

A comparison of psychodynamic measures of level of oedipal functioning and of object relations in bulimic versus drug dependent women.

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Johannesburg

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This dissertation is dedicated to Gordon.

I hereby declare that this dissertation is my own work
and that I have not submitted it, nor any part of it,
for a degree at any other University.



Diana Aber

I hereby declare that this dissertation is my own work
and that I have not submitted it, nor any part of it,
for a degree at any other University.

A handwritten signature in dark ink, appearing to read 'D Aber', with a stylized, cursive flourish.

Diana Aber

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ABSTRACT.

The aim of this research was to examine whether drug dependent and bulimic women would have a similar psychodynamic makeup underlying their addictions. Three groups of women aged 16 to 26 years were selected for this study i.e. a drug dependant group, a bulimic group and a control group. The Thematic Apperception Test was administered to all the subjects and their stories were analysed for the presence of pre-oedipal indicators and for level of object relations. The results indicate that the drug dependent and bulimic women had significantly more pre-oedipal indicators and higher mutuality of autonomy scores than the control group, but that they did not differ significantly from each another. These findings, which suggest that drug dependent and bulimic women have significantly similar psychopathology, have implications for the nature of the treatment provided.

CHAPTER 1 :

INTRODUCTION AND CLARIFICATION OF TERMINOLOGY.

1.1. INTRODUCTION

The concept of addiction is well recognised and has been characterised by the use of such adjectives as compulsive, excessive, impulsive, uncontrolled and indulgent. The literature reviewed in this study establishes that on a behavioural level the addictions manifest in a similar manner. Familial studies indicate a high prevalence of bulimia nervosa in families with problems of drug dependency and vice versa. Co-morbidity studies illustrate a high incidence of substitution of one addiction with another. Despite the commonalities outlined in the literature, there appears to be an absence of empirical investigations exploring the reasons for the addictive pathologies manifesting in such a similar manner. Such commonalities could be understood from a number of different theoretical and etiological models such as genetic, biological, social, personality, familial, systems and cognitive models. Each theoretical explanation is a major focus in its own right and is therefore not within the scope of this study. The view taken in this study is that addictive pathology is due to a number of co-existing factors, but that to most comprehensively answer the question as to why the two pathologies manifest so similarly a psychodynamic explanation would be most useful (Frenkel, 1989).

It is the aim of this study to explore a psychodynamic understanding of the addictions of drug dependency and bulimia in young women, i.e., to secure an understanding of what the addictive symptom accomplishes intrapsychically for the sufferer. This study will concentrate on two specific psychodynamic factors, namely the subject's level of pre-oedipal/oedipal functioning and of object relatedness. The drug dependent and bulimic women will be compared to a control group of women who have neither disorder. The results of this study will bear implications for future treatment of the two disorders in terms of reducing the high risk of substitution and in terms of more cost effective treatment. Before embarking on the literature review it is necessary to clarify terminology central to this study.

1.2. CLARIFICATION OF TERMINOLOGY.

1.2.1. ADDICTIVE BEHAVIOUR.

The terminology used to label such behaviour as drug addiction, alcoholism, excessive eating, bulimia nervosa, pathological gambling etc. varies considerably amongst authors. It was asserted at one time that people who indulged in the consumption of a drug or engaged in some other form of activity to the point of social or physical damage were suffering from a form of mania such as dipsomania, narcotomania, cleptomania or pyromania (Stekel, 1924, cited in Orford, 1985). More recently, such

afflictions as uncontrolled drinking, drug taking, gambling, sex and eating were described as excessive appetites (Oxford, 1985). Similarly, Miller (1980) refers to problem drinking, drug abuse, obesity and cigarette smoking as the addictive behaviours.

Addictive behaviours are viewed as repetitive habits that increase the risk of disease and/or associated personal and social problems (Marlatt & Baer, 1988). These behaviours are often experienced subjectively as a loss of control, i.e., the habit continues to occur despite volitional attempts to abstain or to moderate use. These habits are typically characterised by immediate gratification (short term reward), and are often coupled with deleterious effects (long term costs). Attempts to change an addictive behaviour, via treatment or self-initiation, are typically marked by high relapse rates. Clinical observation of persons with addictive disorders reveals that such persons experience great difficulty with impulse control, deteriorated defences, psychic distress and fluctuating moods. For all the addictions, life revolves around the habit, distorting or replacing interpersonal relationships.

Historically, the major addictive behaviours such as excessive drinking, drug abuse, food abuse and cigarette smoking have been studied as separate entities (Miller, 1980). Currently a growing trend is emerging in which addictive behaviours are considered

as a single area of study, with several common underlying factors. The relationship of one addiction to another is considered to be important for the understanding of each addiction.

Orbach (1978) recognises the commonalities of food and drug addictions, and believes that to be a compulsive eater means to be a "food junky". She explains that compulsive eaters crave their food as badly as addicts crave heroin or an alcoholic craves liquor. Similarly, Saltzman (1972), (cited in Miller, 1980) believes that, as with drug addicts or alcoholics, individuals with severe manifestations of excessive eating are compulsively driven to eat by inner drives that they can neither understand nor control.

The question of the viability of "an addictive personality" continues to be raised in an attempt to define or characterise such persons who become locked into a world of addiction. Historically the concept of the addictive personality had its roots in the realms of psychoanalysis. According to Mirin (1984), the hallmarks of the addictive personality are excessive dependency needs, manipulateness, impulsivity and the inability to tolerate frustration.

To explore the nature of the addictive personality, Hatsukami, Owen, Pyle and Mitchell (1982), (cited in Mitchell, Hatsukami,

Pyle & Eckert, 1988) used personality measurement tests such as the MMPI. They noted certain similarities in the mean composite MMPI profiles of women with bulimia nervosa and those with drug abuse problems. Both groups were characterised by elevations on the 2 scale (depression), 4 scale (impulsivity), 7 scale (anxiety, rumination) and 8 scale (social withdrawal). However, Khantzian, Halliday and Mc Auliffe (1990) propose that there is no particular personality type or "addictive personality" but that certain sectors of vulnerability in personality organisation appear to play a part in predisposing individuals to addiction. Such predisposing factors such as sensation seeking and risk taking may be forerunners of addictive involvement.

Although addictive behaviour covers a large number of different habits, the focus of this study is on bulimia nervosa and drug addiction, both of which will be defined below.

1.2.2. BULIMIA NERVOSA.

Bulimia nervosa is an eating disorder in which there is rapid consumption of large amounts of food in a relatively short period of time. It is characterised by an awareness that the eating pattern is abnormal, by a fear of not being able to stop voluntarily and by depressed moods and self depreciating thoughts after bingeing (Butterfield & Leclair, 1988). The bingeing is accompanied by self induced vomiting, self restrictive diets

and/or abuse of diuretics or cathartics to lose or control weight.

Bruch (1974) views bulimia as an illness which concerns individuals who misuse the eating function in an effort to solve or camouflage problems of living. Welbourne and Purgold (1984) identify bulimia as a disease in which the sufferer is a compulsive eater who cannot restrain herself from bouts of stuffing. The purging is an attempt to rid herself of the fattening effects of the excessive eating.

Clinically, the bulimic presents with a compelling desire to be thin and a preoccupation with food. An abnormal eating pattern characterizes the bulimic person in that dieting deprives the individual of the desired food (usually high caloric food) which leads to a tendency to binge. This in turn leads to feared weight gain and thus to purging in an attempt to regulate weight (Kaye & Gwirtsman, 1985).

The clinical characteristics of bulimic women are quite different from those of anorexic women. Bulimic women tend to be more extroverted, impulsive, sexually experienced and prone to engage in behaviours such as stealing, drug abuse and suicide (Kaye & Gwirtsman, 1985). Bulimia can hence be seen as a disturbance in impulse control and can affect stability as well as result in abnormal eating habits.

Binge eating can be identified as a primary characteristic of bulimia. Binging periods tend to alternate with periods of fasting and very often normal eating patterns do not exist. Binging is seen to be a driven behaviour during which time the urge to eat is powerful, requiring great amounts of money, at times stealing and a deterioration of personal habits (eg. eating from other person's plates or from dustbins). The binging behaviour seems centrally to be aimed at tension relief. Binging is usually followed by vomiting or laxative abuse in an effort to eliminate the possibility of gaining weight. Depressed mood, low self esteem and guilt commonly follow such an episode. The element of depression, whether precipitating a binge following a binge or underlying the condition, is a regular feature of bulimic women (Agras, 1987; Hatsukami, Mitchell, Eckert & Pyle, 1986; Mirin, 1984).

The foregoing descriptions are reflected in the DSM III-R (1987, p.68.), which outlines the following diagnostic criteria for bulimia nervosa:

- A. Recurrent episodes of binge eating (rapid consumption of large amounts of food in a discrete period of time).
- B. A feeling of lack of control over eating behaviour during the eating binges.

- C. The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain.
- D. A minimum average of two binge eating episodes per week for at least three months;
- E. Persistent over concern with body shape and weight.

It is the view of many clinicians that bulimia nervosa was a relatively uncommon disorder prior to the 1980's. Agras (1987) reveals that in the Stanford Eating Disorders Clinic the annual number of bulimic patients did not exceed ten before 1979. Since the 1980's the case load has increased to some 200 patients annually - a clear example of the rapidly escalating problem in young women. Cooper and Fairburn (1983), (cited in Agras, 1987) examined women attending a family planning clinic in England. Results of their study were that 21% of these women reported binge eating episodes, 2.9% had used vomiting to control weight at one time or other, and 1.9% met the criteria for the diagnosis of bulimia. More recent studies continue to support the notion that binge eating, body dissatisfaction, and dieting are common in adolescence and young adult women. Timmerman, Lloyd, Wells, and Chen (1990) cite several studies which suggest that 1.3% to

5.0% of female college students fulfil the DSM III-R criteria for bulimia nervosa. The increasing prevalence of bulimia since the 1970's may be due in part to the increasing social pressure to be thin. Since only a small percentage of women respond to such social pressure one must assume that those who develop the disorder must be predisposed either biologically or psychologically to develop bulimia.

1.2.3. DRUG ADDICTION.

Drug addiction may be defined as habitual non- medical substance seeking and substance taking behaviour which is resistant to extinction or suppression (Wikler, 1971, cited in Alterman, 1985). The concept of drug dependence (which term will be used interchangeably with addiction) is a complex one involving an interaction of biogenic, neuro-chemical and psychological factors (De Miranda, 1987).

The process of dependence entails an uncontrolled urge to satisfy a need and can be said to exist as a result of repetitive use of the chemical substance. There is impairment of functioning (physical and/or emotional and/or social) of the affected individual. The biochemical component is most commonly the development of tolerance to the drug with a resultant withdrawal syndrome should the drug be discontinued. Tolerance, a sign of physical dependence, occurs when over a period of time the person requires larger and larger quantities of the drug in order to

experience the desired effect. Should this greater quantity of the drug be unobtainable and the drug supply stopped, a withdrawal syndrome will result. This withdrawal syndrome will be accompanied by a number of physiological and psychological symptoms such as a runny nose, watering eyes, diarrhoea, vomiting, fever, agitation and depression (Miller, 1980). Withdrawal symptoms vary in accordance with the type of drug abused and the severity of dependence.

The emotional and behavioral component most regularly seen and expressed is the craving, i.e. the uncontrolled urge for the drug. Craving can be viewed as a subjective experience and is often a frequent antecedent of relapse (Miller, 1980).

In the process of addiction a reinforcing pattern emerges whereby the drug taking rewards the user by reducing his or her tension, or by producing a more positive feeling of euphoria or perhaps improved perceptions or illusions. With each subsequent reward following the use of the drug, the drug seeking habit is reinforced. This reinforcement becomes psychological and pharmacological in nature (Glatt, 1974).

De Miranda (1987) believes that once true dependence/addiction has developed, the drugs of choice will dominate the person's existence, and efforts to become independent of the drug will be

extremely difficult. The illness is then fatal and progressive if not treated.

The DSM III-R (1987, p.167) outlines the following diagnostic criteria for psychoactive substance dependence:

A. At least three of the following:

- (1) substance often taken in large amounts or over a longer period than the person intended
- (2) persistent desire or one or more unsuccessful efforts to cut down or control substance use
- (3) a great deal of time spent in activities necessary to get the substance, (e.g. theft), taking a substance (e.g. chain smoking), or recovering from its effects
- (4) frequent intoxication or withdrawal symptoms when expected to fulfil major role obligations at work, school or home (e.g. does not go to work because hung over, goes to school or work "high", intoxicated while taking care of his or her children), or when a substance use is typically hazardous, (e.g. drives when intoxicated)

- (5) important social, occupational, or recreational activities given up or reduced because of substance use
- (6) continued substance use despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by the use of the substance (e.g. keeps using heroin despite family arguments about it, cocaine induced depression, or having an ulcer made worse by drinking)
- (7) marked tolerance: need for markedly increased amounts of the substance (i.e., at least 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount.

NOTE: The following items may not apply to cannabis, hallucinogens or phencyclidine (PCP).

- (8) Characteristic withdrawal symptoms
- (9) substance often taken to relieve or avoid withdrawal symptoms.

- B. Some symptoms of the disturbance have persisted for at least one month or have occurred repetitively over a longer period of time.

The severity of psychoactive substance dependence varies and may be classified as mild, moderate, severe, in partial remission, or in full remission.

Drug addiction has been a concern for many centuries. Mind altering substances have been used as part of rituals, cultural gatherings and for medicinal and recreational purposes. During the 1960's, the abuse of drugs escalated and has continued to increase since then. Today the extent of the drug problem world wide is alarming. In the U.S. there are an estimated five million users of cocaine, 20 million persons smoke marijuana and there are half a million heroin addicts. In Britain there are 60000 users of heroin, cocaine and amphetamines (Searll, 1989). Although statistics for the South African population are not available, there is a growing awareness that, as with other parts of the world, in South Africa drug abuse is a problem of epidemic proportions (Van der Westhuizen & Fourie, 1988). The drug abuse problem is such that " more than 40000 people are arrested annually in South Africa for drug related offenses" (De Miranda, 1987, p.5).

1.2.4. PRE-OEDIPAL FIXATION

Viewed from a Freudian perspective, persons pass through a number of psycho-sexual phases of development, i.e., oral, anal, phallic, latency and genital. Should a person not deal adequately with the expectations of a particular phase, he or she will become fixated there.

A number of features are characteristic of persons who are fixated at a pre-oedipal level of functioning (Bellak, 1986). Such features would include: panic reaction when signal anxiety is appropriate, primitive splitting, denial, part-object experience and perception rather than whole-object experience and perception, unstable internal objects or lack of internal objects, a split in the superego of 'all good' and 'all bad' constructs, extreme affect states, the experience of shame and humiliation, introjective or projective relatedness, fragmentation rather than disintegration, acting and reacting instead of self-observation and self-monitoring, defenses of incorporation and introjection and an inability to delay gratification. The method of identifying these abovementioned features on the Thematic Apperception Test is outlined in Appendix B. A discussion of how these features relate to addiction is discussed in Chapter 2.

1.2.5. MUTUALITY OF AUTONOMY.

Mutuality of autonomy is a term used to describe the level of a person's object relatedness. Mutuality of Autonomy is defined as:

The degree to which people in relationships are conceived of, by the subject, as psychologically autonomous: as possessing an enduring, inherent psychic existence. The subject experiences others as possessing a self, while at the same time objectively recognising his or her own existence as one object among many. Both self and other are simultaneously experienced by the subject as possessing an identity, a will, and the subjective, affective experience of selfhood. The subject conceives of relationships as respecting these attributes independently of fluctuations in the need state of either one's self or of the other individual within the relationship.

(Urist & Shill 1982, p.451).

mutuality of autonomy rating scale delineates the developmental continuum of object relatedness from primary narcissism to empathic object relatedness (Urist, 1977).

This chapter has defined the central concepts of addictive behaviour, bulimia nervosa, drug addiction, pre-oedipal fixation

and mutuality of autonomy. Despite the fact that bulimia nervosa and drug dependency exist as distinct conditions under different diagnostic categories in the DSM III-R, many of the diagnostic criteria of the two conditions are similar. Such common diagnostic criteria include the sense of loss of control, the recurrent repetitive nature of both behaviours, and the preoccupation of the individual with his or her symptoms. The literature review which follows examines common issues in addictive disorders (see section 2.1.). The concepts of pre-oedipal fixation and mutuality of autonomy introduced in this chapter are discussed in greater detail in the literature review (see section 2.2.), where issues of drive theory and object relations in addictions are examined.

CHAPTER 2:

LITERATURE REVIEW.

2.1.COMMON ISSUES IN ADDICTIVE DISORDERS.

Addictive disorders present with a number of common issues which can be explored in terms of behavioral commonalities, familial manifestations and co-morbidity of one addiction with another.

2.1.1.BEHAVIOURAL COMMONALITIES OF ADDICTION.

Many similarities exist in the behavioural manifestations of addictions. The parallels between bulimia nervosa and substance abuse include such issues as the loss of control, the increase in dosage, habituation and state dependent learning (Jager, Liedtke, Kunsebeck, & Seide et al., 1991) [sic.]

Mitchell, Pyle, Eckert and Hatsukami (1990) noted similarities between the problems of bulimia nervosa and drug dependency in that both involved misuse of a substance, craving the substance, and using the substance for a mood altering effect or as a way of coping and avoidance. Both involved repetitive attempts to gain control of usage, and resulted in financial, physical and psychological problems.

Miller (1980) cited what he believed to be the most important similarity between the addictive disorders, namely, that all involve some form of indulgence for short term pleasure or satisfaction at the expense of longer term adverse reactions. This is indeed the case of many food abusers, who are described by Wardle and Beinart (1981), (cited in Orford, 1985, p.78) as individuals who "episodically consume enormous amounts of food in short periods of time in an orgiastic manner and who experience guilt, shame, depression, self condemnation following binges." Similarly for the drug or alcohol abusers the short term gratification may be referred to as a high, a rush, a trip, a release or a relief- a term used to describe the pleasurable feeling after taking the drug. The long term negative consequences are apparent in the deterioration of quality of functioning in important life areas such as health, vocation and social relations (Levison, Gersten & Maloff, 1983).

A further common factor experienced in the addictions is that relapses of drinking, drugging or eating binges are triggered by emotional stress or a feeling of inability to cope with environmental demands. The two most common triggers for binges are emotional stress and the ingestion of small amounts of forbidden food (Orford, 1985). Results of a study by Marlatt and Gordon (1980), (cited in Miller, 1980) examining situational and emotional states of drug and alcohol abuse, has shown that at least 72% of relapses were triggered by emotional stress.

Hamburger (1951), (cited in Orford, 1985) noted that the addictions involve a sense of loss of control and urgency regarding intake. Patients with eating disturbances crave food as an alcoholic craves drink or an addict craves drugs. Bruch (1974), (cited in Orford 1985, p.82.) quoted a typical expression used by her client: "I get this gnawing feeling and nothing can change it but a luscious meal." Similarly, the drug or alcohol abuser craves relief through substance use and will go to great lengths to satisfy this urge.

Another similarity is the fact that a woman's expression of sexuality is inextricably related to her addictive disorder (Fuerstein, 1989). Gomez (1986) believes that in both eating disorders and alcohol abuse, persons are absolved from sexual responsibility.

A further common thread running through these addictive behaviours is the fact that when a person cannot engage in his or her preferred form of addiction, another behavioural excess may be substituted. Substitution involves the reciprocity of abuse substances, in that change in the pattern of use of one substance frequently results in accompanying change in the pattern of use of another (Miller 1980). This concept of substitution has important implications when treating individuals for addiction. This is evident, for example in the danger for a person who discontinues the use of narcotic drugs and begins

abusing alcohol or food or reduces food intake by substituting food with appetite suppressant drugs, (the pattern frequently seen in food abusers).

Glatt (1974) proposes that many alcoholics begin to drink large amounts of sweetened tea or coffee and to eat chocolates and sweets which often they had disliked previously when they were practising alcoholics, i.e. they substitute new excessive eating habits in place of their alcohol addiction. Similarly Orford (1985, p.82), in describing a bulimic patient, states that: "She was afraid to take a cocktail for fear her compulsion would switch from food to alcohol."

Miller (1980) believes that for both eating disorders and drug or alcohol abuse disorders prognosis is poor. He feels that permanent remission has been the exception and short term recovery with proximal relapse the rule. Substance abusers are all at risk in terms of the serious physical and psychological health hazards the abused substances result in. Combined use of these substances adds to the health problem.

In addition to the outlined behavioural commonalities, there exists a high rate of co-morbid addiction and significant family histories of other addictive disorders.

2.1.2. FAMILIAL HISTORY .

Several studies (Bulik, 1987; Mitchell et al. 1988; Vaneslow, Dennerstein, Armstrong & Lockie, 1991) have documented high rates of familial psychoactive substance abuse in family members of patients with bulimia nervosa. There is also a high frequency of major depression in first degree biological relatives of people with bulimia nervosa (Agras 1987). Bulik (1987) proposes that bulimia is, both in combination with other addictions and in its pure form, an alternative expression of a genetic disposition.

Bulik (1987) compared 35 bulimic women with 35 control subjects. He found that alcoholism was the most commonly reported diagnosis for bulimics' first and second degree relatives with 60% of the bulimic sample reporting at least one relative with alcoholism. The control subjects reported a mere 20%.

Hudson et al. (1987), (cited in Mitchell et al. 1988) demonstrate a significantly elevated morbid risk for alcohol abuse and dependence in first degree relatives of patients with bulimia nervosa as controls. Mitchell et al. (1988) examined the outcome of bulimic patients with and without a family history of drug abuse. The results of this report showed that bulimic persons with a positive family history of addiction were more likely to experience drug abuse problems themselves than were those with no family history of addiction. Many of the women with positive

family histories of addiction had been treated for chemical dependency prior to being diagnosed as having an eating disorder.

Vanselow et al. (1991, p.1267) reported on the differences in family psychiatric history of alcohol and drug abuse in bulimic women and stated that: "Bulimic women with co-morbid alcohol abuse or dependence were more likely to have a family member with a psychoactive substance use disorder."

It has been suggested that bulimia nervosa is an expression of a more generalised substance abuse pattern. Bulimia offers a type of compensatory adaptation to dysphoric moods which is similar to that found with persons who abuse drugs and alcohol (Timmerman et al 1989).

2.1.3. CO-MORBIDITY.

The co-morbidity of bulimia nervosa and other forms of drug abuse or dependence is well documented. Russell (1979), (cited in Mitchell, 1990) was a pioneer in the discovery of the high propensity of bulimia nervosa in patients who abuse drugs. Mitchell et al. (1990), in their 1985 report, stated that of 275 out-patient women with bulimia, 34.4% reported a history of having had "problems" with alcohol or other drugs; 23% reported a history of alcohol or drug abuse and 17.7% had previously been in chemical dependency treatment programmes. Similarly Bulik

(1987), in his comparison of bulimic women with control subjects, found that 49% of bulimic women as against 8.6% of control subjects met the DSM III criteria for alcohol abuse.

Stern et al. (1984), (cited in Peveler & Fairburn, 1990) studied 27 patients with a DSM III diagnosis of bulimia and found substance abuse disorders in 30% compared to only 4% of a matched control group without an eating disorder. Beary, Lacey and Merry (1986) provide further support for the strong correspondence of the eating and substance abusing disorders. Their study proposed a 50% chance of bulimic women abusing or excessively using alcohol by the time they were 35 years old.

Lacey and Moureli (1986) conducted a study on 27 alcoholic women with regard to their eating and drinking behaviour. Forty percent of these women gave either a past or present history of major binge eating. Similarities of binge eating behaviour and bout drinking in alcoholics were that both involved an intermittent loss of control and feelings of compulsion. Both behaviours were seen to be an attempt to reduce anxiety about interpersonal problems. Further, there was similarity regarding maintenance factors. These reasons included the manner of dealing with unpleasant emotional states, particularly anger and frustration, and a method of dealing with loneliness and boredom.

The pattern which emerged from the study was that these women began with food abuse, but found it insufficient to deal with their needs and moved to alcohol later as part of a general maladaptive response to their personality difficulties. The results of this study were replicated by Peveler et al. (1990). Abuse of several different substances is not uncommon in those diagnosed as bulimic. Fahy and Treasure (1991) reported case studies of three bulimic women who abused caffeine for its appetite suppressant, diuretic and stimulant effects. Mitchell, Pyle and Fletcher (1991) reported that 65.8% of his bulimic population had tried diet pills and 18.4% had used them regularly for at least one year. A case of gross thyroid hormone abuse for purposes of slimming was reported by Woodside, Walfish and Kennedy (1991). Similarly weight control has been attempted by diabetic women by intentionally omitting or reducing insulin dosage (Fornari, Edleman & Katz, 1990).

The high percentage of drug or medication abuse in bulimic women has prompted Fornari et al. (1990) to propose that the DSM III-R diagnostic criteria for bulimia nervosa be formally expanded to include manipulation or abuse of medications that affect weight. They saw this medication misuse as diagnostically equivalent to purging or fasting as a means of weight control. Fornari et al. (1990) identified three major methods of medication manipulation namely, prescribed medication which is

misused, non-prescribed medication which is obtained and then misused, and use of illegal substances.

Although broader diagnostic criteria for drug or medication abuse have been proposed by Fornari et al. (1990) the use of laxatives or diuretic abuse has been listed as one of the criteria. A study cited in Waller, Newton, Hardy and Svetlik (1990) found an association between laxative abuse and other self-destructive behaviours.

Most of the previously mentioned studies have highlighted the strong prevalence of substance or medication abuse in bulimic women. The prevalence of eating disorder pathology in drug dependent women is equally significant. Jonas, Gold, Sweeny and Pottash (1987) surveyed 259 cocaine abusers and found that 32% met DSM III criteria for anorexia nervosa, bulimia or both disorders. Peveler et al. (1990) administered the self report measure of clinical features of eating disorders to women attending an alcohol treatment unit. The results of this study indicated that 36% of their sample reported binge eating, 26% fulfilled diagnostic criteria for a probable current clinical eating disorder and 19% had a probable history of anorexia nervosa. Mitchell et al. (1990) reported results of their studies which led them to conclude that there is a high rate of prior alcohol and drug abuse problems in women who present for

treatment with bulimia nervosa. The co-morbidity for eating disorders and drug/alcohol dependency is clearly apparent.

Having outlined the behavioural and familial commonalities of addiction as well as the concept of co-morbidity, the focus of the literature review will be to endeavour to explore why such commonalities exist.

2.2. A PSYCHODYNAMIC APPROACH TO ADDICTION

2.2.1. OVERVIEW.

The earliest psychoanalytic insight into addiction was that of Freud (cited in Milkman and Shaffer, 1985) who felt that masturbation was "the primary addiction" and that all other addictions in life entered as a substitute or replacement for it. Freud's concepts were taken up, developed and diverged from in the years following the first world war. Instead of examining issues of primary process, the unconscious and the development of symptoms, aspects of human relationships which influenced character development and the development of symptoms entered the psychological limelight. Increased interest in the agency responsible for repression and other defences eventually led to the emergence of ego psychology. Concurrent developments by Ferenczi revealed the importance of focusing on the therapeutic relationship, and meanwhile the concept of object relations analysis became important (Mitchell, 1986).

With the development and expansion of earlier Freudian notions, the pre-oedipal period and the significance of the primary caregiver-infant relationship began to assume the psychological importance it deserved.

The salient features of pre-oedipal functioning (see Appendix B), and the aspects relevant to the level of mutuality of autonomy (see Appendix C) are integrated into the discussion which follows. Despite the notion that the development of psychosexual functioning and object relations are concurrent, for purposes of clarity these two aspects are initially explored individually in the literature review. Thereafter the literature review applies an integrated approach whereby the indivisibility of a psychosexual and object relations understanding of addiction is discussed (see section 2.2.4.).

2.2.2. ADDICTION: A PSYCHOSEXUAL PERSPECTIVE.

It was Freud who proposed the notion of phases of psychosexual development, i.e., the oral, anal, phallic, latency and genital phase. Individuals who became fixated at a particular phase reflected a conflict inherent in that fixation. Development of Freud's ideas were made by Abraham (1927) who explored the significance of the early oral and anal experiences. It was Abraham (1927) who comprehensively described an oral character (Mitchell, 1986). Both Freud and Abraham suggested that those

with an oral character type would adopt unusual use of oral channels for gratification (Levine, 1981).

Anna Freud (1969) expanded on the notion of addiction being related to a fixation at the oral phase of development. Her concept of Developmental Lines is particularly important to an understanding of the addictive syndrome. Children go through a sequence of libidinal phases (oral, anal, phallic, latency period, pre-adolescence, and adolescent genitality). This sequence leads the infant from utter dependency to emotional self reliance and adult object relations. Other concurrent developmental sequences take place, of which the move from suckling to rational eating (as one aspect of body independence) is of particular note in the discussion of addictive illness. Regression is seen as a common and normal aspect in the developmental lines. Such regression involves part of the drive energy which becomes tied to earlier aims and objects and as such creates fixation points - such a fixation may be of a pre-oedipal dependent nature.

It is seen in the addictions that there is an exaggeration of what could be termed normal tendencies, which accounts for the pathological behaviour. One finds in some children an unusual greed for sweets and other concrete objects, which is similar to that seen in the addictive behaviours.

These children who feel an overwhelming craving for sweets, use the satisfaction of the craving as an antidote against anxiety, deprivation, frustration, depression, etc, as adults do, and, also as adults do, will go to any length, i.e lie or steal, to secure possession of the desired substance.

(Freud, 1969, p.201).

The roots of such behaviour are due to unsatisfied or over stimulated desires of the oral phase. Commonly, in adulthood or adolescence, these wishes for sweets are displaced to other more potentially harmful or less harmful media. This is a less complex process than that seen in adult addiction.

For the adult addict the craved for substance represents not only an object or matter which is good, helpful and strengthening, as a sweet is for the child, but one which is simultaneously also felt to be injurious, overpowering, weakening, emasculating, castrating, as excessive alcohol or drugs actually are.

(Freud, 1969, p.202).

The complex relationship or attitude towards food reveals a possible fixation at the oral phase. More recent psychoanalytically based views on alcoholism, based upon Freud's

psychodynamic theory of personality development, continue to emphasize fixation at the oral phase of psycho-sexual development as being a major causal factor of abuse of substances. Dysfunctional interaction between mother and child which frustrate or over-satisfy the child's dependency needs are viewed as a source of the conflict. The dependency problem has its roots in the early phases of development and tends to manifest as substance dependence problems later in life. Dependency upon alcohol develops to relieve the emotional conflict (Scatura, 1987)

Fuerstein (1989) believes that oral dependency conflict is central to a psychoanalytic understanding of addictive illness. By oral dependency conflict Fuerstein (1989, p.170) means "an anxiety provoking fantasy to regress from the oedipal level and/or to more fully experienced feelings associated with the pre-oedipal developmental stage". Such fantasies would include wishes to suck, chew or bite at the breast or would represent the person's desire to be held, fed, comforted or engulfed by a maternal object (Laplanche & Pontalis, 1973, cited in Fuerstein 1989).

Fuerstein (1989) suggests that males and females do employ gender linked differences around dependency issues. Females tend to state their dependency wishes more directly and the defence

employed against these wishes has a greater transparent quality. A larger proportion of female patients use food as a vehicle of defence (i.e. repression, denial or displacement) against primitive types of anxiety around dependency. This acting out may take the form of overeating, undereating or a combination. Men however, tend to employ alcohol abuse and sexualisation in the service of a defence against similar types of anxiety. Fuerstein (1989) however finds that intermittent drug use and tobacco smoking seem less gender related and are employed by members of both sexes in comparable proportions.

Freud (1924) terms the phase of exclusive attachment to the mother, the pre-oedipal phase. The pre-oedipal child has not yet negotiated the oedipus complex. The pre-oedipal/oedipal negotiation is somewhat different for the girl than the boy, requiring two extra tasks, i.e. a change in erotogenic zone and secondarily a change from the first object, namely the mother, to that expected in the oedipal situation i.e. the father. Freud (1924) proposed that the girl is less motivated than the boy to leave the mother and hence disrupt the infantile genital organisation (Fuerstein, 1988). It is for this reason that the task of becoming a separate individual is seen to be more difficult for girls than boys and is associated with much ambivalence towards the mother. With regard to issues of gender identity, the girl needs to positively identify with the

mother/primary object's feminine qualities, while at the same time moving to the father as a primary object. From him she receives positive encouragement about her femininity. Furerstein (1989) proposes that a girl might employ food and eating as a defence against an oral dependency wish. Other forms of addiction may be seen as a displacement of the original object, i.e food, but serving the same function.

A woman's expression of her sexuality is closely related to her addictive disorder. Many women who have eating disorders perceive there to be a major association between their eating habits and their sexuality e.g. "often I used to go out and eat for my sensual sexual experience for the day. I actually would be turned on by it" (Abraham, 1984, cited in Orbach, 1978).

Fixation at a particular stage of psychosexual development has repercussions for one's general psychosexual development and therefore for sexuality. Those persons who become drug addicts tend to prefer the pleasure obtained from the drug to sexual pleasure. As a result, because of its superiority as a substitute, genital pleasure becomes unnecessary (Milkman and Shaffer, 1985). The universe of real objects from whom genital pleasure might be obtained is no longer of interest to the addict. A most striking feature of drug elation is the extraordinary elation in self regard. In the drug elation narcissistic and erotic satisfaction coincide. The regression

probably extends back to a time where there was no distinction between satisfying self regard and satisfying erotic needs (i.e. the time of nursing). A fixation that is pre-genital and probably oral-narcissistic determines whether, after ingestion of the drug, there will be a wish for repeated episodes of elation and consequent addiction.

2.2.3. ADDICTION: AN OBJECT RELATIONS PERSPECTIVE.

Unfortunately the terms "object relations theory" does not have a commonly agreed upon definition. Object relations theory may be described as a theory which is

Concerned with exploring the relationship between the real, external people and internal images and residues of relationships with them, and the significance of these residues for psychic functioning.

(Mitchell, 1983, cited in Kramer & Akhtar, 1988, p.547).

Kramer and Akhtar (1988) propose, following an examination of Kernberg's definitions, that the term object relations theory should be employed to designate an approach which examines the sequence of internalisation of the dyadic object relations that lead to the consolidation of the psychic apparatus and its functions. The theoretical approach should be a focused psychoanalytic one. In a similar vein, Bornstein, Leone and Galley (1988) view object relations theory as a theory which

regards internalised self-and-object-representations as fundamental determinants of later personality dynamics.

Psychoanalytic theorists have proposed object relations disturbances as an important precipitant of eating disorders, with the relationship to food seen as a manifestation of the relationship with the object. Bulimia can be understood as a simultaneous enactment of conflicting wishes for merger and autonomy (Becker, Bell, & Billington, 1987). Furerstein (1989) believed that acting out with food, alcohol and sex all have a common theme of requiring ingestion (or incorporation) of the symbolic breast-mother.

Klein (cited in Mitchell, 1986), was one of the pioneers of child analysis. She based her theory firmly on the Freudian concepts, while focusing a new light on early infantile object relations. It was Klein who first conceptualised the child's internal object world as organised around internal object relations. Klein emphasized the influence of the child's endowment and his/her subjective response to the mother as central to the child's development. According to Kleinian theory, in the early stages of normal ego development, the child's internal experience of other people and him or herself is split primarily into all-good or all-bad, 'part objects' representations (Humphrey & Stern, 1988). Due to the child's fear that the bad will in some way destroy the good, he or she utilises defence mechanisms to

protect the early ego against primary anxiety, primitive regression and possible disintegration. Children are unable to develop beyond the stage of part-object relations and as a result, remain greatly dependent on others for their emotional survival (Humphrey & Stern, 1988).

Dana and Lawrence (1988) in their readings of Klein, propose that in an attempt to keep the good and bad separate, the bulimic person begins to use the defence of splitting. She uses the defence of splitting in order to maintain her sense of goodness. She projects into the symptom of bulimia everything which is bad within herself. This enables the good breast, i.e. the idealised mother, to be preserved and kept separate from the alienating badness.

Recent psychoanalytic theorists have emphasized impairments in ego functioning, lack of affect tolerance and affect regression, and the use of primitive (borderline) defence mechanisms. Kernberg (1975), (cited in Rinsley, 1982) delineated four stages in the development of object relations. His first stage represents that of an undifferentiated matrix. In stage two, self and objects are not differentiated but the self-object representation may be negatively or positively experienced. Stage three results in endopsychic structures due to differentiation of self and object representations. The fourth stage involves integration of positive and negative self and

object representations. Successful integration results in a stable self representation and in object constancy. Fixation at either of the first two stages results in psychosis. Fixation at the third stage or regression to it results in borderline pathology. They have poor interpersonal relationships, poor impulse control and use characteristically primitive defences. They have failed to integrate 'the good' with 'the bad'. Many afflicted persons regress to or were fixated at this stage of development.

Winnicott (cited in Humphrey and Stern, 1988) places emphasis on the early nurturance experience of the infant. Winnicott's concept of the holding environment is a particularly important object relations construct, referring to the nature of the dyadic relationship between the mother and child. Early failure to provide such a holding environment, and to provide the child with a 'good enough' mother in a child's first few years, can explain certain deficits and distortions of the ego found in character disorders.

Nurturance is a fundamental element of the early mother-infant holding environment. Humphrey and Stern (1988) propose that the early nurturance in bulimic families is faulty, leading to an emotional hunger and a sense of deprivation and neediness which

compels the bulimic person to binge eat to fill that emptiness. Failure in the early holding environment is commonly accompanied by inadequate and inconsistent soothing and tension regulation when the child is distressed. The result is a chronic deficiency of the ego or self to regulate mood, tension and self-esteem.

Management and acceptance of internal states appear to be faulty in the bulimic family resulting in an over-controlled or under-controlled pattern. Humphrey and Stern (1988) propose that fathers (of bulimic women) are typically under-controlled and that they are orientated towards immediate gratification; they impulsively act out and they use external, artificial means such as alcohol and drugs to regulate tension.

Similarly for drug addicts there have been experiences of insufficient caring and protective functions of early caregivers. The result is that addictive persons lack a sense of self worth and the ability to receive comfort or nurturance from within. They therefore rely on others or drugs to provide them with a sense of worth. They are unable to fulfil their needs and as a result they are inconsistent, alternating between seductive and manipulative attitudes to extract satisfaction from the environment and contemptuous attitudes of independence and self sufficiency that dismiss the needs of others (Milkman & Shaffer, 1985). This style of relating obviously has repercussions for the quality of their interpersonal relationships.

Another significant factor in the early environment of bulimic women is the failed empathy and affirmation of the child as a separate identity. In order for the child to exist as a separate person, the mother has to respond adequately to the child's spontaneous gestures to separate. All too often in bulimic families there is a negative response to the child's behaviour; the child's separate self is criticised, ignored, or enlisted in meeting the parents' needs. Thus, there is no cohesive sense of selfdeveloped.

The issue of separateness is central to Mahler's (cited in Kramer and Akhtar, 1988) theory of symbiosis/separation-individuation. Mahler's work, which involved the observation of normally developing infants and toddlers, led her to identify normal phases in the process of development. During the initial phase, infants experience the self and mother as one, i.e. as a dyad unit which represents the state of fusion in which 'I' has not yet been differentiated from 'not I'. The child then moves to the symbiotic phase which is the origin of the sense of self. Mahler suggests that the child develops a benevolent feeling about the self and towards the object, and that this phase contains the origins of infantile fantasies of omnipotence shared with the mother. The child then moves to the separation-individuation process which has four sub-phases: differentiation, practising, rapprochement and that of being 'on the road to object constancy'. The differentiation sub-phase takes place

from approximately the fifth to ninth month, during which some effort and energy is directed towards the outside of the self-mother dyad. The practising sub-phase (approximately ninth to sixteenth month) is characterized by an exploring exuberant child who can distance him or herself from the mother for periods of time as long as she is available for moments of 'emotional refuelling'. The rapprochement sub-phase is characterized by much ambivalence and at times negativistic regression as the child is burdened by intrapsychic conflict with the co-existing need for closeness (at times merging with mother) and the conflicting desire for separateness and autonomy. The final sub-phase sees the child on the road to self and object constancy. Successful negotiation of this phase leads to increasing integration of both self and object representations. This integration permits healing of earlier splits between 'good' and 'bad' self-representations and 'good' and 'bad' object representations (Kramer & Akhtar, 1988). A further important development during this phase is that of object constancy. The disengagement from the first dyadic relationship prepares the child for negotiation of the oedipal relationship.

Mahler's theory highlights the importance of successful transition through these stages, and assists in the understanding of the aspects of failure seen in character pathology commonly underlying addiction.

Milkman and Shaffer (1985) suggest that failure to consolidate a separate image of the self from the mother in infancy may provoke the adult usage of drugs. In the second year of life separation-individuation requires the presence of a permissive yet protective figure. If unavailable, the individual may fail to develop an ability to channel aggression, hence the addict relies on drugs for a safe merger with an omnipotent object.

Failed nurturant support during the rapprochement phase results in a sense of fragmented self, impaired self esteem, impulsivity and depression, which are temporarily relieved by drugs.

Drugs simultaneously represent the ambivalently held object and provide a sense of satisfaction and an outlet for sadistic and masochistic components of unresolved rage.

(Milkman & Shaffer, 1988, p.32).

The addicted individual commonly has failed to develop object constancy and, hence, ego functions such as reality testing and impulse control are faulty. The addicted person has been unable to become independent from the mother and mourn this loss. As a result, addicts defend against such potential feelings of loss or separation by blanking out their reality with drugs.

Dana and Lawrence (1988) have worked extensively in the area of eating disorders with women, and have based much of their understanding of the bulimic syndrome on the work of Guntrip, who recognises the importance of the nature of the early mother-daughter relationship in the development of bulimic pathology. Guntrip (as cited in Dana & Lawrence, 1988, p.80) states, "The situation which calls out the reaction is that of being faced with a desired but deserting object."

In terms of the bulimic pathology, the conflict is acted out over food in that the girl who is hungry/needy is unable to fulfil this need and ends up rejecting both the food (via vomiting) and other people (through avoidance or rejection of intimacy). Her early experience of being faced with a desired yet unreliable object leads her to rapidly consume excessive amounts only to then deny this hunger to herself by then purging. The bulimic person feels she is not able to get enough and hence she develops an attitude which is 'incorporative'. Her aim is to get something inside herself where she cannot be robbed of it as she has no confidence about being given enough (Dana & Lawrence, 1988). Somehow in the process or experience of early feeding, the totally dependent baby has developed a need to consume the whole breast as the unreliability of the feeding has made the baby want to ensure that it cannot be taken away. As it no longer feels adequate taking in from the breast, the impulse has

changed into an omnivorous urge to take in the whole breast itself (Dana & Lawrence, 1988).

The woman's early experiences of feeding lead to her maladjusted reaction to food and relationships in later life. Typically, the bulimic woman develops troublesome interpersonal problems as she not only wants to possess or devour her object, but she also experiences enormous anxiety that the devoured object will hence be destroyed and be unable to exist as a source of love, which she is so desperately seeking. Her response to this is often to satisfy the urge in her symptom of excessive food consumption and to somehow withdraw from the world of real interaction. In this way she keeps people away from her experienced destructiveness and yet satisfies the oral-sadistic urge in secret. She has to split off and deny an extremely vulnerable or needy part of herself. The bulimic symptom represents the split-off part of herself.

In a similar sense, drug addicts have experienced an absence of a pleasurable maternal object, or have experienced problems in mother infant interaction. Drug addicts therefore abuse drugs as they facilitate homeostatic regulation or substitute for human attachment (Milkman & Shaffer, 1985).

2.2.4. THE INDIVISIBILITY OF A PSYCHOSEXUAL AND AN OBJECT
RELATIONS UNDERSTANDING OF ADDICTION.

Spruiell (1988) proposes an indivisibility of Freudian object relations and drive theories. He offers through presentation of case studies, an illustration of Freudian object relations theory simultaneously at work with Freudian drive theory. Spruiell (1988, p.597), in relation to the illustrated case history, states:

... the psychoanalytic theory of the ego (both as abstraction for structure and as self) and its object relations, and the psychoanalytic theory of drugs, together became the figure of the gestalt.

The other point of view of the metapsychology - structural, economic, dynamic, genetic and adaptational - serve as the ground of the gestalt. These ways of looking at analytic events are on differing levels of abstraction and relate to each other in overlapping ways. They are all ways of conceiving some of the facets of one unity (Spruiell, 1988).

Similarly, other writers, Blatt (1974), and Bornstein, Leone and Galley, (1988), highlight the importance of a gestalt approach to the psychodynamic understanding of development. Bornstein et al. (1988) posit that self and object representations formed during the oral stage have a profound influence on later object relations, attitudes and interpersonal behaviour.

Because the formation of self-and-object-representations takes place during the first year of life (Mahler 1967, Spitz 1965), research in this area provides a potential link between psychoanalytic formulations regarding the psycho-sexual development - especially oral dependency - and predictions derived from the object relations perspective.

(Bornstein et al. 1988, p.648).

Kramer and Akhtar (1988) suggest that Mahler's theory (of the phases of symbiosis and separation - individuation) demonstrates the unity of drive, ego and object relation psychology and is totally compatible with the theory of pre-genital drives, thus dovetailing with classic oedipal theory. The nature, adequacy and outcome of both the symbiotic phase and separation-individuation process have profound effects on the fate and shape of the oedipus complex.

Rado (1926) (cited in Milkman & Shaffer, 1985) was instrumental in turning theorists' attention away from exclusively libidinal considerations to the focus on a development of affect, ego and defence. He formulated three major aetiological factors in addition: partial fixation of the libido at oral and anal sadistic levels, a marked tendency for the personality to regress to a narcissistic state of ego organisation, and a disordered primitive conscience which utilises the primitive ego mechanisms of projection.

Hartmann (1969) (cited in Milkman & Shaffer, 1985) revised Rado's points some thirty five years later. He stated that in addition, "there have been early wounds to narcissism and poor ego development; there has been an early lack of satisfying object relations; there is an attempt to develop pseudo-object relations to overcome the lack of affectionate and meaningful object relations."

In the preceding examination of the psychodynamics of addictions, the obvious central tenet is around issues of deprivation or disturbances of early infancy with regard to drive, ego and object relations.

CHAPTER 3.

RESEARCH METHODOLOGY AND PROCEDURE.

3.1. RATIONALE FOR THE STUDY.

Both drug addiction and bulimia nervosa are serious psychiatric diagnoses bringing much unhappiness to the persons with such disorders as well as to their families, friends and communities. Unfortunately, the identification and implementation of lasting and effective intervention has been difficult (Miller 1980). The challenge of successful permanent or at least stable recovery continues to be the burden of health professionals.

The addictive disorders continue to be treated separately despite the well documented evidence of the common underlying issues, namely:

- (a) There are numerous similar behavioural presentations (see chapter 2, Section 2.1.1.).
- (b) Regularly the abuse of drugs, alcohol or food is found in the families of drug dependent or bulimic women. (see Chapter 2, Section 2.1.2.).
- (c) The co-morbidity of bulimia nervosa with drug abuse has become clearly apparent (see chapter 2, Section 2.1.3.).

A number of theoretical models could be used to understand the abovementioned commonalities of the addictive disorders. Such aetiological models would include the cognitive-behavioral, systems, biological, genetic, psychosocial, psychodynamic etc. The psychodynamic model of understanding addiction has been chosen in this research as the writer believes this model can most comprehensively explain what underlies the two conditions, and can provide a greater depth of understanding than the other approaches. The writer strongly advocates the value of other theoretical models in the goal of treatment but believes that they are limited in providing a comprehensive etiological explanation of the addictive illnesses.

Psychodynamic literature focusing on drug addiction and bulimia nervosa in relation to level of pre-oedipal/oedipal functioning and object relations has highlighted numerous similarities between the two addictions. In the literature review the writer has attempted to link psychodynamic literature on bulimia and drug addiction in a more comprehensive manner, theoretically bridging the gap between the two disorders. Although theories reviewed in the literature review have discussed similar dynamic issues underlying each disorder, they seldom discussed both conditions together. No previous empirical study has been done comparing the bulimic and drug dependent person's psychodynamic make-up. It was hence the purpose of this study to empirically

explore the extent to which bulimia nervosa and drug dependency in women were symptoms of the same underlying psychodynamic issues. The psychodynamic features explored in this study were elicited by the Thematic Apperception Test (T.A.T.) which was then analysed for the presence of pre-oedipal/oedipal indicators and level of object relatedness.

3.2. RESEARCH QUESTIONS.

The study examined two fundamental questions in order to establish whether drug dependency and bulimia nervosa were symptoms of the same psychodynamic pathology, or not. The first research question focused on the extent to which drug dependent and bulimic women had the same fixations and/or regressions to pre-oedipal levels of functioning. The second research question examined whether drug dependent and bulimic women were fixated or had regressed to the same level of object relatedness, that is whether their measures on a scale of mutuality of autonomy on the T.A.T. were the same.

3.3. SUBJECTS.

The sample for this study consisted of eight bulimic women, eight drug dependent women and a control group of eight women. The drug dependent and bulimic women had been hospitalised for their addictive problems as they had been unable to control abuse on an out-patient basis. The drug dependent women had been diagnosed by the clinical staff at a drug rehabilitation

treatment centre as having one of the psychoactive substance use disorders outlined in the DSM III-R. Likewise, the bulimic women had been diagnosed by clinical staff of the hospital and met the diagnostic criteria for bulimia nervosa on DSM III-R. Drug dependent subjects were tested three weeks after admission as intoxication and withdrawal interfere with performance on psychological test batteries, ten days to two weeks after intoxication (American Psychiatric Association, 1987). The bulimic women were also tested three weeks after admission so as to standardise the time between date of admission and date of testing for the two groups. The control group consisted of a random sample of the writers associates and neighbours who had no identified psychopathology.

The women in all three groups fell within the age range of 16 to 26 years with an average age of 21 years. The study focused on this age group as bulimia tends to peak in adolescence and early adulthood (MacLeod, 1981). A similar peak is observed in drug dependency. The choice to limit the study to women only was reinforced by the literature reviewed by Beckwith (1986) on sex differences in addiction studies. The conclusion of Beckwith's study was that any study of eating, drinking and/or smoking behaviours which included both sexes would need to treat the data separately for each sex as prevalence and attitudes to these addictions differ greatly between the sexes.

3.4. INSTRUMENT.

The Thematic Apperception Test was used as it has been one of the most widely used projective tests in clinical practice and research. The cards used are listed and described in Appendix A. It was first developed by Murray and his associates in 1938 at the Harvard Psychological Clinic (Anastasi, 1988). The nature of the projective test requires individuals to 'project' aspects of their inner world into the story telling process, revealing aspects of their personality which are primarily unconscious (Anastasi, 1988). Bellak (1986, p.190) supports this notion and proposes that psychoanalysis can be seen as a perceptual theory, as the concept of projection involves a perception i.e. 'the structuring of some contemporary experience by apperceptions previously laid down.' Mills and Cunningham (1988) have confirmed the appropriateness of the T.A.T for psychodynamic measures as they suggested that oral conflicts could be inferred from the results of projective tests. Masling, Rabie and Blondheim (cited in Bornstein et al. 1988) found that assessment of oral imagery for the T.A.T. and Rorschach protocols differentiated obese from normal weight persons. Thus there seemed to be support for the usefulness of T.A.T cards in eliciting psychodynamic material.

The T.A.T., however, has been one of the most controversial devices used in the field of psychology (Keyser & Sweetland,

1985). Murray (cited in Keyser and Sweetland, 1985) comprehensively critiques the T.A.T., concluding that when appropriately used, it can demonstrate great utility. However when the interpretation of the T.A.T. is based on methods of untested reliability the outcome can be potentially dangerous. The effectiveness of identifying and reliably tapping the outlined constructs of pre-oedipal/oedipal functioning, (see Appendix B) and of measuring levels of object relations, (see Appendix C) with T.A.T stories has been well established by Bellak (1986) and Westen, Ludolph, Lerner, Ruffins and Wiss (1990) respectively.

In the present study the T.A.T. stories were analysed using two separate methods to test the two research questions. The first research question, which examined the extent to which drug dependent and bulimic women had the same fixations and/or regressions to pre-oedipal levels of functioning, was investigated by analyzing stories in accordance with the list of salient indicators of pre-oedipal and oedipal levels of functioning outlined by Bellak (1986) (See Appendix B). The presence or absence of indicators on Bellak's list assisted in identifying whether a psychiatric disorder which was characteristically pre-oedipal or a disorder which was predominantly an oedipal level neurotic disorder existed. This method of analysis of T.A.T. stories was useful in the identification of pre-oedipal pathology.

The second research question, namely, the extent to which drug dependent and bulimic women were fixated or had regressed to the same level of object relatedness, was explored by examining the object relations within the stories. Much work has been done to develop a reliable method of measuring an individual's concept of human relationships. Urist (1977) proposed that an individuals' way of experiencing themselves and others within relationships could be documented as definable points along a developmental continuum. He explained that individuals tended to experience self/other relationships in consistent, enduring characteristic ways which correspond to the various stages of object relatedness. Such stages were delineated by Urist (1977) in terms of a rating scale of mutuality of autonomy.

The method of analysis of measure of object relations used in this study was modified from the scale of mutuality of autonomy described by Urist (1977). Urist's seven point scale, used to analyse Rorschach protocols, was modified to a five point scale to be used on the T.A.T. (See Appendix C). The rationale for reducing the scale to five points was to improve the accuracy of marking and reduce error for instances where T.A.T. responses overlapped two categories. The modification of Urist's scale was made by the writer and a supervising clinician and research psychologist prior to the availability of a five point scale for Mutuality of Autonomy for the T.A.T. outlined by Westen et al. (1990). Although Westen et al. (1990) do not explicitly

discuss the rationale for a five point scale in their study, this modified scale provided support for the notion assumed in this study i.e. for the T.A.T. a five point scale is superior.

3.5. PROCEDURE.

An appointment was set up for each subject, during which time eight T.A.T. cards were administered individually (See appendix A). Cards were selected by the examiner prior to the session and were administered in a standardised order in accordance with the instructions outlined by Bellak (1986). The tester asked the subject to tell a story which included what was happening in the card, what had happened prior to that and what the outcome of the story was. Subjects were also required to indicate the emotions experienced by the characters in the stories. When insufficient or incomplete responses were given, the tester enquired about the abovementioned details.

The stories were analysed by two clinical psychology interns using the two outlined methods for the separate research questions. Subjects were randomly assigned the first 24 letters of the alphabet so as to ensure blind analysis. Discrepancies in marking were discussed and consensus was reached about the most appropriate scoring.

3.6. STATISTICAL ANALYSIS AND SCORING.

Since the samples were small and the data ordinal in nature, non-parametric analyses were considered appropriate. There were three groups to be compared; the control group, the drug dependent group and the bulimic group. The Kruskal-Wallis test was the most suitable test to use for both research questions (McCall, 1970). The Kruskal-Wallis is useful when there are more than two samples and is a non-parametric alternative to the one-way analysis of variance (Minium, 1970).

The first research question examined the fixation and/or regression of drug dependent, bulimic and control groups to a pre-oedipal level of functioning. Each subject was randomly assigned a letter, and each of her stories was scored for the presence of pre-oedipal indicators outlined in Appendix B. The presence of pre-oedipal features was shown by a tick in the appropriate column on the mark sheet (see Appendix D). For each subject the number of stories in which such indicators occurred was recorded such that a maximum score of eight could be obtained if pre-oedipal indicators were found in all eight stories. Each subject obtained a score between zero and eight.

The second research question examined the level of object relatedness of the drug dependent, bulimic and control groups.

Each story was examined and a score between one and five given for Mutuality of Autonomy in the story in accordance with Appendix C. The Mutuality of Autonomy score for each story was recorded on the mark sheet (See Appendix E). A total score for all stories was obtained for each subject. A maximum score of five could be obtained for each of the eight cards, thus a score of 40 was the highest possible score a subject could obtain.

CHAPTER 4.

RESULTS.

PRE-OEDIPAL FUNCTIONING DATA

The median pre-oedipal functioning scores may be seen below in Table 1 and are represented graphically in Figure 1.

TABLE 1 : Median pre-oedipal scores for each group, n=8.

CONTROL	DRUG DEPENDENT	BULIMIC
2	3.5	4

The pre-oedipal scores for each subject in each group were submitted to a Kruskal-Wallis test (Chi-square conversion) using the SAS PROC NPARIWAY procedure, version 6 (SAS User's Guide, 1991). The analysis yielded a significant difference ($X(2)=6.1833$; $p<0.0454$). A post-hoc analysis indicated no significant difference between the drug dependent and the bulimic groups ($p>0.8$), which served to confirm the source of significance as being the lower scores evidenced in the control group ($X(1)=6.128$; $p<0.0133$).

The results may be taken to indicate that the drug dependent and bulimic subjects had significantly more pre-oedipal indicators than did the control group, but did not differ significantly from each other.

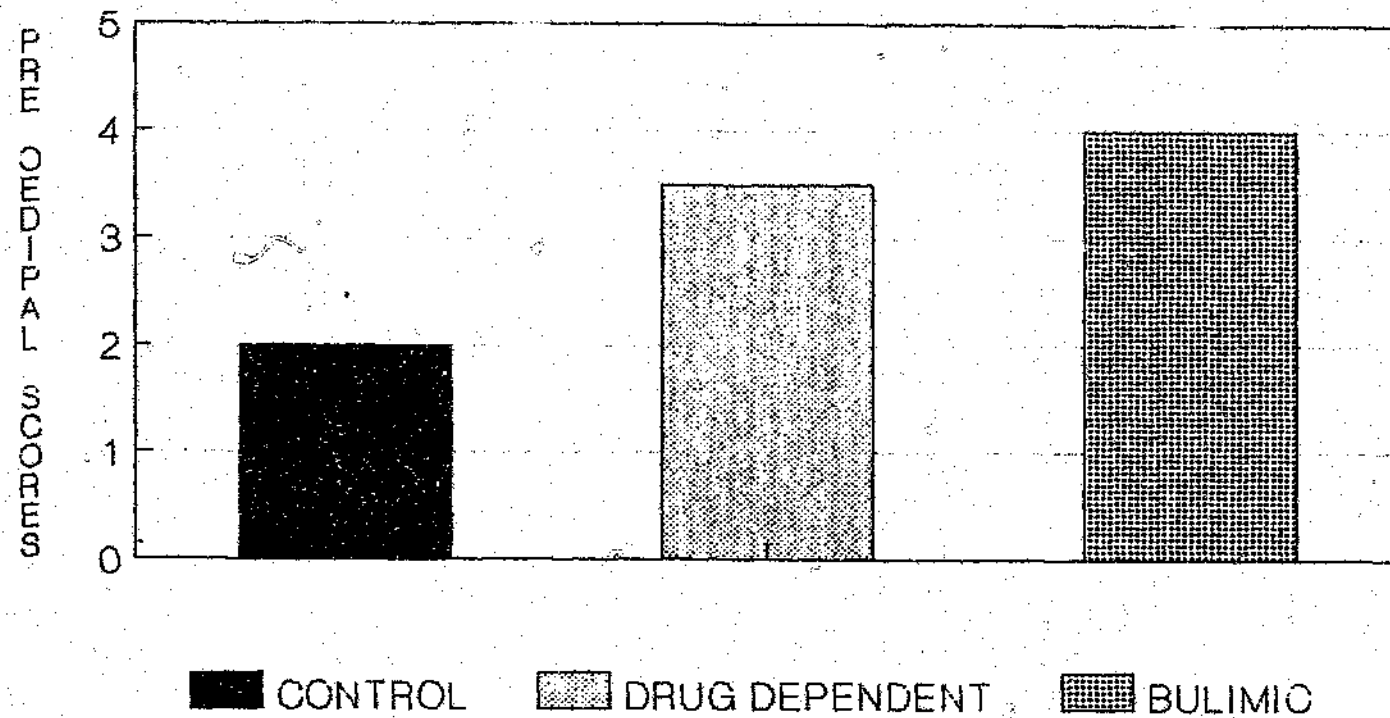


FIGURE ONE:
Bar Chart showing median Pre-Oedipal
functioning scores for the three groups

MUTUALITY OF AUTONOMY DATA

The median mutuality of autonomy scores may be seen below in Table 2 and are represented graphically in Figure 2.

TABLE 2: Median mutuality of autonomy scores for each group, n=8.

CONTROL	DRUG DEPENDENT	BULIMIC
18.5	24.5	26.5

The mutuality of autonomy scores for each subject in each group were submitted to a Kruskal-Wallis test (Chi-squared conversion) using the SAS PROC NPARIWAY procedure, version 6 (SAS User's Guide, 1991). The analysis yielded a significant difference ($X(2)=8.8787$; $p<0.0113$). A post-hoc analysis indicated no significant difference between the drug dependent and bulimic groups ($p>0.9$), which served to confirm the source of significance as being the lower scores evident in the control group ($X(1)=8.8633$; $p<0.0029$).

These results may be taken to indicate that the drug dependent and bulimic subjects had significantly higher mutuality of autonomy scores than did the control group, but did not differ significantly from each other.

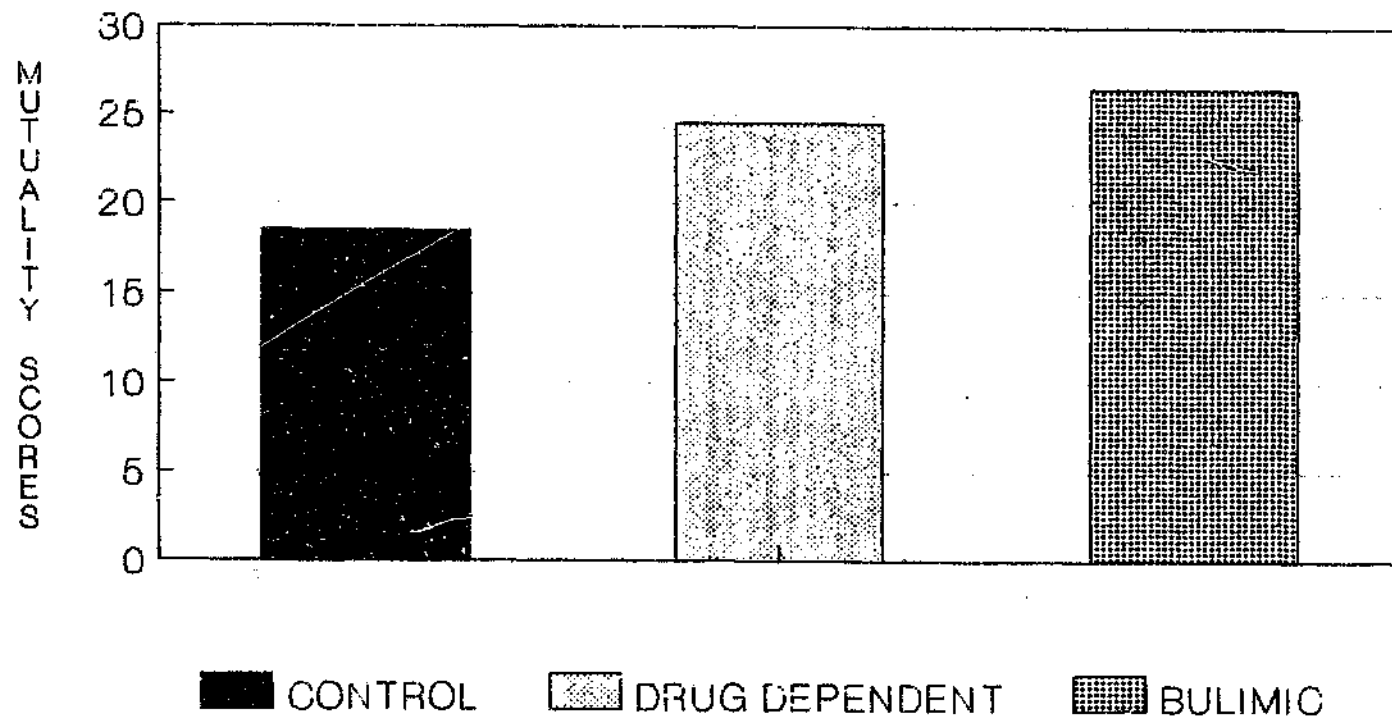


FIGURE TWO:
Bar Chart showing median Mutuality of
Autonomy scores for the three groups

CHAPTER 5.

DISCUSSION.

5.1. DISCUSSION OF RESULTS.

The results from this study support the notion that drug dependent and bulimic women have similar underlying psychodynamic features, in that they regress to or are fixated at the same level of oedipal/pre-oedipal functioning and display similar types of object relatedness. Although no previous empirical study has been done to establish the psychodynamic phenomena underlying drug dependency and bulimia nervosa, the results of the present study support the notion that they are both addictive illnesses and symptoms of the same psychopathology. The research questions explored in this study were formulated and tested in an attempt to link psychodynamic theory of bulimia nervosa with that of drug dependency and hence empirically gain clarity on why the two conditions present so similarly, behaviourly.

The results obtained by testing the first research question confirmed that the drug dependent and bulimic women in this sample were fixated or had regressed to the same level of pre-oedipal functioning and that these two groups were significantly different to the control group. The drug dependent group have an average of 3,875 pre-oedipal indicators in their protocol, which is similar to the bulimic subjects who have an average

of 3,625 pre-oedipal indicators in their stories. Bellak (1986) suggests that the severity of pre-oedipal pathology is seen by the number of pre-oedipal indicators found in subject's stories. The subjects with the highest pre-oedipal scores i.e., those with six or seven of the thirteen indicators, were equally represented in the drug dependent and bulimic groups, whereas, in the control group the highest score was three. The results confirmed that the severity of pre-oedipal pathology was similar in the drug dependent and bulimic groups yet far less apparent in the control group.

Closer examination of the oedipal/pre-oedipal features found in the addictive women's protocols in this study support psychodynamic notions of addiction explored in the literature. The writings of Bornstein et al. (1988); Fuerstein (1989); Freud (1969); Devine (1981) and Scatura (1987) support the hypotheses of the first research question i.e. addictive persons are partially fixated at pre-oedipal levels of psychosocial development. The writings of Kernberg (1975), (cited in Rinsley, 1982) and Fuerstein (1989) posit that the addictive process is accompanied by primitive defence mechanisms. These primitive defence mechanisms were clearly apparent in the protocols of the drug dependent and bulimic women in this study. In particular, the defence of splitting was apparent in the addictive women's protocols. This finding is in keeping with the work of Dana and Lawrence (1988) who concentrated in their writings on bulimic

women. The protocols in this study illustrated an equally strong splitting defence mechanism in drug dependent as in bulimic women. The poor ability to develop beyond part object representations which was mentioned in the literature review (especially in the works of Humphrey and Stern, 1988) was apparent in the protocols of both drug dependent and bulimic women. As mentioned by Milkman and Shaffer (1985) the universe of real objects is no longer of consequence to the addict. The addicted women's protocols displayed a poor capacity to see beyond part object relations. 'All good' or 'all bad' perceptions of the world and interpersonal relationships existed in the protocols of both bulimic and drug dependent subjects. The need for immediate gratification and the poor impulse control discussed in the literature by Humphrey and Stern (1988) and by Milkman and Shaffer (1985) was expressed in the bulimic and drug dependent women's protocols.

Bellak (1986) suggests that the two most common pre-oedipal disorders are the Narcissistic Personality Disorder and the Borderline Personality Disorder; such disorders are functioning fundamentally on a pre-oedipal level. Although the samples on average displayed several pre-oedipal indicators, the protocols were not predominantly pre-oedipal. Hence one may posit that many features of narcissistic personality disorder and/or borderline personality disorder are found in both drug dependent and bulimic women and that the severity of such features varies

in a similar manner within each group. The control group had few pre-oedipal indicators, thus confirming that the presence of narcissistic or borderline features was rare and significantly less apparent than in the drug dependent or bulimic groups.

Kohut and Kernberg (cited in Rinsley, 1982) support the notion of narcissism or narcissistic features in addictive illness. They suggest that addiction is a manifestation of infantile narcissism due to early deficits in the mother-infant relationship, and there is a breakdown in normal development of the self. The mother has failed to accommodate and respond to the child's omnipotent narcissism, which results in a developmental arrest. Examination of the presence of borderline and narcissistic pathology in eating disorders and drug dependency continues to be focused on in the literature (Derksen, 1990).

This study has served to shine a confirmatory light on the notion of the existence of narcissistic and borderline features in bulimic and drug dependent women. Of particular value is the confirmation that drug dependent and bulimic women have statistically significant similar pre-oedipal/oedipal levels of functioning which is different from that of a control group of women.

The results of testing of the second research question support the hypothesis that drug dependent and bulimic women are fixated or have regressed to the same level of object relatedness. The deficit/disturbances of object relations found in bulimic and drug dependent samples are significantly similar to one another and significantly different from the control group. For the drug dependent and bulimic women the average functioning on the mutuality of autonomy scale was three whereas for the control group the average score was two. A score of three reveals functioning on a Dependent-(reflection)-Mirroring Stage,

i.e. a person is dependent on an external source of support and is unable to rely solely on their own initiative. The relationship between objects here conveys a sense that the definition of stability of an object exists only insofar as it is an extension or reflection of another.

(Urist, 1977,p.4).

In comparison to the addictive person's type of object relatedness the control group experienced a far healthier level of object relatedness. The control group's average score of two on the mutuality of autonomy scales reveals interpersonal relationships dominated by cooperation and simple interaction, not a dependent interpersonal style.

Available literature on bulimia nervosa and drug dependency respectively had suggested that both populations experienced poorly consolidated object relations (Becker et al. 1987; Dana & Lawrence, 1988; Milkman & Shaffer, 1985). Becker et al. (1987) posit that persons with bulimic eating disorders show greater object relations disturbances than those without. Specifically, they display a particular fear about abandonment, and their relationships lack autonomy. Likewise, Milkman and Shaffer (1985) examined the deficit seen in object relations of drug addicts. The drug dependent person is seen to be unable to function autonomously as she has not adequately separated from early care givers - and uses the drug to create a sense of identity and independence to avoid possible depression associated with separation. This study shed light on the notion that bulimic and drug dependent women experience similar disturbances of object relatedness which is significantly more pathological than the object relatedness of the control group of women.

In conclusion, results of this study empirically confirm that on the two chosen psychodynamic factors, drug dependent and bulimic women are significantly similar and therefore that the two conditions are manifestations of the same psychodynamic pathology.

5.2. LIMITATIONS.

Due to the small sizes of the samples (i.e. 8 women per group) there is a limited generalizability to the population at large. It is for the abovementioned reason that this study can be seen as a pilot study, a precursor to a more substantial research project.

Unfortunately the method of assessing object relations on the T.A.T. outlined by Westen et al. (1990) was not available at the time of collection and analysis of raw data for this study. Had this information been available, it could have been used instead of the modified version of Urist's (1977) scale. The method outlined by Westen et al. (1990) would have been a more reliable scale as it was specifically designed to be used on the T.A.T. whereas Urist's (1971) scale was designed for assessment of the Rorschach.

This study is further limited in that it does not consider the possibility that there is a common depressive component underlying the two addictions. The presence of depressive pathology in both bulimia nervosa and drug dependency is well documented (Jonas et al. (1987); Peveler and Fairburn (1990)). Despite the high concurrence of depression with both eating disorders and drug addiction it has not been explored in this study. The relationship between addiction and depression is beyond the scope of this study as it is a major focus in its own right.

CHAPTER 6

CONCLUSIONS AND IMPLICATIONS OF THE STUDY.

6.1. CONCLUSION

This study empirically confirms much of what is mentioned yet not strongly linked in the literature with regard to object relations and level of oedipal/pre-oedipal functioning of drug dependent and bulimic women. The results indicate that drug dependent and bulimic women present with the manifestation of addiction as a symptom of the same underlying psychodynamics i.e. that their level of pre-oedipal functioning and object relatedness are the same.

This study highlights specific aspects of psychodynamic functioning which are problematic due to deficits or dysfunction in the bulimic and drug dependent samples' early development. Both bulimic and drug dependent women have the presence of pre-oedipal indicators of functioning. The groups function at the same overall oedipal/pre-oedipal level of development with similar ranges of severity seen in each group. Within the two samples, women experience to a varying degree, features of narcissistic and borderline personality traits. The scores on the scale of mutuality of autonomy of subjects in this study

reveals that both drug dependent and bulimic women have dependent object relations.

As a result of the aforementioned factors, drug dependent and bulimic women experience similar problems namely: low self esteem (Levine 1981); poor interpersonal relationships (Dana & Lawrence 1988; Kernberg (1975), cited in Rinsley, 1982); they are dependent on others for emotional survival (Humphrey & Stern 1988), they experience problematic issues around sexuality (Rado (1926), cited in Milkman & Shaffer 1985; Orbach 1982), and they have failed to consolidate a separate sense of self (Rinsley 1982).

This study suggests that when examined from a psychodynamic perspective bulimia and drug dependent women are from the same population and hence could be treated as such. Regardless of treatment approach taken, a psychodynamic understanding of the addictive problems of women is useful.

5.2. IMPLICATIONS OF THIS STUDY

The results of this study, although limited in generalisability to the population at large, do present with implications in terms of further research and treatment. The results encourage further work on the two addictions to be consolidated, especially in the light of present trends, 'i.e specialists in each of these areas have worked in relative isolation from one another, seldom

communicating with each other about treatment and research issues' (Miller, 1980).

6.2.1. IMPLICATIONS FOR TREATMENT

This study confirmed the presence of several common factors which could be addressed in a specialist treatment programme for women addicts. Regardless of whether psychodynamic, cognitive-behavioral, systems or other approaches be applied, treatment goals of the two addictions would be similar. Such treatment goals would include: encouragement of independent autonomous functioning, improving self-esteem, encouraging and developing insight into interpersonal relationships in order to improve their quality, improving frustration tolerance and impulse control, exploring issues of sexuality, assisting with mood regulation and lifting depressed mood, acknowledging and working with emptiness and sense of futility in life.

Problems specific to each addiction could be dealt with separately as could problem areas specific to each person. Treating bulimia nervosa and drug dependency together would alleviate the problem of substitution of one drug with another and assist those with co-morbid addictions. Should the addictions of women be treated together, the possibility of a more successful outcome might occur.

6.2.2. IMPLICATIONS OF THIS STUDY FOR FURTHER RESEARCH

Due to the limited nature of this study, it can only be regarded as a pilot study and could be a trial for far larger projects of this nature. Hopefully this study facilitates interest in the area of addiction with regard to women. The high incidence of relapse of both illnesses, i.e bulimia nervosa and drug dependency, is disturbing and research into the reason for such trends would be invaluable. Further research into understanding the nature of addiction and possibly more effective treatment methods would be useful. A better understanding of the relationship of bulimia nervosa and drug dependency to depression may serve as a useful clue. Further research needs to be carried out on evaluating present existing treatment programmes for the two pathologies, in order to explore how treatment centres can successfully amalgamate an approach to women with problems of addiction.

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APPENDIX A:

Thematic apperception test

1. **Card 1:** 'A young boy contemplating a violin which rests on a table in front of him;' (Bellak, 1986, p. 52).

Important themes elicited from this card;

1. The nature of the relationship with parental figures, i.e. were parents perceived as aggressive, domineering, helpful, understanding or protective.
 2. Symbolic sexual response.
 3. Self-image.
2. **Card 2:** 'Country scene: in the foreground is a young woman with books in her hand; in the background a man is working in the fields and an older woman is looking on' (Bellak, 1986, p. 54).

Important themes elicited from this card;

1. Indications of subject's family relations.
 2. Autonomy vs compliance in the family (separation and individuation).
3. **Card 4:** 'A woman is clutching the shoulders of a man whose face and body are averted as if he were trying to pull away from her' (Bellak, 1986, p. 55).

Common themes elicited from this card;

1. Needs and sentiments with reference to male-female relationships.
2. Sexuality.

4. Card 6.G.F: 'A young woman sitting on the edge of a sofa looks back over her shoulder at an older man with a pipe in his mouth who seems to be addressing her' (Bellak, 1986, p. 56).

Common themes elicited;

1. Relationship of female to her father or,
2. male-female (i.e. heterosexual) relationships.

5. Card 7.G.F: 'An older woman is sitting close beside a girl, speaking or reading to her. The girl, who holds a doll on her lap, is looking away' (Bellak, 1986, p. 57).

Common themes elicited;

1. Mother-daughter relationship.
2. Rejection issues.

6. Card 11: 'A road skirting a deep chasm between high cliffs. On the road in the distance are obscure figures. Protruding from the rocky wall on one side are the long head and neck of a dragon' (Bellak, 1986, p. 58).

1. Infantile or primitive fears.
2. Stories of oral aggression.

7. Card 13 M.F. 'A young man is standing with down cast head buried in his arms. Behind him is the figure of a woman lying in bed' (Bellak, 1986, p. 60).

Common themes elicited;

1. "Sexual conflicts.
2. Oral tendencies.

8. Card 18 G.F. 'A woman has her hands squeezed around the throat of another woman who she appears to be pushing backwards across the bannister of a stairway' (Bellak, 1986, p. 63).

Common themes elicited;

1. Females' handling of aggression.
2. Mother-daughter conflicts.

APPENDIX B:

Salient Indicators of Pre-Oedipal and Oedipal Level Functioning

This extract has been reproduced from Bellak, 1986, (p. 200-204).

The following features are characteristic pre-oedipal vs. oedipal diagnostic indicators:

1. Panic reaction, when signal anxiety is appropriate.
2. Primitive splitting, rather than ambivalence.
3. Denial and splitting as defences, rather than repression to fend off awareness.
4. Part-object experience and part-object perception, rather than whole-object experience and whole-object perception.
5. Unstable internal object or lack of internal object, rather than stable, internalized object constancy (the ability to hold in one's mind and image of another person independent of being in the other person's presence).
6. Superego is split between extreme punitive "all bad" and libidinal "all good" images, rather than being flexible, reasonable, appropriate, and in tune with society's ethical principles.
7. Affect states are extreme and "pure" forms of love, hate, fear, sadness, and joy, rather than a

neutralized, modulated array of feelings and nuances of feelings in between.

8. Shame and humiliation is experienced rather than oedipal neurotic guilt.
9. Introjective/projective relatedness [...] of self object relatedness [...], rather than identifiatory relatedness or relating to others as independent, separate individuals.
10. Fragmentation and disintegration, rather than synthetic function (ability to organize experience and perception into integrated "Gestalt," or meaningful wholes).
11. Acting and reacting, rather than experiencing and acting with a presence of observing ego function (self-observation and self-monitoring).
12. Defences of incorporation and introjection, rather than identification.
13. Immediate discharge of impulses in acting out, rather than delayed gratification.

T.A.T. indicators of the above characteristics of pre-oedipal versus oedipal developmental stages are the following:

Panic anxiety rather than signal anxiety can be seen in characters in a story engaging in sudden, wild, frenetic, or repetitive actions in the face of danger or threat. A monster threatens and a small animal simply jumps up and

down, runs, screams, or does an action over and over on the C.A.T. or the smaller animal may simply "freeze", immobilized and overwhelmed with fear.

A signal approach would be to mention a danger in the future and an attempt to plan, prepare, and cope with the danger, as in calling for help, building a fort, hiding, or working out a trap. In the chapter on neuropsychological assessment, we give the example of a child who symbolized the need for signal function by the need for the story figures to have a fire alarm to call the firemen to put out a fire in the kitchen [...].

Primitive splitting rather than ambivalence is the key feature for borderline pathology according to Kernberg [...]. He defines primitive splitting as the keeping apart of extreme affects of love and hate, extreme impulses of aggression and libido, and extreme images of the self and of other people (called self and object representations) that are characterized as "all good loving" and "all bad hating". One sees T.A.T. characters that are either angels or devils, good guys or totally evil ones, without evidence of story figures who are somewhat good and somewhat bad, who have more than one side to their personalities. Volkan [...] speaks of such fantasies of borderline patients as being all in black and white, rather than in technicolour. Ambivalence is seen in the T.A.T. by such statements as "either this..... or that". Splitting in narrative style would be something more like, "It's

this. No, it is only that". The concept of splitting, its soundness, and its usefulness have however been widely questioned ... [...].

Part-object rather than whole-object experience and perception is seen on the T.A.T. in splitting, as we have discussed above, where there is not a development of characters that have a combination of different feelings, traits, and activities, but a juxtaposition of good vs. bad characters.

Object Constancy is seen in behaviour when the toddler begins to be able to play alone, with the mother in the next room or having left in the care of a baby sitter. When the mother leaves, there is no longer the temper tantrum panic reaction to separation anxiety. The child can now realize that the mother still exists independent of the child's immediate perception of her. Prior to object constancy, the child experiences the separation as a death, "out of sight, out of mind". If the child doesn't see or hear his mother, then mother must be dead. Hence the extreme level of panic and the extreme tantrums. The lack of object constancy can therefore be seen in T.A.T. stories as a theme of separation anxiety, upset shown when one figure leaves another. Right after leaving home, for example, the next action is falling and getting hurt (as in C.A.T. story #2 where one part figure lets go of the rope and the child on the other side falls and gets hurt, symbolizing separation from the parent), getting

attacked by a storm or by a threatening figure, or getting sick. Object constancy could be seen in characters who leave others, who leave home, and can plan, use strategy, and use defences to handle the dangers that occur in the future. Little Red Riding Hood telling the wolf along her path through the woods that she is going to grandma's house is an example in story form of maintaining an image in ones's mind of the mother figure in the face of separation and threat.

Pre-oedipal superego is seen in T.A.T. stories of extreme punishment for mild transgression, as when a character is jailed or killed because he urinated on the floor or falls down a cliff and dies because he just "didn't look where he was going". A more oedipal, neurotic, or normal level of superego exists when the punishment fits the particular crime. The child spills his food on C.A.T. story #1 and the mother asks him to clean it up and not spill the next time. Or one character calls the other a name and then apologizes for it. Pre-oedipal children do not usually think to say, "I'm sorry", because their punishment for a crime is much more extreme than that, they feel as if they should be or - are going to be -severely beaten for what they did. A mere apology is not in their scheme of things due to the lack of development of an oedipal level of the superego. Pre-oedipal superego is often split between this very primitive, punitive, extreme punishment for extreme and even very mild infractions and extremely, magically good, all-forgiving godlike features. The

child violates a taboo, such as stealing the giant's belongings in Jack and the Beanstalk and the primitive superego punishment is seen in the giant trying to eat and/or kill Jack. The all-good superego is seen in the ending, where Jack has the giant's magical belongings to share safely alone with his mother "happily ever after".

Extreme effect states rather than neutralized, modulated affect states are seen in T.A.T. stories in the use of extreme affect words, such as "hate", "love", "devastated", or "ecstatic", predominantly, rather than a range of gradations of affect words, such as "somewhat saddened", "a little annoyed", "interested", "surprised but understanding", etc. This goes along with #2 above (use of primitive splitting rather than ambivalence) and #4 (part-object rather than whole-object experience and perception). Shame and humiliation rather than guilt is seen in stories where the antagonist ends up with his pants down in front of an audience, slipping on a banana peel, or publicly embarrassed in some way. While the guilt is seen in characters expressing remorse over actions that caused harm to others, expressing sorrow over a missed opportunity due to doing something reckless or stupid, or expressing self-criticism or self-recrimination for actions they feel interfered with the happiness of other people. Egocentrism versus role-taking ability is related here in that the pre-oedipal individual becomes more upset over shame and humiliation and seeks to avoid doing things that will humiliate

himself, while the oedipal individual is more concerned about the feelings of others and more guilty over causing hardships to others.

Introjective/protective rather than identificatory relatedness is seen in very young children relating to the mother as if they are and extension of the mother and as if the mother is an extension of them. The infant acts as if the mother is only there to feed and comfort him or should smile and laugh when he smiles and laughs. The toddler, when angry with the parent, may project this anger onto the parent and imagine the parent is a monster furious with the toddler. The young child treats the parent as a self-object, then, rather than as a separate individual with independent needs. The parent is treated as both part to the self and part of the other, part self and part the parent. This is seen in the T.A.T. in frequent changes of a character's identify, sex, changes of pronoun from singular to plural and back to singular, and magic transformations from one thing to another. The theme of eating up another or being eaten up on C.A.T. stories represents this oral incorporative, introjective attempt to obliterate the independent existence of the self and the other as separate individuals. The idea of one figure "reading another's mind" or having the exact same thought as the other at the same time is another example of this kind of symbiotic oneness characteristic of pre-oedipal individuals. This is seen in emphasis on symmetry or seeing "twin" context on Rorschach and also on T.A.T. as the theme of twins.

Fragmentation rather than synthetic function is seen on T.A.T. in stories that are disjointed, aimless, and lacking in a sequential organization towards a logical ending. The story may begin about a little chicken eating and abruptly switch to a baby sleeping on its bed as in a free association without a clear connection between the two themes.

Acting rather than re-acting with self-observation is seen on T.A.T. stories in which the characters simply do different things, while there is no attempt to reflect on meaning about the actions or the picture. The boy looks at the violin, tries to play it, then puts it down (on card #1) is an example of acting without self-observation. By contrast having the boy thinking about what he should play, how long he should practice, if his parent is happy with his practising, or comments about whether the picture reminds the storyteller of some of his own feelings, etc., are examples of the observing function more characteristic of the oedipal level of development. Finally, defences of incorporation and introjection rather than identification are seen in stories where a figure experiences a separation or loss and reacts by eating up the other, being eaten up by the other, or imagining one is seeing a ghost of the deceased, rather than dealing with loss by doing something similar to the deceased person's former activities, such as taking up an activity that used to be the hobby of the deceased. Acting out versus delayed gratification is seen in eating right away, screaming for

something one wants, demanding something immediately, rather than waiting.

APPENDIX C

Mutuality of Autonomy Scale

The modified scale comprises 5 levels describing different levels of object relations - they are as follows:-

1. Reciprocity - Mutuality:- Collaboration:

"Figures are engaged in some relationship or activity where they are together and involved with each other in such a way that conveys a reciprocal acknowledgement of their respective individuality".

The persons are seen as autonomous and there is a sense of mutuality expressed in the relationship. (e.g.: Card II The young woman and man may represent a married couple, he works hard on the land and she teaches on the farm - both saving for their future home).

2. Cooperation - Simple Interaction

"Figures are engaged together in some relationship or parallel activity. There is no stated emphasis or highlighting of mutuality".

¹ Urist, J (1977) The Rorschach Test and the Assessment of Object Relations. Journal of Personality Assessment 41(1), 3-8

- ² Although there is no sense of mutuality, the individuals do not interfere with, nor depend on one another. (For e.g.: Card 7G.F. This is a story of a mother and her daughter waiting for dad to come home from work. Mom reads, while the little girl plays with her dolls).

3. Dependent - (Reflection) - Mirroring

"Figures are seen as leaning on each other, or one figure is seen as leaning or hanging on another".

- ³ There is a situation where one person is dependent on some external source of support and is unable to rely solely on their own initiative. The relationship between objects here conveys a sense that the definition of stability of an object exists only in so far as it is an extension or reflection of another.

- ⁴ (e.g.: Card 6G.F. The young woman has been summoned by her father who wants to know when she will make an effort to find a job as she should be autonomous at her age).

² Urist, J (supra)

³ Urist, J (supra)

⁴ Urist, J. (supra)

4. Magical control - coercion - persecution

"The nature of the relationship between figures is characterized by a theme of malevolent control of one figure by another. Themes of influencing, controlling, casting spells are present. One figure may literally or figuratively be in the clutches of another. Such themes portray a severe imbalance in the mutuality of relations between figures".

⁵ There is a situation where the autonomy of the individual is being hindered by another, often in a destructive manner, e.g.: one figure physically restraining or torturing another. (For e.g.: Card 13M.F. This man has just forced his wife to have sex with him. He is aggressive and abusive but she cannot leave him).

5. Envelopment - incorporation

"Relationships here are characterized by an overpowering, enveloping force. Figures are seen as swallowed up, devoured, or generally overwhelmed by forces completely beyond their control:.

⁶ e.g.: Card 7G.F. The little girl is being "baby-sat" by her aunt who will not allow her to play upstairs on her own; nor with her brothers in the lounge. She is young so therefore aunt, feels she must be watched at all times. The little girl is confused.

⁵ Urist, J (supra)

⁶ Urist, J (supra)

APPENDIX D:

PRE-OEDIPAL MARK SHEET

INDICATORS OF LEVEL OF PRE-OEDIPAL VS OEDIPAL LEVEL OF
FUNCTIONING

SUBJECT'S LETTER:

CARD NO PRESENCE OF PRE-OEDIPAL INDICATORS 1-13

1	2	3	4	5	6	7	8	9	10	11	12	13
2												
3												
4												
5												
6												
7												
8												

NO. OF STORIES IN WHICH PRE-OEDIPAL INDICATORS WERE FOUND =

APPENDIX E:

MUTUALITY OF AUTONOMY MARK SHEET

SCORE OF MUTUALITY OF AUTONOMY

SUBJECT'S LETTER:

LEVEL OF OBJECT RELATIONS

1	2	3	4	5
2				
3				
4				
5				
6				
7				
8				

TOTAL SCORE =

Author: Aber, Diana.

Name of thesis: A Comparison Of Psychodynamic Measures Of Level Of Oedipal Functioning And Of Object Relations In Bulimic Versus Drug Dependent Women.

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