings, defensive emotional displays to keep people at a distance, and suicidal thinking.

Subjects were surprised to realize, in the course of the research interview, that experiences of feeling rejected, criticized, judged, demoralized, or abandoned had occurred prior to their relapse. A part of their astonishment was due to the fact that they had become so accustomed to these experiences that they disregarded them and no longer regarded them as important. This was often due to the fact that a parent, or spouse, had "always acted that way", or "always treated them badly." Subjects discounted the fact that such behaviors toward them still angered, hurt, or frustrated them. Subjects minimized their

own responses to emotional ruptures in their relationships, perhaps because they were hypervigilant to their own failures and feared that to confront the difference of opinion with a loved one might result in being abandoned or admonished. Discord was tolerated in a smoldering personal inferno, which led to avoidance mechanisms and later to relapse.

Whether the subject revealed many past experiences of perceived conflict, control, frustration, and loss (in other words, a collective of years of incidents which distressed the subject), or a brief series of recent episodes occurred, the subjects responded similarly. They became emotionally upset and moved quickly to avoidance strategies, laying the foundation of their own relapse.

The hypersensitivity of these subjects to criticism and other issues related to self psychological constructs, such as the inability to comfort and protect the self and fleeing from conflict, suggests that many of these subjects lack a sense of self cohesion. Their reactions suggest that they have known many emotional ruptures during the course of their lives, leaving them feeling inadequate in the face of conflict. The selfobject needs of mirroring, idealizing, and twinship have not been met or have been insufficiently incorporated into the structure of the psychological self, leaving subjects defensive and avoidant.

Question: (2) What does the experience mean to the

relapsing person?

The experiences preceding relapse appeared to represent psychological strife to these subjects resulting in behaviors which reflected the avoidance of feeling states. The commonality of incidents with others of disconnection, rupture, negative criticism or abandonment hurt them and caused them emotional pain. Also experienced in common was the attempt to escape from the pain, the flight from personal acknowledgement that something had happened which created internal discord and behaviors of avoidance.

From the viewpoint of self psychology, the subjects perceived these experiences of disconnection, negative criticism or abandonment as ones symptomatic of failures in empathic attunement or failures in the selfobject needs of mirroring, idealizing, and twinship. The events which created internal conflict were of feeling misunderstood, of feeling inept in the eyes of some other person, of being criticized, judged, and deemed worthless (deficits in mirroring).

Likewise, there were failures in feeling comforted or protected by others, and subjects felt ashamed that they needed understanding or comfort. This emotional response appeared related to failures in the early life need to idealize a parent and resulted in the diminished capacity to comfort and calm themselves. They rationalized that an adult should not expect to receive affirmation for upholding

"normal" responsibilities, but were aware that they experienced a deficit within themselves when validation did not occur.

In reference to twinship needs, subjects struggled to transfer their social needs to drug-free environments. For some, this represented losses related to the sacrifice of old friendships and social occasions with their families. It meant relinquishing traditions of neighborhood parties, and/or going out after work with their work colleagues because these environments were not drug-free. Events involving drugs/alcohol were dangerous to their sobriety, but the relationships were very important to them also. For most subjects, the only known island of sobriety safety was 12-step meetings (AA, NA, CA). Their families and former social world might no longer be included in their lives if they were to maintain sobriety, and this was experienced as an immense loss.

The experience brought about through failures in feeling selfobject support was a deepening of feeling worthless, alone, depressed, and angry. Briefly the acknowledging that a kinship had been broken, subjects defended against the emotions of pain through an unconscious process of social withdrawal. They then used tactics of avoidance (social isolation, aggressive behavior, becoming silent) to defend against further disintegration, only vaguely aware that something important had happened to them

which set them another step closer to relapse.

In essence, their responses to conflict represented the desire to protect the self, to escape from the threat of harm or attack, and to preserve themselves. In the defense of avoidance they quickly moved to self anesthetized states, using their drug(s)-of-choice. The tragedy is that the reaction was futile. Their memory of the perceived injustice would await their sobriety to haunt them until it was resolved. This accumulation of emotional ruptures had become overwhelming to many of the subjects in this study.

Question: (3) Does the experience reflect a failure in the need to respond or be responded to in certain ways?

There is a double bind for these subjects in the "need to respond" in certain (different, new) ways. If feelings of conflict or ruptures in selfobject relationships cause one to move into avoidance of feelings, and ultimately toward relapse into drug/alcohol use, then to encourage the confrontation of those same experiences risks relapse. In this regard, several subjects reported that they wanted to drink alcohol or use drugs following attendance at an AA meeting, when issues of family loss were discussed. The point is not that these subjects have "failed" in responding to life situations; it is that they do not know how to identify the components of controversy with others, are frightened by the magnitude of feeling that they experience periodically (anger, rage, depression), feel inept at



describing their own emotional worlds, and do not know how to attend to their own needs for comfort, protection, and self worth.

Of course, there is a failure. The subjects have not attended to life stressors, conflicts and criticisms in a timely way, nor in a manner which acknowledged their emotional, intellectual, social, and physical needs. Instead of resolving their differences with others, they have retreated. Sometimes that withdrawal has been to isolate from others (physically or verbally), become aggressive with others in defense, or to use alcohol and drugs.

But whose failure is it? Are the parents responsible because they did not meet the subject's selfobject needs as a child? Are the treatment providers in error due to having provoked occasional ruptures in empathy?

More likely, the experience of "failure" is shared, due to the lack of knowledge regarding relapsing persons. The most humbling is that present treatment modalities simply do not work for some individuals. Due to shortened stays in chemical dependency treatment centers and the complexity of some case needs, therapists simply do not have adequate time to provide the multifaceted diagnostic assessment and treatment needs required in these perplexing challenges.

Yet, to repeatedly return the subject to a model of treatment that fails adds insult to injury, deepening the

patient's sense of personal hopelessness and putting some clients at life risk. The recapitulation of the same cycle of treatment is a financial dilemma for patients, treatment centers and insurance providers. The professional knowledge necessary to be able to treat patients this complex is extensive and involves the combined expertise of chemical dependency, mental health, and relapse prevention professionals.

Relapse, in part, does reflect a failure in responsiveness, particularly in the ability to deal with life stressors, hurts, and conflicts in a timely and direct manner. However, it also reflects the subject's inexperience of knowing how to: (1) identify one's feelings, (2) utilize an array of calming, soothing, drug/alcohol free mechanisms to deal with those feelings, (3) apply interpersonal and problem solving skills which are effective in dealing with emotional stressors, and (4) assertively set boundaries with others which protect against anxiety and depression and which serve to minimize experiences which promote unsolicited doses of criticism. Because many of these subjects exhibited symptoms of dual diagnosis, where sobriety enhanced their awareness of intense emotions, the challenge of their progression in recovery must be respected.

It does seem crucial that treatment providers recognize that they are models to their patients. Treatment should

include the recognition that some patients will consider their primary care givers in high esteem; idealize them. Patients with high selfobject needs of mirroring and idealizing are often acutely aware of both the verbal and non-verbal behaviors of their models. As such, providers must monitor their criticisms carefully, remaining constructive and supportive in their endeavors to help patients. The providers must also monitor their own non-verbal behaviors which have the latent ability to promote feelings of doubt or hopelessness to patients. Providers might also consider the impact of the other side of idealization, that of teaching patients how to calm themselves. The modeling by professionals in terms of idealizing selfobject needs has a great deal of potential to inspire recovery.

#### **Limitations Specific to the Findings**

The limitations portion of the study are many. The questions of the structured interview merely touched upon the events precipitating the last relapse event. The study is limited to the self report of subjects and the study tools. Although subjects reported circumstances of tribulation prior to their use of alcohol and drugs (mirroring or idealizing failures), phenomenon triggering relapse should be further investigated to gain more knowledge about the types of events that promote the desire

to flee into relapse.

The information gained in this study is based on a single interview with respondents and is limited by that condition of data gathering and observation. Subjects may have experienced distortion in the recall of alcohol and drug use or in their feelings which represented before first treatment, due to the length of time since these events occurred. Some subjects experienced past relapse states of daily intoxication. Their past history of being chronically anesthetized may have influenced the accuracy of their memories in self reports to the researcher. The narcissistic needs of subjects may have inclined them to report data in a department which they viewed as satisfying to the researcher or they may have tried to present themselves in specific ways for reasons unknown to the researcher. The choice of language used in the structured questions may have been interpreted by subjects differently than the intent of the researcher in exploring subjective data.

This population of subjects was small (N = 24) representing several cultural groups, and only four women. The exploratory nature of the study did not lend itself to in-depth consideration of each subject's interpretation of emotional ruptures or gains, but looked for trends, patterns, and themes of these relapsing individuals.

The trend toward avoidance of feelings represented in

this population of subjects should be considered a topic for further research. The combination of compounded losses and dual diagnosis adds a complexity to this population, raising other variables which may influence relapse events, and the subjects' ability to deal with conflict. Further limitations recognized in this study are that clinical evidence regarding dual diagnosis was gained through observation by the researcher and self report by subjects and did not have the resources of collaboration by the treatment facility's doctors, staff, or medical charts.

### **Conclusion**

This chapter has reviewed the content analysis of the structured interviews completed in this study, associated themes and patterns, and three research questions. Chapter 6 will address the two remaining research questions, and will draw together issues of the study's implications for research, knowledge and practice in clinical social work.

## CHAPTER 6

### SUMMARY: THE QUEST FOR ANSWERS TO RELAPSE

#### Introduction

Chapter 6 will focus on the following components of the study: (1) the findings pertinent to relapse and empathic failures in mirroring, idealizing, and twinship; (2) the findings germane to the subject of narcissistic personality disorder; (3) findings regarding communication as a key to recovery, and also considering suicidality; (4) researcher's comments on the interviews; (5) implications of the findings; (6) application to clinical social work; and, (7) conclusion.

#### Research Questions

Earlier in this study the considerations of several research questions were reviewed. The two remaining research questions, are:

##### Question 1

1) What kind of relationship exists between relapse and the empathic failure of response to significant emotional needs, and (a) mirroring, (b) idealizing, and (c) twinship?

## Question 2

2) In what other ways does the presence or absence of empathy affect the perceived desire for the drug(s)-of-choice?

## Findings on Question 1

Chapter 4 reported about the subjects' increase of negative feelings over the course of time from before their first treatment to the period of time of their last relapse. In a like manner, they reported a decrease of positive feelings during the same time periods. Thus, the researcher concluded that continued addictive use of alcohol and drugs results in an increase of negative emotional states.

Chapter 5 reports on data gathered during personal interviews with subjects, revealing that subjects avoided situations entailing emotional conflict, criticism, and negative judgements. They often used alcohol and drugs as one form of avoidance or fleeing. The subjects stated that they did not want to feel and used the drug(s)-of-choice to anesthetize themselves. Relapse is a symptom, and an experience of loss.

The researcher concludes that the process of addictive use of alcohol and drugs not only intensifies emotional states of psychopathology, but that an outcome of addictive use is also an increased state of the desire to defend against these symptoms of emotional conflict through

avoidance mechanisms of various sorts. Relapse is a symptom, in that it is only one strategy of avoidance among many for these subjects. The subjects avoided their own feelings and eluded various persons, problems and responsibilities.

Mirroring. Mirroring relates to relapse in that subjects were unable to deal with the loss of self respect, sense of worthlessness, shame, depression and anger which they experienced after encounters with family and significant others prior to relapse. Subjects reported incidents of discord and abuse in their early years of life with parents, and reported recent events which resulted in experiences of ruptured empathy. The subjects reported that these events of conflict, and criticism, were not recollected (until the researcher asked them to describe what had happened prior to their relapse), but resulted in feelings of anger, depression, or emptiness. From these emotional states, they fled to the use of the alcohol and drugs.

This fleeing from emptiness, or empty depressions because of a lack of psychic structure, to the desire to feel whole through the use of a drug, is mentioned by several authors of self psychology (Elson, 1986; Kohut, 1977; Levin, 1987; Wolf, 1988). However, the sense of feeling "whole" may be questionable. It is more likely that the subjects fled the awareness of emotional states which



were acutely uncomfortable, to avoid the sense of fragmentation that was experienced when sober. "Wholeness", for these subjects, was more indicative of maintaining some sense of internal cohesion than a state of emotional balance and integrity.

States of emptiness and depression were a result of the probable lack of mirroring in the past experiences of the subjects and the present experience of demoralizing encounters with others. Thus, the historical absence of mirroring experiences as a child, which affirmed the greatness and wholeness of the individual, likely resulted in structural psychic deficiencies. Experiences in the present, which reflected a lack of empathic attunement and critical, judgmental statements (a lack of positive mirroring experiences), resulted in emotional states of emptiness, depression, anger, and feelings of worthlessness. From these feelings, subjects recoiled into defensive avoidance, one form of which appeared to be the use of alcohol and drugs. Examples of this type of emotional withdrawal were cited frequently in Chapter 5 of this study.

The experiences of losses by subjects in this study appeared to exacerbate the feelings of helplessness and failure. Herbert Freudenberger (1985) reiterates the addict's sense of loneliness, emptiness, depression, and inability to form intimate relationships. He states that addicts "do not feel authentic to, or with, anyone. They do

not trust" (p. 339). In experiences of loss, identified often in the content analysis portion of this study, subjects weathered profound human losses (for example, divorce; the death of a child or a friend), without the ability to trust that they could turn to others to be affirmed, understood, and cared about. Instead, they exploded in rage, pushing away those who loved them when events of loss occurred. They were hypersensitive to rejection and defended against the risks of trust and intimacy. These behaviors suggest the deficiency of self structure due to a lack of mirroring.

Idealizing. In idealizing, subjects portrayed deficiencies too. These were cited in Chapter 4 in the absence of feelings which were reflective of self calming, soothing, or a sense of feeling whole. Particularly in the time period during the last relapse, there existed a deficit in positive feelings related to the structural integration of the ability to decrease stress and tensions or to protect oneself from harm.

Khantzian (1981, pp. 163-188) has written about the alcoholic's inadequacy in self care functions and in their inability to regulate feelings. In self care, Khantzian suggests that the mechanisms of defense are impaired. In this study, the subjects referred to the use of alcohol and drugs as the most predominant method through which they comforted the self when let down, angry or depressed.

Subjects also referred to their own children as a source of comfort to them. However, one would expect that this reflected more inappropriate, than appropriate, choices of comforting resources. One would expect the adult to comfort the child, rather than the opposite.

These difficulties in self care or in calming and comforting the self are a result of failures in idealizing selfobject needs. In early development of the self structure, the self is bipolar, that is, it consists of two structures. One part is a differentiated self; the other is the idealized selfobject, which is experienced as a part of the self (Levin, pp. 230-231). When there is inadequate internalization of the functions prototyped in patterns performed by the idealized parent, the result is deficits in the self structure or a lack of cohesion of the self. This is reflected in the inability of the individual to regulate internal tension and the fear of fragmentation.

Thus, an outcome of this study was the affirmation that these subjects did not have the capacity to self calm or comfort in ways which excluded the use of alcohol and drugs. Instead, their relapse events appeared connected to their unconscious strategies of maintaining a sense of cohesion, in that they avoided the experience of fragmentation of the self through evasion of feeling states. Unable to modulate tensions, complicated by the fact that stimuli may enter the person's experience without adequate screening (through the

functions of the stimulus-barrier), they used the drug(s)-of-choice to self anesthetize.

Likewise, the need to form relationships with idealized others may be a necessary component of the building of psychic structure in order to gain the strength, and leadership, which the insufficiently idealized superego cannot provide (Kohut, 1987, p. 49). This would lead individuals to recurrently seek idealized others and would intensify their experience of pain when frustrated by criticism or non-approval by those selfobjects. This may be the circumstance for these subjects who depended upon counselors at treatment centers as idealized selfobjects and who became frustrated by the perceived lack of empathic understanding in those relationships. Additionally, this may apply to other idealized selfobjects, including parents, spouses, and AA members or sponsors who have not met the idealized expectation of recovering persons. Their loss in experiences of this kind may reflect the degree of earlier idealizing disappointments of traumatic proportions.

Twinship. The selfobject need of twinship relates to the need to have common bonds, kinship, interests, partnership, or similarity with others. This selfobject need is sometimes referred to as the alter-ego need (Kohut, 1987, p. 115) and was originally categorized by Kohut under mirroring needs. Later he incorporated twinship as a separate type of selfobject need and posited that it had a

separate line of development (Elson, 1986, p. 51). Miriam Elson refers to this need, noting: "It is not a cliché to say that hope springs eternal in the human breast: it is available to be rekindled--that hope is to be accepted as a worthwhile member of society" (Elson, 1986, p. 52).

Twinship experiences have been described earlier in Chapter 5, particularly with subjects relating their bonds with fellow AA members. The sense of kinship, and of feeling cared about brought to subjects through the fellowship of Alcoholics Anonymous, is an important component of this study. One reason for its distinction is the fact that AA, or other 12-step programs, were the single factor that brought these subjects a place to meet with other people seeking sobriety. Not only were certain AA members idealized (such as a chosen sponsor) but meetings were a place to find new friends (twinship). These shared experiences of meaning, where members were encouraged to discuss their use of alcohol and drugs and to talk about the feelings they had encountered in the process of their addiction, assisted subjects in dealing with feelings of social isolation and past/present failed empathic bonds. To allow oneself to feel was identified by subjects as an important component of relapse risk, for many had used alcohol and drugs to numb their feelings. Thus, the ability to meet and interact with others, in a structured drug-free environment where feelings could be disclosed, was viewed as

simultaneously beneficial and fearsome to many subjects.

Conversely, past twinship experiences were reported by subjects, where friends, work colleagues, and family, often used alcohol and drugs. Subjects reported a mourning process regarding the relinquishment of these social contacts, where substance use was a major element of past contacts with others. The loss of connection with these important others, because the subjects realized they could not participate in the social functions without relapse, was painful. The subjects found a rather stable rationalization regarding the giving up of old friends or work colleagues but voiced particular confusion and pain over the need to sacrifice family contact or significant other relationships where they might be exposed to the use of alcohol and drugs. This was reflective of their struggle with the integration of major twinship selfobject needs involving their identity, commitments, and values. Some disconnections were intolerable to them.

Twinship needs are worthy of further research. Although a few subjects reported participation in other activities, in general most lacked the curiosity to find interests and activities that were fun, fulfilling, or challenging. Past leisure activities had included substance use, so that these past ventures were considered risks to relapse. Fishing was the most popular activity for self calming, and often included time with friends or loved ones

in natural environmental settings. Religion or spiritual activities also provided some subjects a sense of twinship with others.

### Findings on Question 2

Empathy, or empathic attunement, to this population of subjects represented the sense of being "in tune" with the their own feelings; a sensitivity to their words, perceptions, demeanor, and experience as they reported their life stories. Being empathic did not represent the need to agree with what the subjects said as much as the focus of understanding what they said, felt and experienced. Spending time in these interviews with subjects often resulted in their reporting that the interview was helpful to them and gave them information which they would take into their primary counselor and discuss further. They often reported that just "talking" about their histories was helpful and necessary to their recovery. Thus, the interview seemed to enhance their recovery one step further.

For this population of subjects, it became apparent that the lack of empathic attunement, no matter its source from persons in the subject's life, detracted from the recovery. When ruptures of empathy occurred, the desire to comfort and calm the self led to the thought of drinking or using drugs. Because sobriety was important to these individuals, they practiced new ways of dealing with these

thoughts of relapse, like a child struggling to learn new things, painfully seeking others to talk to and attempting to understand their own reactions.

When empathic attunement was present, subjects reported a feeling of hope, a sense of feeling that they had the ability to deal with the goal of their sobriety. Often this confidence came from their work with treatment staff. Subjects praised their primary counselors habitually, and indicated the importance of their mutual endeavors in clinical treatment. Likewise, when subjects had found sponsors from AA whom they felt close to and trusting of, they praised them.

Empathic Attunement and Treatment Providers. The attitude of treatment personnel, and the associated empathy or compassion, was a critical factor to the recovery of these subjects. Clients had become acutely sensitive to the presence or absence of empathy. They could read its presence in silence and sense when it did not exist with their counselor. An example of the loss of empathy was reported by one subject who had brought his expensive after shave lotion to the unit, when he was hospitalized for treatment. He was extremely hurt that his counselor referred to the lotion as "cheap smelling stuff", as it cost him \$50.00 a bottle. At a deeper level, he felt that there was no reason whatsoever to be criticized for something about himself that he enjoyed and which had no relationship



to his treatment. He stated, "When you have lost so much of your self respect, why do you have to be told you smell bad, too?"

This lack of empathy on the part of the counselor had direct impact on the subject, and interfered with the subject's ability to idealize the counselor, or trust the counselor's judgement as a leader and guide in recovery. It also deepened the subject's sense of depression, anger, and despair. Outside of treatment settings, this subject may have relapsed in order to avoid the rage he experienced in this event. Instead, he vented his frustration and loss to the researcher, which represented a resource for his release from the fury of his ruptured trust.

In a similar experience, the researcher saw a subject who had to leave early during the structured interview, because he was dependent on another person for transportation. A second appointment time was set for him. This young man had repeatedly attempted suicide but had completed his treatment in in-patient care and was in outpatient care at the time. The researcher returned to the treatment facility for the second appointment and waited in the lobby for him.

Two counselors came to the reception desk and asked the researcher whom she was waiting for. When told, they laughed and said not to expect him to come in, because he was "a real loser." The researcher immediately was stunned

by the desperation she had witnessed in the first interview with this subject. She feared that he would not have hope. If hope was not available through the counselors at the treatment setting, in providing him the empathic cohesion of their own structures toward the rebuilding of his fragmented self, from where would it come? The researcher also considered the sense of depression and helplessness which might be experienced by treatment staff in witnessing many individuals who could not attain the goal of sobriety and that their seemingly sarcastic comments may have provided them an outlet for their own anguish. The subject did not show for the second interview and left treatment. Through this experience, the researcher recognized that treatment staff often underestimated the importance of their own idealized status to subjects, and the significance of attitudes of continued faith, belief in, and hope for the patient, since these were structures which patients could not provide themselves.

Fears: Success and Failure. An interesting outcome of studying empathic bonds, is that subjects were sensitive to the responsibilities of success, when positive outcomes of mirroring (affirming, encouraging statements) were conveyed to them. In the face of success, they became anxious, fearing failure. This tension sometimes led subjects to relapse, for they could not manage the fears or excitement. This may relate to the stimulus-barrier issues of self

cohesion and the inability to calm the self (Wolf, 1985, p. 32). Subjects struggled with communication about their feelings in matters of this kind, unable to identify that the fear of success is worthy of discussion with counselors, sponsors or trusted others.

An outcome of this study was the confirmation that subjects in treatment are developing new, and frail, empathic bonds. Treatment personnel need to be aware that their relationship with patients may be clients' only consistent thread of hope toward healthy relationships. The therapist role is one of great responsibility since empathic ruptures are bound to occur in any relationship. However, the sense of optimal frustration, wherein structure building in the patient causes an occasional setback, will not deter the gradual construction of cohesion. Cohesion is established through attendance to empathic attunement and can amplify the potential of recovery for patients.

#### Narcissistic Personality Disorder

In Chapter 4, seven feeling states representative of narcissistic personality disorder were identified as symptoms commonly experienced by subjects in this study during periods of sobriety. These feelings included: anxiety, depression, emptiness, low energy, inability to be objective, sense of panic, and worthlessness. The presence of these symptoms suggested the clinical diagnosis of co-

existing mental health and chemical dependency conditions. The researcher determined that the dual diagnosis might cut across many classifications of diagnosis. More likely, many of these subjects fell into the categories of narcissistic personality disorder and narcissistic behavior disorder, as outlined by Kohut and Wolf (Ornstein, 1990, pp. 359-385).

Kohut and Wolf suggest that the addictions are more represented in narcissistic behavior disorders. For purposes of this study, and due to the inclusion of other considerations of narcissistic personality disorder as outlined in Chapter 2 (Literature Review) of this study, the term "narcissistic personality disorder" was used to include both profiles.

The failure of selfobject needs for subjects in this study often represented ruptures of both mirroring, and idealizing needs. Kohut stresses the need for therapists to consider these factors in the rebuilding process of psychic structure of the patient and to attend sensitively to the patient's deficiency of self esteem. He also notes the inability of patients that have experienced idealizing failures to provide themselves with goal-setting structures in their lives (Kohut, 1977, p. 195). These symptoms of self structure deficits (serious problems in relationships with both parents, low self esteem, and the inability to set goals) were identified in many of the subjects in this

sampling.

These needs, in combination with the poverty of empathic attunement, raise questions discussed below that relate to both diagnosis, and to models of treatment for subjects in this study.

Diagnosis. Two factors reported by these subjects included: (1) high ratios of symptomatology related to dual diagnosis, and (2) the fact that 87% of this population relapsed within 24 months. This suggests the need for diagnostic assessments which screen for dual diagnosis in chemical dependency treatment evaluations. It also emphasizes the need to explain the outcome of evaluations clearly to involved patients in order to encourage their understanding of the impact of mental health symptoms on their potential future relapse. Patients knowledgeable about their mental health conditions can better adjust to changes in emotional flux and judge their own needs for professional support or intervention. It appeared that subjects who were aware of their dual diagnosis were relieved to have an explanation about their emotional states when sober. Unfortunately, this was the exception, and many indicated only that they were on prescription drugs, but did not know why.

Subjects who expressed significant symptoms of depression, and worthlessness appeared reluctant to reveal or request information from their therapists about their

dual diagnosis. This may have implied a sense of further loss of control to them or perceptions of personal failure. This was a double bind. Subjects needed to understand their total diagnostic picture, for it would influence their behaviors and feelings after discharge from the treatment setting. Yet, they were guarded about confirming a diagnostic label and avoided the knowledge of their condition. This left them inclined to minimizing the needs for medication and follow up consults with their psychiatrist and therapist when discharged. It also presented a risk for relapse.

Treatment Models. A rethinking of models of treatment for relapsing individuals with symptoms of dual diagnosis is necessary. The costs of time, emotional investment, financial burden, and quality of life have been high for these individuals. Traditional treatment models are inefficient, because they recycle the same programs and ultimately lead the patient to despair. The cost is comparably high in expenditures to family, insurance companies, and treatment personnel.

Therapists of the future need to consider the relationship of NPD, or disorders of the self in their methods of practice. Clinical trainers may wish to educate staff in the role of being idealized, and the outcome of idealization related to the ability to comfort the self. Models of treatment should include the education of patients

about the need to learn methods of self calming, to assist them in the development of strategies to comfort overwhelming emotional states. Strategies regarding self soothing might be creative, playful, and consider the subject's need for both individual and shared social activities which provide comfort and pleasure. Models of treatment might also be constructed which consider new approaches to respond to twinship needs or common bonds with others interested in sobriety.

Along with these treatment needs, the individual who cannot respond to AA or other 12-step self-help models should be considered. Some individuals could not relate to a "Higher Power" model, and resisted the large group meetings wherein painful discussions threatened their sense of cohesion. Small group meetings, such as Relapse Recovery, or the CENAPS model of relapse groups, might be encouraged instead. However, further research and the development of newer models of relapse treatment, also must be fostered.

Additional Findings. "Talk" was expressed as a need in recovery by all subjects. This represented the need to share one's feelings, concerns, and conflicts, through the use of verbal exchange with another trusted person. Talk was the bridge to empathic attunement, and therefore the key for many subjects in a process of change which moved them toward intimacy in emotional communication with others.

The significance related to loss of job, or of a threat to job and employment status, was important because it referenced an identity which subjects believed was significant. Beyond the survival needs represented in financial gain through a job, subjects referred to jobs as a part of their own self understanding and cohesion. Without a job, this sense of self was threatened. This finding should be further studied in order to determine the interaction of job loss or threat and relapse. Employers may have a pivotal role in supporting models of relapse prevention.

The fact that a notable number of these subjects reported suicidal ideation, or attempts (21 reports of ideation, 21 reports of attempts), is very important. This information was spontaneously offered by these subjects and was not prompted by a structured question. Many subjects reported multiple attempts of suicide, reflecting the degree of despair in their lives. Treatment providers must screen patients for suicidal potential and consider the degree of life threat that exists for this population. Particularly at a time in history when lengths of stay in treatment are minimal, patients should be considered for transfer to psychiatric units following their chemical dependency treatment when their suicide potential is high.

Another factor in suicidality, which was reported by subjects, is the fact that if they had a friend who had



committed suicide, or if their family had suicide attempts, the thought of suicide was prominent for the subjects. Deaths of loved ones also appeared to increase the subject's thoughts of suicide and might be further studied. It also was noteworthy that subjects were inclined to be very subtle about the introduction of information regarding a death which had influenced their emotional status. The researcher found that she had to return to this information, and in that revisiting of the comment, the subjects acknowledged that they were highly impacted by the loss.

#### **Researcher's Comments: Joining the World of the Subject**

The Researcher's Comment Sheet was a form which was completed at the end of each interview with subjects. The form (Appendix D) listed 26 symptoms of narcissistic personality disorder, which were drawn from various authors, not all of which were consistent with the views of self psychology. The form also included a section for comments on impressions and responses of the researcher in terms of empathic experience with the participant, and a section for any other features or thoughts about the interview.

The researcher found this form helpful in identifying the behaviors of subjects which were not expressed verbally, but were observed in the course of the interview. For example, a subject may not have mentioned low self esteem directly during the course of the verbal interview, yet

would be unable to make eye contact with the researcher, or would be speaking in whispers, crying, or struggling to continue with the interview for its duration.

During the process of several interviews, the researcher stopped to ask the subject if they might want to get a glass of water or take a brief break due to the intensity of emotion that the subject displayed. Without exception, subjects requested to continue, though some did go to get a drink of water.

Depression, anxiety, emptiness, low self-esteem, pessimistic mood, mood swings, a sense of panic, worthlessness, feeling fragmented, lack of internal cohesion, feelings of inferiority, the requirement of admiration from others, entitlement, idealization, a lack of empathy, reactiveness, and signs of learning disability were categories which were observable during the interview with the researcher. The other categories were sometimes referred to and then were included on this comment sheet. These included: tendencies toward periodic hypochondriasis, unprovoked aggression, grandiose thinking, the inability to be objective, regression, devaluation or contempt of others, exhibitionism, exploitative behavior, and envy.

The researcher expected that some subjects would not exhibit empathic responses during the course of the interview for two reasons. First, she believed that a lack of historical empathic attunement would lead these subjects

to be defended against a stranger requesting information about their past relapses; and, second, because the elements of narcissistic behaviors described by various authors suggests devaluation or contempt of others, exhibitionism, entitlement, and exploitative behaviors. These expectations were in error. Subjects invariably were intensively responsive to the researcher, and were serious participants in the desire to be understood in the various components of the research process. In fact, they were hypervigilant to the responses by the researcher, and responded to her consistently with respect, sometimes with a clear sense of humility.

Approximately three subjects indicated histories which were suggestive of the probability that they had certain learning disabilities. These were noted in childhood academic struggles with reading and comprehension and with short term memory difficulties. Subjects who had this type of history often reported their difficulty with putting their thoughts into words, and needed more affirmation during the course of the interview regarding the fact that they were making sense, could be understood, or were doing a good job at the attempt to inform the researcher of their life experience. Subjects with apparent learning disabilities also exhibited particularly low self esteem and had deemed themselves "stupid" due to aforementioned academic problems.

The Researcher's Comment Sheet also assisted the researcher in remembering potential problem areas (identified by subjects) which were shared with the primary counselor. Subjects who were observed to have intense affective states of depression, or other emotional symptomatology, were referred (with their permission) to their primary therapists, through a written memorandum, submitted directly following the interview. The memoranda usually identified that: (1) the interview had been completed with their patient; (2) specific information was noted by the subject as important to discuss further with their primary therapist; and (3) specific affective states were observed, when appropriate, which might be further assessed for dual diagnosis.

The Researcher's Comment Sheet also assisted the researcher in maintaining a focus on the issues of empathic attunement between the researcher and the subject being interviewed.

### **Implications of the Findings**

This study has several implications. The findings support the likelihood of dual diagnosis in many relapsing subjects in this study. Several respondents also met the criteria for NPD, as outlined in self psychological theoretical perspectives.

The study supports the applicability of the theory of

self psychology, including views of selfobject needs, to the needs of the addicted and relapsing person. The findings suggest that experiences precipitating relapse, and which constitute matters of perceived conflict, criticism, and demoralization for the subject, result in the client fleeing from intolerable emotions and potentially toward the use of alcohol and drugs. As such, relapse is seen as one symptom of many avoidance tactics which are defensive in nature. Following experiences of empathic rupture the subjects fled from affective states to calming mechanisms that had assisted them in anesthetizing feelings in the past, the drug(s)-of-choice. It is theorized by the researcher that these defenses were used to avoid a still greater risk: the fragmentation of the self due to the already precarious state of the self structure.

Relapsing persons interviewed as subjects in this study were barely able to recall empathic ruptures that preceded their relapse, until asked to consider the events which occurred prior to the relapse. They were surprised to uncover events which hurt, angered, or depressed them. When they did acknowledge the affect associated with the event, historical patterns of feeling disappointed in a like manner in the past emerged. They admitted they could not deal with these historical ruptures with others and that they used alcohol and drugs to numb their feelings. Thus, the meaning of these events of empathic ruptures in their lives

represented the belief that they were neither respected nor cherished by significant family and friends and that their worth was minimized.

Subjects reported experiences of failures in mirroring, idealizing, and twinship throughout their lives supporting the theories of self psychology and addictive use. They had become hypervigilant to others, a laser beam searching out rejection and expecting empathic ruptures. Subjects were surprised that they felt worse when sober than when intoxicated, because they had not considered that the memories of their past emotional ruptures with others still caused emotional conflict within them. Subjects were unable to respond in ways which negotiated their affective needs and were verbally deficient in self expression. Yet, they underlined the fact that they must talk with others and build intimate relationships of trust in order to recover.

Models of treatment that criticize and demean the patient seem to be missing the point. It would appear that there is minimal cohesion of the psychic structure of these clients, represented in repeated relapse experiences. Thus, to suggest that the patient of this profile is egocentric is confusing the defenses with the cure. Some commonly used models of treatment promote the philosophy that egocentricity is a core problem in addicted individuals and this concept may be toxic to some patients in recovery. These types of treatment models do not represent what some

clients are experiencing, and may blame the patient for their defenses, which may be all they have to keep from fragmentation. In this regard, it would be helpful to have future research studies which compare relapsing individuals with those who achieve sobriety after one treatment intervention. Because of the 87% ratio of relapse within 24 months, the non-relapsing comparison group should have at least 36 months of sobriety. The researcher speculates that the non-relapsing group would not be dual diagnosed.

In Chapter 4, correlation studies were presented concerning selected word pairs used in the instruments which collected feelings during two time periods (before first treatment and during last relapse). These correlation studies appeared to verify content validity, in that each word was measured against all others, to determine the credibility of words with similar meanings being paired together. This proved to be reliable. It would be useful to see future research studies focus on the development of these word pairs, in order to develop instruments which might assist in the diagnostic assessment of relapsing individuals. The early formulations of the correlation studies suggested that the presence of negative emotional states, and the absence of positive emotional states, is predictive, but is not yet generalizable due to the small population studied in this research study.

The use of both quantitative and qualitative

methodology enhanced the reliability of data gained in this study. It heightened the capability of viewing the data from several perspectives and to study the population of the sample more thoroughly. The frequency distributions, cross-tabulation, and correlation studies allowed the data to be assessed for particular information of interest [such as length of sobriety and drug(s)-of-choice cross-tabulations]. The structured interviews, and content analysis of those interviews, allowed the researcher to view the experience of relapse from the view of the subject and to consider the perceptions, empathic bonds and selfobject needs of those subjects more sensitively. Thus, this study approached the research on relapse using several methods of inquiry (Frances & Miller, 1991, p. 11).

#### **Application to Clinical Social Work**

Clinical social workers are not strangers to the recognition that addiction and relapse are serious problems. The incidence of alcohol and drug abuse is approximately one-fifth of the adult population (Frances & Miller, 1991, p. 3). The social worker frequently encounters populations involved in addictive use of alcohol and drugs or the ramifications of use to family and significant others. Yet, there is a need for more clinical social workers to become formally educated, and certified, in the field of addictions and relapse prevention.



Academic programs in colleges and universities are now beginning to provide courses to their social work students which expose them to the knowledge of addictions and relapse prevention. This is crucial to their futures in the field of clinical social work, for it is impossible not to encounter clients who are struggling with the consequences of this disease. All socioeconomic groups are touched with the suffering of the addictions and there are serious ramifications in terms of violence, financial costs and health issues for all involved.

This study, viewed through a self psychology theoretical framework, provides several insights which may assist the clinical social worker in understanding the treatment needs of the relapsing person. Among these are:

- (1) that the relapsing individual has a high probability of being diagnosed as having an addiction and coexisting mental health disorder, and as such may have more intense emotional issues with symptoms of depression, anger, worthlessness, sense of being alone, and with suicidality;
- (2) that issues of loss, including job loss, are important factors to consider in the diagnostic assessment;
- (3) that empathic attunement with clients is crucial to their healing process and to the development of a cohesive self structure;
- (4) that verbal communication will be difficult for relapsing clients, and that talking about their problems and feelings is an achievement in itself for individuals accustomed to avoidance tactics;

- (5) that the process of treatment and disclosure of feelings may need to move slowly, due to the fact that individuals with relapse histories are particularly fearful of disclosure and flee to substance use in the face of these fears;
- (6) that affirmation of the client, in sincere and genuine behaviors, is essential in the service of mirroring needs;

- (7) that the clinical social worker may be idealized, and should accept that role as crucial to the client's sense of hope for recovery in that the client will absorb the attitude of belief, or non-belief in recovery projected by the social worker as a part of him/herself;
- (8) that the client who has a history of relapse will need assistance, education, and guidance in finding activities and methods for calming the self, and that the social worker's attitude regarding calm approaches to the client will be absorbed by the client;
- (9) that strategies for drug-free environments which attend to the social isolation and need for becoming a worthwhile part of the society will be required; and,
- (10) that the family of the client who has a history of relapse will require intervention by the social worker or some other professional in order to rebuild trust in the family bonds.

Clinical social workers should be aware that since there is such a high rate of relapse in addicted persons, there is a need to encourage clients and their families involved in the relapse cycle, through a resilient sense of tenacity. Clients involved in the addictions tend to think in black and white. They expect that with sobriety a miracle of change in behaviors will occur. It is important that they are assisted in understanding that a recovery does not mean that a person will remain sober, and sobriety does not guarantee emotionally euphoric life experiences. There is no "magic pill". It is crucial that they are prepared for an approach to treatment which considers each forward step a success, but which views the journey toward health as one expected to value endurance over efficiency. This is

very difficult for families who have already been through years of pain. They desire immediate answers from a clinician who is altering the course of treatment as it unfolds, according to the client's needs.

### Conclusion

The researcher completed this study during the course of her studies at Loyola University of Chicago. The study was complex, involving both quantitative and qualitative components. To her best knowledge, the research study was original, and drew from the theoretical propositions of many theorists, particularly that of Heinz Kohut and self psychology.

The field of relapse prevention is open to the exploration, and research inquiry of interested students and researchers. There are more questions than there are answers. Yet, the suffering of individuals who experience relapse in the addictions warrants a commitment to their cause. They are people who are dependent on research studies for answers to their treatment needs, and for some those answers represent their very survival.

The researcher is particularly grateful to the subjects who participated in this study, and for the time and efforts they gave in advancing this field of knowledge. Likewise, the chemical dependency treatment centers who allowed the research to commence, and were consistently supportive of

the researcher, deserve the respect and appreciation that are extended to them. These facilities and their staffs were very cooperative in all endeavors which supported this study.

In many journeys of learning, the outcome is to discover what one does not know. This study, while shedding light on many new facets of learning about relapse, has taught the researcher more about the needs and challenges of relapse prevention than about what will ensure recovery. Thus, the inspiration of unanswered questions still beckons to those who long for answers.

APPENDIX A  
RELAPSE HISTORY INVENTORY



APPENDIX B  
DRUG-OF-CHOICE AND FEELING CHECKLIST -  
BEFORE FIRST TREATMENT



**DRUG-OF-CHOICE/FEELING CHECKLIST -BEFORE FIRST TREATMENT**

Please check the drug you most frequently used before your first treatment at the chemical dependency treatment center:

\_\_\_\_\_ Alcohol \_\_\_\_\_ What do you usually drink?

\_\_\_\_\_ Sleeping Pills

\_\_\_\_\_ Tranquilizers (Librium, Valium, etc.)

\_\_\_\_\_ Amphetamines (uppers, speed)

\_\_\_\_\_ Narcotics (heroin)

\_\_\_\_\_ Hallucinogens (LSD)

\_\_\_\_\_ Phencyclidine (PCP)

\_\_\_\_\_ Cannabis (Marijuana, hashish, pot, etc.)

\_\_\_\_\_ Cocaine \_\_\_\_\_ Other (Please specify \_\_\_\_\_)

\*\*\*\*\*

Please check the feelings you had when you used this drug:

\_\_\_\_\_ empty

\_\_\_\_\_ low energy

\_\_\_\_\_ anxious

\_\_\_\_\_ hyperactive

\_\_\_\_\_ lonely

\_\_\_\_\_ elated

\_\_\_\_\_ humiliated

\_\_\_\_\_ fragmented

\_\_\_\_\_ falling apart

\_\_\_\_\_ appreciated

\_\_\_\_\_ soothed

\_\_\_\_\_ vulnerable

\_\_\_\_\_ resentful

\_\_\_\_\_ insecure

\_\_\_\_\_ let down

\_\_\_\_\_ betrayed

\_\_\_\_\_ angry

\_\_\_\_\_ valued

\_\_\_\_\_ calmed

\_\_\_\_\_ shamed

\_\_\_\_\_ composed

\_\_\_\_\_ serene

\_\_\_\_\_ safe

\_\_\_\_\_ depressed

\_\_\_\_\_ happy

\_\_\_\_\_ outraged

\_\_\_\_\_ mellow

\_\_\_\_\_ loved

\_\_\_\_\_ alone

\_\_\_\_\_ complete

\_\_\_\_\_ loss

\_\_\_\_\_ passion

\_\_\_\_\_ esteem

\_\_\_\_\_ worthlessness

\_\_\_\_\_ distress

\_\_\_\_\_ panic

\_\_\_\_\_ paranoid

\_\_\_\_\_ cheerful

\_\_\_\_\_ hurt

\_\_\_\_\_ afraid

\_\_\_\_\_ courageous

\_\_\_\_\_ shy

\_\_\_\_\_ whole

\_\_\_\_\_ outgoing

\_\_\_\_\_ affectionate

\_\_\_\_\_ needed

\_\_\_\_\_ frightened

\*\*\*\*\*

Did you often use more than one drug per week  
\_\_\_\_yes \_\_\_\_no

If yes, what other drug did you often use? \_\_\_\_\_

APPENDIX C  
DRUG-OF-CHOICE AND FEELING CHECKLIST -  
DURING LAST RELAPSE

DRUG-OF-CHOICE/FEELING CHECKLIST - DURING LAST RELAPSE

Please check the drug you used most frequently during the last relapse event, before you came to the chemical dependency treatment center:

- Alcohol \_\_\_\_\_ What do you usually drink?
- Sleeping Pills
- Tranquilizers (Librium, Valium, etc.)
- Amphetamines (uppers, speed)
- Narcotics (heroin)
- Hallucinogens (LSD)
- Phencyclidine (PCP)
- Cannabis (Marijuana, hashish, pot, etc.)
- Cocaine \_\_\_\_\_ Other (Please specify \_\_\_\_\_)

\*\*\*\*\*

Please check the feelings you had when you used this drug:

- |  |  |
|--|--|
| <input type="checkbox"/> empty         | <input type="checkbox"/> happy         |
| <input type="checkbox"/> low energy    | <input type="checkbox"/> outraged      |
| <input type="checkbox"/> anxious       | <input type="checkbox"/> mellow        |
| <input type="checkbox"/> hyperactive   | <input type="checkbox"/> loved         |
| <input type="checkbox"/> lonely        | <input type="checkbox"/> alone         |
| <input type="checkbox"/> elated        | <input type="checkbox"/> complete      |
| <input type="checkbox"/> humiliated    | <input type="checkbox"/> loss          |
| <input type="checkbox"/> fragmented    | <input type="checkbox"/> passion       |
| <input type="checkbox"/> falling apart | <input type="checkbox"/> esteem        |
| <input type="checkbox"/> appreciated   | <input type="checkbox"/> worthlessness |
| <input type="checkbox"/> soothed       | <input type="checkbox"/> distress      |
| <input type="checkbox"/> vulnerable    | <input type="checkbox"/> panic         |
| <input type="checkbox"/> resentful     | <input type="checkbox"/> paranoid      |
| <input type="checkbox"/> insecure      | <input type="checkbox"/> cheerful      |
| <input type="checkbox"/> let down      | <input type="checkbox"/> hurt          |
| <input type="checkbox"/> betrayed      | <input type="checkbox"/> afraid        |
| <input type="checkbox"/> angry         | <input type="checkbox"/> courageous    |
| <input type="checkbox"/> valued        | <input type="checkbox"/> shy           |
| <input type="checkbox"/> calmed        | <input type="checkbox"/> whole         |
| <input type="checkbox"/> shamed        | <input type="checkbox"/> outgoing      |
| <input type="checkbox"/> composed      | <input type="checkbox"/> affectionate  |
| <input type="checkbox"/> serene        | <input type="checkbox"/> needed        |
| <input type="checkbox"/> safe          | <input type="checkbox"/> frightened    |
| <input type="checkbox"/> depressed     |  |

Did you use more than one drug during this relapse?

yes no

If yes, what other drug did you use? \_\_\_\_\_

Are you on any prescription drugs at this time?

Yes No

If yes, please specify what drug:

\_\_\_\_\_

APPENDIX D  
RESEARCHER'S COMMENT SHEET

RESEARCHER'S COMMENT SHEET

Research Participant # \_\_\_\_\_ M \_\_\_\_\_ F

Date: \_\_\_\_\_ Facility: \_\_\_\_\_

Impressions of affective states:

\_\_\_\_ Depression<sup>1</sup>: \_\_\_\_\_ situational \_\_\_\_\_ chronic\_\_\_\_ Anxiety<sup>2</sup> \_\_\_\_\_ situational \_\_\_\_\_ chronic\_\_\_\_ Emptiness/feelings of deadness<sup>3</sup>\_\_\_\_ Tendencies toward periodic hypochondriasis<sup>4</sup>\_\_\_\_ Low self-esteem<sup>5</sup>\_\_\_\_ Pessimistic mood<sup>6</sup>\_\_\_\_ Unprovoked aggression<sup>7</sup> (this may include rage<sup>8</sup>)\_\_\_\_ Mood swings<sup>9</sup>: \_\_\_\_\_ reported \_\_\_\_\_ witnessed\_\_\_\_ A sense of panic<sup>10</sup>\_\_\_\_ Worthlessness<sup>11</sup>\_\_\_\_ Grandiose thinking<sup>12</sup>: (identify symptoms) \_\_\_\_\_\_\_\_\_ Inability to be objective<sup>13</sup>\_\_\_\_ Feeling fragmented<sup>14</sup>\_\_\_\_ Regression<sup>15</sup> (identify symptoms) \_\_\_\_\_\_\_\_\_ Lack of internal cohesion<sup>16</sup>: (identify symptoms) \_\_\_\_\_\_\_\_\_ Devaluation or contempt of others<sup>17</sup> (circle what applies)\_\_\_\_ Exhibitionism<sup>18</sup>\_\_\_\_ Feelings of inferiority<sup>19</sup>

\_\_\_ Requirement of admiration from others<sup>20</sup>

\_\_\_ Entitlement<sup>21</sup>

\_\_\_ Idealization<sup>22</sup>: (who or what was idealized?) \_\_\_\_\_

\_\_\_ Exploitative behavior<sup>23</sup>: (how was this expressed?) \_\_\_\_\_

\_\_\_ Envy<sup>24</sup>

\_\_\_ Lack of empathy<sup>25</sup>

\_\_\_ Reactiveness<sup>26</sup>: (identify behavior) \_\_\_\_\_

\_\_\_ Signs of Learning Disabilities<sup>27</sup>: (identify what was noted) \_\_\_\_\_

Identify impressions related to your response and empathic experience with this participant:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Identify any other features/thoughts you desire to remember or return to about this interview:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## ENDNOTES

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19. Akhtar & Thomson, 12-20.
20. Ibid.
21. Ibid.

22. Ibid. Also, Kohut, 10-11, 18, 51, 55-57, 217-218, 275.
23. Ibid. Akhtar & Thomson, 12-20.
24. Ibid, 12-20.
25. Ibid.
26. Ibid.
27. Ibid.

APPENDIX E  
QUESTIONS FOR THE STRUCTURED INTERVIEW

**QUESTIONS FOR THE STRUCTURED INTERVIEW**

(In Person - Taped)

Introduction:

I am going to ask you some questions about your experience in using alcohol or drugs, especially related to your experience of relapse. There may be things you would like to add, that I have not covered in the questions. You will have a chance at the end of this interview to add your own thoughts on what is important. Your thoughts are important to me. I hope you will feel free to add your ideas and feelings about what is important to relapse. In this way you add to our knowledge about this subject. Are you ready to begin?

1. What was it that brought you to this treatment center? (Begin review of relapse event)
2. How long has it been since your last relapse? (Checks against relapse event sheet; discrepancies will be clarified in the interview.)
3. Describe your last experience of drinking or using drugs. (Continues review of relapse event)
4. What is your drug of choice? Do you often use more than one drug? What are the drugs? Which one do you commonly use?
  - a. before first hospitalization for treatment?
  - b. during the last relapse(Items a and b identify any changes in use)
5. What feelings do you have when you use that drug? (Checks verbalized feelings against feeling checklist)
6. What feelings do you have when you do not use that drug? (Identifies potential of dual-diagnosis in self-medication for depression, anxiety, etc.)
7. In what ways do people that you associate with make you feel more like using alcohol/drugs?
  - a. Who are they?
  - b. What is it about them that encourages a relapse? (Identifies twinship issues, identifies states of anxiety regarding mirroring and/or idealizing needs).

8. In what ways do people that you associate with make you feel less likely to use alcohol/drugs?
  - a. Who are they?
  - b. What is it about them that encourages your sobriety?  
[Identifies twinship which supports sobriety; identifies use of support systems and self-help groups which provide idealizing (protection)]
9. In what ways does your relationship with these people influence the way you feel about yourself? (Identifies needs for mirroring, idealizing and/or twinship).
10. What are the types of things that increase your desire to relapse?
  - a. Can you describe them?
  - b. How do you feel about yourself when you think about those things?

(The use of the word "things" provides a vehicle for non-human relationship items; Examples that may relate to relapse are: loss of a loved pet, loss of a job, feeling rejected in social situations. The "things" are often situational, and clarify areas of symbolic loss. The use of language is important in responses and relates to mirroring, idealizing and/or twinship needs. Mirroring and idealizing needs are particularly identifiable in this question.)

11. How were these people or things present in your life just before your last relapse?
  - a. Describe how you felt about those people or things.

(This question further defines the potential experience of loss, the event prior to relapse. Mirroring and idealizing needs are further defined in this question)

Note: In the pilot interview, the participant described fear related to job performance. He was aware of using alcohol as a substitute for human relatedness, when anxiety and fear related to his job became overwhelming.

12. What was your relationship like before the relapse?
- Describe what seemed important to you about the person or thing.
  - What did you want from the person or thing?
  - Did you get what you wanted?

(These questions define the mirroring, idealizing needs of the individual further; the language of the response is what clarifies which selfobject need is most desired).

13. How did those people feel about you, or respond to you, before your last relapse?
- What, if anything, was said to you by those people?
  - What, if anything, did you feel about what they said about you?

(These questions relate to mirroring needs)

14. Do you recall any experiences of feeling let down, depressed, or angry, before your last relapse?  
(If "yes":)
- What was that like for you?
  - What did you hope for before you were let down?

(These questions relate to mirroring/idealizing needs)

15. What people or things are in your life that comfort you or help you to feel protected, when you are depressed or angry?
- Who are those people ?
  - What are those things?

(This question relates to idealizing needs)

16. What have been your experiences of being understood and/or misunderstood with a therapist?
- What feelings did you experience when that occurred?
  - Who or what helped you to cope with those feelings?

(This question relates to mirroring, idealizing and/or twinship needs. Selfobject needs are defined by the language used in the answers.)

17. In what ways did those feelings remind you of any other times when you had those same kind of feelings?

(This question relates to the link of frustration with parents or significant others in all three selfobject needs, including trust, protection and loss of empathy)

18. What are some of the ways you cope with feelings of being misunderstood?

(This question relates to mirroring needs for affirmation, and to self-coping strategies involved in internalized idealizing needs).

19. What are some of the people or things that you find a comfort now?

(idealizing needs)

- a. Describe the people or things that are most comforting to you.

(the answers to this can relate to either mirroring or idealizing needs; they could also relate to twinship if the answers suggest kinship and/or association to like-kind experiences)

20. What are some of the ways that you find you share something in common with other people?

a. Describe those people

b. Do you feel you are like them?

c. What do you feel you share in common with them?  
(Twinship issues).

21. What are some of the things you feel are important that we have not talked about?

22. What do you feel is important about your relapse that this interview has not covered?

23. What questions would you add to this interview, if you were talking to people?

24. Is there anything that we talked about during this interview that troubled you?

25. Is there anything that we talked about during this interview that you found helpful?

Closure:

We have finished our interview. I am very thankful for your help and the knowledge you have shared with me about your experience. As you know, your confidentiality is important and no names will be used in any way. You may want to know about the results of this research. If you do, you may let your therapist know that you want to receive a copy of the report on this. It will not be available for several months. But we will be sure that you receive a copy when it is done. Again, thank you for your help.



APPENDIX F  
INFORMED CONSENT FORM

INFORMED CONSENT FORM

I, \_\_\_\_\_, agree to participate in a research project conducted by Jeanne Engel as a part of her requirements for fulfilling the Doctorate in Social Work program at Loyola University of Chicago, School of Social Work. I understand that the purpose of the research is to gain a better understanding of the emotional needs of individuals who experience relapse into drug and alcohol use.

My participation will involve completing a set of three questionnaires which ask my feelings about myself, my most recent relapse, and my history of relapses. It is expected that my written participation may take up to one-half hour to complete. I also understand that I will participate in a one hour interview in order to further explain my responses about relapse experiences.

I understand that my participation in this study is voluntary. I may refuse to answer any particular question or at any point not complete the questionnaires. If I participate in the interview, I understand I can stop the interviewing at any time I choose.

I further understand that the information that I give is confidential. I understand that I can choose to give the researcher permission to contact my therapist about my responses, to help identify issues which have influenced my past relapses. I do not have to give my name or address on the questionnaires, and do not have to use my full name for the interviews. All the information used will be summarized in a manner in which no individual participant can be identified.

As a participant in research, I am aware that I may be asked about sensitive issues. If I experience any stirring up of emotions, I am aware I can discuss this with my therapist. I also understand that I may drop out of the study at any time and can discuss this with my therapist. However, there are no known risks to the participants in this research, beyond those mentioned above. If at any time I have questions about the research, I may contact the researcher at 708-369-3838.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I give permission to discuss any responses with my therapist:

\_\_\_\_\_ Yes \_\_\_\_\_ No  
Signature \_\_\_\_\_ Date \_\_\_\_\_

I give permission to tape record the interview:

\_\_\_\_\_ Yes \_\_\_\_\_ No  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Please return to: Jeanne M. Engel, LCSW/CADC  
1934 Hansom Court  
Naperville, Illinois 60565

APPENDIX G

CODEBOOK

CODEBOOK

CPAL	Use of alcohol for comfort and/or protection
CPD	Use of drugs for comfort and/or protection (drug)
CPP	Use of people for comfort and/or protection (alcohol)
DCAL +/-	Drug of choice: (+ = does use/- = does not use)
DCDR +/-	Drug of choice: (+ = does use/- = does not use)
DDR	Dual diagnosis reference
DUI	Arrest: Driving Under the Influence of an Intoxicating Substance
EEA+	Experience of empathic attunement
EEA-	Loss of empathic attunement
FLANG	Feeling: anger
FLANX	Feeling: anxious
FLBLA	Feeling: blame
FLDEN	Feeling: denial
FLDEP	Feeling: depression
FLDIS	Feeling: discouragement
FLFEA	Feeling: fear
FLGO	Feeling: good
FLNO	Inability to feel or to identify his/her feelings
FLWOR	Feeling: worthlessness
HOS	Hospitalization or request for help in treatment
IDEA	Idealizing need expressed
JOB	Job/work/profession/impact on job
LOFAM	Loss of family
LOJB	Loss of job
LOSR	Loss of self respect or shame
LOSO	Loss of significant other
LOGN	Loss, general statement of loss
LOTH	Loss related to threat to his/her own life
MIR	Mirroring need expressed (desire for affirmation)
MO+	Motivation (+ = readiness/willing to seek help/change)
MO-	Motivation (- = no motivation)
PHY	Physical state; change of physical health
PR	Participant response without significant data
RE	Relapse event description
REAL	Relapse event, specific to alcohol use
REDR	Relapse event, specific to drug use

REF	Reflection on a particular situation with insight
RQ	Research question
RR	Researcher's response
SEC	Secrecy with self, family, or others
SO	Period of sobriety; refers to a specific period in time
SOISO	Social Isolation
SSR+/-	Spiritual/religious reference as a support system
SSP+/-	Sobriety support person (+ = support; - = non-support)
SSG+/-	Sobriety support group (+ = support; - = non-support)
SST+/-	Sobriety support - thing (+ = support; - = non-support)
SUIA	Suicide attempt (ideation)
SUIG	Suicidal gesture (action against life)
SUIDTH	Suicide which is referred to, which ended in death
T	Twinship expressed
TALK	Talking to others, communication, as important to change
WI	Withdrawal symptoms in detoxification period

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