

The Object Relations of individuals who misuse alcohol and have  
co-morbid Depressive or Bipolar Disorders and/or Personality  
Disorders.

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## **ABSTRACT**

This study explored the Object Relations of a sample of 45 subjects who were using alcohol and were diagnosed with co-morbid Depressive or Bipolar disorders and/or Personality disorders. All subjects were receiving treatment at a government psychiatric hospital in South Africa. The similarities and differences in the Object Relations of these individuals were identified. A biographical questionnaire, the Alcohol Use Disorder Test (AUDIT), which was used as a screening measure, and the Bells Object Relations and Reality Testing Inventory (BORRTI) were administered to obtain information from a purposive sample. Descriptive and inferential statistics were used to analyse the results of the assessment measures. Analysis of the BORRTI data indicated a high rate of depressive and personality disorders within this sample. Results of the sub-sample (n=29) whose scores were included in the Pearson's Correlation Coefficient analysis indicate that higher levels of alcohol consumption result in increased levels of hallucinations and delusions. Other correlations were identified between high levels of alcohol consumption and heightened levels of reality distortions and more uncertainty in the perceptions of these individuals. Significant differences in the scores of the male and female participants were identified. With the female participants, the higher the level of alcohol consumption, the lower the individuals scored in terms of pathological levels of egocentricity, uncertain perceptions, insecure attachments, alienation, social incompetence as well as hallucinations and delusions. Alternatively, in the male sample, higher levels of alcohol consumption result in increased hallucinations and delusions, reality distortions, uncertainty in perceptions, alienation, social incompetence and egocentricity.

Keywords: Addiction; Alcohol Abuse; Alcohol Use; Alcohol Misuse; Bipolar Disorders; Mood Disorders; Object Relations Theory; Personality Disorders; Psychodynamic Therapy

## **CHAPTER 1: CONTEXT OF THE RESEARCH**

The phenomenon of excessive alcohol use plagues societies worldwide and South Africa is no exception. Alcohol consumption has been found to be concurrent across most cultural groups, with the exception of certain exclusive religious communities (e.g. Muslims) who represent small minorities in the general population (Dada, Pluddemann, Williams, Parry, Bhana, Vawda, & Fouriel, 2012).

Ellis, Stein, Meintjies and Thomas (2011) state that substance abuse, which is an enormous social problem in South Africa, especially when combined with the use of Tik (crystal meth, or methamphetamine) has devastating effects on society. It aggravates poverty and crime and contributes to child abuse and gender violence.

The consequences of alcohol use on society are discussed in a vast amount of literature. The Diagnostic Statistical Manual of Mental Disorders Fifth Edition (DSM-5) (2013, p. 493) states that alcohol is the most frequently used brain depressant and is a cause of considerable morbidity and mortality. Dada et al. (2012) refer to the role alcohol plays in mortality rates and a range of chronic health problems due to violence, criminal activity and unsafe sex practices. The latter may lead to unwanted pregnancies, Foetal Alcohol Syndrome and the transmission of Human Immunodeficiency Virus (HIV). The functional consequences mentioned in the DSM-5 (2013, p. 596) may negatively affect the driving of vehicles and operation of machinery, school and work tasks, interpersonal relationships and communication. Although many individuals with Alcohol Use Disorder may continue to live with their families and function within their jobs, they are prone to higher incidents of absenteeism, job-related accidents and low employee productivity. Furthermore, alcohol abuse may lead to suicidality through disinhibition and impaired judgment.



Alcohol withdrawal also poses a real danger. In alcohol-dependent individuals, signs and symptoms of alcohol withdrawal syndrome (AWS) may develop within 24 to 48 hours after the individual's last drink of alcohol. Abrupt cessation may result in delirium tremens (DTs), which involves a state of severe "dysautonomia and encephalopathy" as well as withdrawal-related seizures, either of which may be fatal (Fantus, 2014).

Rehm, Gmel, Sempos, and Trevisan (2003) found that alcohol is a causal factor in approximately 60 types of diseases and injuries and a component cause in 200 others. These fall into six broad categories: Infectious disease; Cancers and Malignant Neoplasms such as mouth and oropharynx cancers, oesophagus cancer, liver cancer, breast cancer and other neoplasms; diabetes mellitus; neuropsychiatric disease, such as unipolar major depression, epilepsy and alcoholism; cardiovascular disease (CVD) such as hypertensive disease, coronary heart disease, Cerebrovascular disease, ischemic stroke and haemorrhagic stroke, as well as liver and pancreas disease that are categorised under digestive diseases such as cirrhosis of the liver.

Similarly, Rehm et al. (2003) also provide a list of conditions, which are attributable to alcohol use, that are presented in the International Statistical Classification of Diseases and Related Health Problems 10<sup>th</sup> Revision (ICD 10), namely: Mental-induced pseudo-Cushing's syndrome; mental and behavioural disorders – Dependence syndrome, withdrawal state, withdrawal state with delirium, Psychotic disorders (Residual and late-onset psychotic disorder), amnesic syndrome; unspecified mental and behavioural disorder, and degeneration of the nervous system. Excessive alcohol use is also related to the following health issues: Polyneuropathy, myopathy, cardiomyopathy, gastritis, liver disease, fatty liver, hepatitis, fibrosis and sclerosis of the liver, cirrhosis of the liver, hepatic failure, unspecified, alcohol-induced acute pancreatitis, alcohol-induced chronic pancreatitis, foetal alcohol syndrome (dysmorphic) and poisoning by and exposure to alcohol.

Although alcohol abuse has many negative consequences, relapse rates remain high and large gaps exist in the literature with regard to alcohol use, prevalence, etiology, gender differences and treatment methodologies.

## **PROBLEM STATEMENT**

Alcohol abuse may have extreme consequences for individuals and society at large, both in South Africa and internationally. However, there are still controversies regarding current research findings as well as gaps in the literature with regard to the aetiology and definition of Alcohol Use Disorder. Furthermore, psychological theories provide numerous perspectives as to the etiology, cause and treatment of Alcohol Use Disorder. The ubiquity of alcohol use is clear, yet there is still much controversy within the psychological, scientific, biological and social communities regarding this phenomenon. Although statistics indicate an alarming number of alcohol-related problems, to date, no exact criteria that define alcohol use and can be used across different fields of practice, including the medical and psychological fields, have been established. Instead there are many differing theories and schools of thought that differ in their general definition and theory regarding the psychological effect of alcohol use and addiction in terms of etiology, definition and treatment.

### **1.3. OBJECTIVES OF THE RESEARCH**

The main objective of the study was to explore the Object Relations of individuals who misuse alcohol and have co-morbid Depressive or Bipolar disorders and/or Personality Disorders and who were in the early phase of rehabilitation. The primary aims of this research were to:

1. explore the Object Relations of a group of individuals who used alcohol and had been admitted to a tertiary psychiatric hospital,
2. investigate and describe the ways in which the individual's Object Relations presented according to the BORRTI, and

3. determine the correlations between the individual's Object Relations scores and their level of alcohol use scores.

### **Structure of this Study**

This study is presented as follows:

#### **Chapter 2: Research Review**

This chapter discusses various theories and previous research findings relating to the aetiology, prevalence, gender differences and treatment methods of alcohol use from an Object Relations perspective.

#### **Chapter 3:**

Chapter 3 describes the methodology of the empirical study.

#### **Chapter 4:**

This chapter provides a discussion of the results.

#### **Chapter 5:**

Chapter 5 arrives at conclusions and the limitations of the study. Furthermore it recommends possible future research studies within the field of addiction.

## **CHAPTER 2: RESEARCH REVIEW**

This chapter discusses the topics of addiction, alcohol misuse and Object Relations. The gaps and shortcomings in theory are explored.

### **2.1. ADDICTION**

According to West and Hardy (2006), there is, as yet, no appropriate operational definition of addiction. In addition, definitions change and there is no consensus as to what constitutes true addiction. Craving is a subjective feeling and difficult to quantify. Another issue is that addiction is a socially defined construct, which suggests that addiction exists only in relation to observers, such as theorists who understand addiction through their perceptions. This is problematic as addiction is then defined subjectively as opposed to scientifically. Furthermore, it is difficult to distinguish between addiction and dependence (West & Hardy, 2006). It is also stated that although no tests currently exist that can measure the severity of an addiction, the two main criteria being used by mental health professionals currently are the ICD-10 and DSM-IV-TR definitions (West & Hardy, 2006).

Bean, Khantzian, Mack, Valliant and Zinberg (1981), who are noted supporters of Alcoholics Anonymous, explore the problems of an alcohol misuse diagnosis. They argue that differentiating between heavy drinking and early alcoholism is problematic as it is difficult to distinguish between the self-medicating individual with alcoholism and the person with alcoholism and an underlying disorder. In general, a number of different views in this regard are presented, some of which are explored in more detail at a later stage. According to Howells (cited in Ellis et al., 2011, 443), when addiction sets in, the initial high is replaced by the feeling of wanting to get the same high again, with the result that the barrier where the brain feels the body has had enough is thereby broken.

The international definition from the International Statistical Classification of Diseases and Related Health Problems 10<sup>th</sup> Revision (ICD-10), which is used by the professional psychological community abroad, will be overviewed. Hereafter the definition provided by the American Psychiatric Association (2013) will be discussed and, finally, the definition from the Alcoholics Anonymous community will be explored.

The ICD-10 defines Alcohol Use Disorder as a manifestation of three or more symptoms which continue for more than a month at a time. Symptoms include a strong desire to consume alcohol, difficulty controlling drinking, physiological withdrawal, increased tolerance and preoccupation with alcohol and/or persistent use, despite harmful consequences.

The DSM-5 (American Psychiatric Association, 2013) uses similar criteria, however, the manual specifies harmful consequences in terms of the individual's cessation or reduction of important social, occupational or recreational activities. Another difference is that the ICD-10 speaks of symptoms continuing for more than a month at a time, while the DSM-5 outlines that three symptoms must continue for more than twelve months at a time (Refer to Appendix A). Importantly, the major change in the Fifth Edition of the DSM with regard to substance disorders has been the removal of the distinction between the term abuse and dependence (American Psychiatric Association, 2013a).

Although Alcoholics Anonymous (AA) does not provide a psychologically academic classification, this community has played a pivotal role in the field of alcohol misuse. The AA methodology has been incorporated in 95% of the treatment centres within the USA and it also forms the basis of most treatment centres in the rest of the world including South Africa (Brown, cited in Bristow-Braitman, 1995).

Mental health professionals differ from the AA community in their definition of alcoholism, which is now referred to by mental health professionals as Alcohol Use Disorder. The foundation of the AA Minnesota Model is the disease concept, which explains alcohol dependence as a disease and stress

that it is not caused by moral weakness as traditionally argued (Anderson, McGovern, & DuPont, 1999). Similar to the above, this model differentiates between what they term alcoholism and alcohol dependence, stating that not all individuals who are alcohol dependent have a disorder. Rather, the individual might be physically addicted, but not have the psychological factor that is responsible for the development of Alcohol Use Disorder. It is theorised that an individual who does not have the disease of addiction is capable of stopping drinking as they have the power of rational thought. Whereas, a person who is classified in the AA community as an alcoholic does not have access to rational thoughts and reasoning in relation to alcohol, as such a person suffers from a disease as opposed to a disorder and rational thought and reasoning does not take place. The dependent alcoholic will therefore continue to drink and will be powerless over alcohol – a concept developed by Emil Jellinek (1960, cited in Levin & Weisser, 1996, p. 153).

Drug effect, drug availability, drug necessity as well as a concern with the legal, physical and psychological effects of the drugs all need to be considered when attempting to define the concepts of addiction.

## **2.2. THE AETIOLOGY OF ALCOHOL USE**

Ekleberry (2009) suggests that the individual who suffers from Alcohol Use Disorder feels empty when not attached to their object of addiction and, as such, the urge to consume alcohol becomes compulsive. Yalisove, (1997, p. 2) states that, “Certainly addiction is the perfect vehicle to consider the cultural, social, spiritual and adaptive as well as psychodynamic and biological factors in the causation of a syndrome”.

Initially, Sigmund Freud (1895, cited in Yalisove, 1997, p. 91) distinguished four types of causes for an emotional disorder, which are supported by Wurmser, namely precondition, specific cause, concurrent cause and precipitating cause. Preconditions are stated to be caused by a history of family

pathology resulting in narcissistic disturbances vis. massively overvalued images of self and others. Such a narcissistic crisis is said to be accompanied by intense emotions such as disillusionment, rage, depression or anxiety, which lead to lifelong massive conflict about omnipotence and grandiosity, meaning and trust, which are often present in individuals with alcohol use disorders (Yalisove, 1997).

A concurrent cause refers to value conflicts in the individual's culture and basic philosophical questions about the limitations of human existence. One crucial element is the conflict between democratic philosophies, postulating the dissolution of most external representatives of the superego and the increasing abolition of the restraining powers of authority and tradition. Drugs and alcohol for many individuals represent liberation from authority. A second element is the paradox with regard to mastery and domination of an individual's outer and inner life, while another factor is between immediate material gratification versus punitive and often corrupt authority (Yalisove, 1997).

However, a notable aetiology suggested is social degradation, overcrowding and drug-using peers, who form a substitute with which to replace the lack of a family structure (Yalisove, 1997).

Jacobs (cited in Yalisove, 1997, p. 167) states that an addict is predisposed to a lifelong persistent state of either hypo or hyper arousal, which leaves the individual with a narrow "window" of stress-reducing response style to potentially addictive substances or experiences. The second set of predisposing factors is of a psychological nature, which arise from social and developmental experiences in childhood and early adolescence, and convince these persons that they are inferior, unwanted, unneeded and/or generally rejected by parents and significant others. The drug then assists the individual in escaping from painful reality. Jacobs states that both of these predisposing factors must coexist for an addiction to occur.

Jacobs (cited in Yalisove, 1997, p. 171) states that an addiction results when an individual attaches to a behaviour or substance in order to better equip them to deal with their environment.

Addiction, according to Jacobson (cited in Yalisove, 1997, p. 171) is considered to be a dependent state that is acquired over time by a predisposed person, which results as an attempt to correct a chronic pre-existing stress condition. If the individual has the predisposition and is subjected to specific environmental conditions, the individual can become addicted after using the substance once, which is due to the relief produced by the substance or experience.

As mentioned, the dynamic understanding of alcohol use was first based on the drive theory formulated by Freud, and extended by Abraham, Glover, Menninger, Fenichel and Szasz, (cited in Levin & Weisser, 1996). Classic psychoanalysts argue that, “psychic energy exerts pressure on the ego and in this way alcoholism develops as a result of a struggle between expression and repression of forbidden impulses” (Levin & Weisser, 1996, p. 157). Ego psychologists, such as Rado, Raskin and Wurmser (cited in Bean et al., 1981, p. 157 & Levin & Weisser, 1996, p. 6), emphasise the role of the adaptive function of alcohol use and the role of ego defenses, more specifically denial and rationalisation.

The premorbid hypothesis argues that a substance-related disorder is the premorbid disorder, which supports the ideas of Jellinek (1960) and Valliant (1983) (cited in Fabricus et al., 2007, p. 95) who studied more than 600 individuals over a 55-year period, the results of which indicated that depression occurred as a result of substance abuse, as opposed to causing it. This theory suggests that individuals who abuse substances are more likely to develop a psychiatric disorder than those who do not. However, Fabricus et al. (2007) emphasised the importance of considering individual variability and suggest that individuals may be predisposed to developing psychiatric disorders if and when they consume certain substances.

Fabricus et al. (2007) are supported by Nora D. Volkow (cited in Fabricus et al., 2007, p. 95), a prominent drug addiction researcher and director of the National Institute on Drug Abuse (NIDA), who argues that those who suffer from substance dependent disorder share similar genetic brain



structures to people with attention deficit hyperactivity disorder (ADHD). These individuals have been found to have dopamine resistant circuitry, so the effects of using substances are pleasing to them as opposed to overwhelming them. This theory proposes that the presence of psychiatric disorders exacerbates the occurrence of a substance abuse disorder and vice versa. This theory is supported by the fact that depression and anxiety are often highly associated with substance abuse.

An alternate view proposed by Fabricus et al. (2007) suggests that no clear causal relationship exists between substance abuse and a psychiatric disorder. This theory acknowledges the relationship, but suggests that there is no clarity regarding causality of this relationship (Fabricus, Langa, and Wilson, 2007). This again draws attention to the gap in the current psychological literature.

## **2.3. ALCOHOL USE PREVALENCE**

### **ALCOHOL USE PREVALENCE**

Having accurate research regarding the prevalence of alcohol use is important, as it is the first step to understanding the problem. Statistics indicated in more detail in the Research Review section show that alcohol use differs according to location and gender.

According to Yalisove (1997), although there is a high rate of co-morbidity between Alcohol Use Disorder and other mental illnesses, they suggest that 37.5% of treated patients have co-morbid disorders. Zinberg (cited in Yalisove, 1997) states that the effects of drugs and the lifestyle of such individuals negatively affect ego functioning and this results in mental illnesses. Although a clear link has been described by many, Yalisove (1997) suggests that it is best to view mental illness and addiction separately, with each having separate degrees of intensity.

West and Hardy (2006) propose a number of reasons as to why prevalence rates vary between the sexes, as the prevalence of all addictions is higher in men than women, while economic variations also influence rates of prevalence. However, the main influences are thought to be cultural and regional variations.

#### AN INTERNATIONAL PERSPECTIVE ON ALCOHOL USE

The international statistics mentioned in the DSM-5 (American Psychological Association (APA), 2013) also estimate that one in five intensive care unit admissions is related to alcohol and that 40% of individuals in the USA experience an adverse event related to alcohol at some point in their lives, with alcohol accounting for up to 55% of fatal driving incidents. International statistics are further reported on by Fleischmann et al. (2011), who conducted a study of the consumption of alcohol, patterns of drinking and health consequences in the member states of the World Health Organisation (WHO) (2011). These member states include 193 states, of which 191 are independent countries and members of the United Nations. The other two members are the Cook Islands and Niue, which are territories of New Zealand. WHO members are divided into six regions, namely: Africa (Brazzaville, Congo), Europe (Copenhagen, Denmark), Southeast Asia (New Delhi, India), the Americas (Washington, DC, USA), the Eastern Mediterranean (Cairo, Egypt), and the Western Pacific (Manila, Philippines). This organisation's findings indicate that the harmful use of alcohol results in approximately 2.5 million deaths each year, globally, and that alcohol consumption is the world's third largest risk factor for disease and disability – in middle-income countries, it is the greatest risk. Almost 4% of all deaths worldwide are attributed to alcohol, which is greater than deaths caused by HIV/AIDS, violence or tuberculosis. Alcohol is also associated with many serious social issues, including violence, child neglect and abuse, and absenteeism in the workplace. Despite these figures, alcohol remains a low priority in public policy.

Fleischman et al. (2011) state that although lower socioeconomic status and educational levels result in a greater risk of alcohol-related death, disease and injury, and that the world's highest alcohol consumption is found in the developed world, such as Western and Eastern Europe, this does not however always translate into high alcohol-related problems and high-risk drinking. Western European countries have some of the highest consumption rates but their net alcohol-attributable mortality rates are relatively low – yet that being said, their alcohol-related disease burden may be high. Many eastern European countries have the highest consumption rates along with risky patterns of drinking and, accordingly, high levels of alcohol-related deaths and disabilities, with every fifth death in the Commonwealth of Independent States (CIS) being due to harmful drinking. Rates of disease and disability attributable to alcohol are said to be considerably high in Mexico and in most South American countries as well, while the highest and most harmful drinking patterns were also found in the Russian Federation.

In the Comparative Risk Assessment in the Global Burden of Disease Study, which took place in 2000, a pattern of drinking was developed for the various nations around the world. The riskiest patterns of drinking prevail in Kazakhstan, Mexico, the Russian Federation, Ukraine and, notably, South Africa. South America (with the exception of Argentina, which produces wine), and many countries in Africa and South-East Asia, take an intermediate position (Fleischmann et al., 2011). Heavy episodic drinking has been found to be one of the most important indicators for acute consequences of alcohol use. This kind of heavy episodic drinking is stated to be high in countries such as Brazil and South Africa. In contrast, low consumption occurs in countries such as India, Malawi, Pakistan and Zambia.

Worldwide, about 11.5% of drinkers have weekly heavy episodic drinking occasions. In the more developed regions like Europe or the Americas, heavy episodic drinking is more common than in poorer countries. In developing or emerging regions such as Africa or South-East Asia, richer

countries show a higher likelihood of heavy episodic drinking. Death, disease and injury related to alcohol consumption have been linked to economic status. Lower economic development and socioeconomic status generally mean greater health problems related to alcohol (Fleischmann et al., 2011).

#### SOUTH AFRICAN PERSPECTIVE ON ALCOHOL USE

South Africa is indicated to be one of the countries that consumes large amounts of alcohol. This is supported by the South African Community Epidemiology Network on Drug Use (SACENDU), which provides community-level public health surveillance of alcohol and other drug use trends. The SACENDU project of 2011 studied the alcohol misuse levels in the nine provinces in South Africa, namely: Western Cape; Kwa-Zulu-Natal; Eastern Cape; Mpumalanga and Limpopo (combined as the Northern Region); Gauteng; Free State, Northern Cape, and Northwest (combined as the Central Region). It was found that alcohol remains the dominant substance of use across all sites except the Western Cape and the Northern Region; only 28% of the Western Cape patients admitted to treatment and 30% of the Northern Region's patients were found to have alcohol as a primary drug of use. In Gauteng, on the other hand, 38% of patient's primary drug of use was alcohol; in the Eastern Cape, 49%; 62% in Kwa-Zulu Natal and 70% in the Central Region. The mean age of patients ranged from 33 to 40 years of age (Dada et al., 2011).

Similarly, Dada et al. (2011) published a report which detailed data from specialist substance use treatment centres based on the SECUNDA model, namely the Western Cape, Kwa-Zulu Natal (KZN), Eastern Cape, Gauteng, Mpumalanga and Limpopo provinces, and the Central Regions of Southern Africa. Data was collected on a monthly basis from twenty-three treatment centres in Cape Town, from fourteen treatment centres in Gauteng, from six treatment centres in the Northern Region, four treatment centres in Port Elizabeth, all South African National Council on Alcoholism and Drug Dependence (SANCA) centres in the Central Eastern Cape region, six treatment centres in Kwa-Zulu

Natal and five treatment centres in the Central Region. Findings indicate that alcohol was still the most common primary substance in most sites across the country and still causes the greatest burden of harm in terms of secondary risk, including injury, premature non-natural deaths, foetal alcohol syndrome, and that it acted as a potential catalyst for sexual risk behaviour and hence HIV transmission (Dada et al., 2012, p. 1). The findings of this study concur with the contemporary literature.

## **2.4. PSYCHOLOGICAL THEORIES ON ALCOHOL ABUSE**

### **PSYCHOLOGICAL THEORIES ON ALCOHOL ABUSE**

Numerous psychological theories focused on alcohol use and alcohol abuse exist. From a psychological perspective, the main theory applied to this phenomenon to date has been Cognitive-Behavioural Therapy (CBT), which focuses on changing behaviours, which will then change beliefs and feelings. This is considered a more short-term solution. CBT, together with the Alcoholics Anonymous 12-step programme, is the most popular methodology in the majority of the rehabilitation centres in South Africa. However, relapse rates continue to be alarmingly high, suggesting that current treatment methods are inadequate. This alludes to the potential for a depth psychology focused on long-term outcomes to be applied to the field of addiction more readily. The focus of this research is to explore this topic in more detail.

Early psychoanalysts emphasised the link between addiction and masturbation and the challenges presented in attempting to wean oneself from the self-soothing effects of either. Freud (cited in Matusouw & Roseblum, 2013, p. 239) stated that, “Masturbation is the major habit, the ‘primal addiction’ and it is only as a substitute and replacement for it, that the other addictions – to alcohol, morphine, tobacco and the like – come into existence”. Similarly, Sandor Rado linked the effect of

substances with orgasmic states. Ernest Simmel (cited in Matusouw & Roseblum, 2013, p. 239) focused on the idea that addiction assisted in transforming the aggression that the individual felt towards the “loved yet hated introjected object”. Freud, Abraham, Clark and Clover (cited in Matusouw & Roseblum, 2013, p. 239) also postulate that “each substance represented a penis or breast that was ingested, injected or inhaled, either in hatred or in love, but always in an unending cycle of hopelessness and despair”.

Early psychoanalysts additionally suggested that all infants come into the world as substance-dependent, which results in the alcohol-dependent individual replacing the need for nourishment with an addiction. The infant forms an association between the bottle and the nipple as being satisfying and soothing. Oedipal conflicts and homosexuality have also been implicated in the exacerbation of addictive behaviour (Matusouw & Roseblum, 2013).

As stated before, this study is focused on exploring a depth psychology, namely psychodynamic and object relations schools of thought, in relation to alcohol misuse. There are numerous theories within the depth psychology field. In an attempt to provide a broad introduction, some of the less prominent theorists, who studied alcohol misuse and addiction specifically, will be overviewed. Hereafter more detail will be provided regarding the more prominent psychodynamic and object relations theorists’ understandings of alcohol misuse.

#### **2.4.1. PSYCHODYNAMIC UNDERSTANDING OF ALCOHOL USE**

According to Yalisove (1997), two main themes in the psychoanalytic literature revolve around the understanding and treatment of addiction. Freud started out by treating neurotic patients and only thereafter did he analyse addicts. This, according to Yalisove (1997, p. 1), “makes psychoanalysis the first modern discipline to study addiction”. Furthermore, early analysts suggested that an addiction occurs as a result of a fixation in the oral phase of psychosexual development.

According to Yalisove (1997), Karl Abraham was the first psychoanalytic theorist who focused significantly on the topic of addiction in his paper titled, “The Psychological Relations between Sexuality and Alcoholism”. In this paper he theorised using mostly classical drive theory and argues that human motives are caused by “infantile sexually suppressed or overindulged drives that were repressed and later emerged in a compromise formation as partially gratified in a neurotic symptom or directly gratified in perversion”. In line with this, Abraham linked drinking and perversion, suggesting that drinking could represent the sexual activity of the alcoholic rather than prelude to it “through adult geniality but through gratification of an infantile wish” (Yalisove, 1997, p. 16).

Edward Glover suggested that not only libidinal drives were involved in addiction, but that sadistic, aggressive drives too were implicated. He also placed an emphasis on preoedipal and oedipal problems as etiological factors in addiction. Both Glover and Rado state that tolerance problems occur in addiction and that this results in the drug providing a protective function. This adaptive function links to Ego Psychology’s understanding of addiction (Yalisove, 1997).

It is stated that Rado’s (cited in Yalisove, 1997, p. 17) ideas, which are suggested to have been unusual at the time in the psychoanalytic population, formed a view that influenced theorist for decades thereafter. He described the narcissistic equilibrium and the ego, which is stated to be affected by the cycle of drug-taking and temporary abstinence.

In 1933, Rado (cited in Yalisove, 1997, p.1) is stated to have launched the modern psychoanalytic understanding of addiction, in his paper “The Psychoanalysis of Pharmacothymia (1984)”, which suggests that drug-taking was the individual attempting to adapt by using drugs. During the same time period Glover suggested that drug use was a way for the individual to suppress aggressive impulses. Both of these views are stated to have fundamentally influenced Ego Psychology (Yalisove, 1997).

In 1954, the scope of psychoanalytically focused literature expanded and several significant changes occurred. The most consequential is suggested to be the development of psychoanalytic psychotherapy (Yalisove, 1997).

Schloss Tegel, situated in Berlin, Germany, is described as the first psychoanalytic sanatorium and Simmel is stated to have devised a treatment programme, based on the drive theory, for those suffering from morbid cravings also known as an addiction. Knight worked at the Menninger Clinic in the USA, a psychoanalytic sanatorium, and he recommended further modifications in the treatment of addicts, which revolved around the development of a trusting relationship with the patient (Juni & Stack, 2005).

The Menninger Clinic in Houston, USA, developed a treatment for borderline conditions and the Chicago school developed specialised treatment for psychosomatic disorders. During the same time period Chafetz applied psychoanalytic principles to develop an alcohol treatment programme for individuals with alcoholism. Further to this, in 1950, Brown, a psychoanalyst, began to apply the understanding of transference and countertransference to addicted individuals. Gustafson, a self-psychologist, suggested that the counter-transferences and transferences of an addict were much more intense than those seen in other patients and as such could not be adequately analysed (Juni & Stack, 2005).

The drug epidemic that occurred during the 1970s is said to have inspired a number of psychoanalysts, who devoted all their energies towards understanding and treating addiction (Juni & Stack, 2005).

During this period, Ego Psychologists developed theories which suggested that addiction occurred as a result of deficits in specific areas of ego functioning (Juni & Stack, 2005). Currently, there is still a controversy as to whether these defects are a premorbid character of the addict or if they result due to failure of internalisation of the parental functions. Zinberg supports the ego defect theory rather than



the premorbid view. As such, “the pathogenesis of addiction involves the *atrophy* of ego functioning” (Juni & Stack, 2005, p. 85). Juni and Stack highlight that there is a failure of internalisation in individuals with addiction similar to the internalisation failures seen in individuals with personality disorders and psychopathy. Ego Psychologists argue that ego defects make it difficult for addicts to tolerate psychoanalytic treatment and as a result they generally motivate a number of other treatments. Psychodynamic theorists also differ in their views regarding the way in which someone acquires an addiction. Jaffe and Knazler (cited Yalisove, 1997, p. 8) outline certain stages, namely, “initiation, regular use, accelerated or heavy use, and addiction”, and once the individual becomes addicted it impacts their adjustment. This is similar to the CBT view, which is also based on a continuum theory (Juni & Stack, 2005).

EDWARD GLOVER

Glover (1932) and Yalisove (1997) states that there have been three main sources of psychoanalytic interest in drug addiction. Firstly, its aetiology is still obscure and therefore the treatment is also lagging behind psycho-neuroses. In the case of addiction, however, it is important for the psychoanalyst to enforce psychoanalytic treatment in a directive manner – “this is considered to be the difference between analysing a drug-addict and analysing drug addiction” (Yalisove, 1997, p. 8).

The next source of interest is related to psychopathological states and their correlation to addiction, which arises from the connection between drug addiction and psychoses and drug addiction and sublimatory defense-reactions. The third source of interest is related to sadistic and aggressive impulses, as opposed to analysts who are strongly focused on libidinal impulses and frustrations (Yalisove, 1997).

Drive theorists focus on transference neuroses and libidinal disturbances, specifically castration anxiety occurring in the phallic phase of libidinal development. The result is believed to be a

preconstruction of psychic events, in terms of fixation of libido at anal or oral levels. Historically, unconscious homosexuality was implicated in the development of an addiction. It was also theorised that symbolic castration occurred later in the addiction, in the form of impotence (Yalisove, 1997, p. 25).

Elements of unconscious homosexuality had never satisfactorily accounted for variations in the structure of different addictions. Flight from unconscious sexuality was also suggested to account for the symptom of paranoia and was considered to be the underlying factor in obsessive states and a source of violent resistance in characterological analyses. However, this emphasis on regressive libidinal aspects of homosexuality and genital anxiety were not satisfactory. A purely libidinal aetiology was considered to be superficial (Yalisove, 1997).

Addiction was also thought to act as a protective function in terms of regression, since in this situation the drug restores some link to reality (Yalisove, 1997).

#### EARLY UROGENITAL/ GENITAL ANXIETIES AND ADDICTION

A new perspective was formed that considered sadism and reaction formations. One view regards sadism as occurring as a result of transference neuroticism and is valued in term of genital development. Other theorists argue against the sadistic impulse theory; rather they focus on the correlations between character fusions of aggression and psychopathological states, psychoses and addiction and to a lesser extent compulsive formulations (Yalisove, 1997, p. 27).

These differing views can be seen in the work of Freud who emphasised the death-wishes role in paranoia. Schreper (cited in Yalisove, 1997) did not place emphasis on aggressive impulses and described paranoia as a libidinal conflict, which was related to repression of the Oedipus situation. Freud placed a large amount of emphasis on hate, aggression and destructive impulses in relation to ego-development. Whereas, in Erik Erikson's psychosocial development terms, an addict depends on

a negative identity for a measure of self-esteem and self-definition. They make use of defenses such as projection and introjection, and denial and repression are stated to be consistently prominent defenses. Many drug addicts' sense of self is derived from their negative social and psychological responses such as antisocial activities and rebellion, which are suggested to be expressions of aggression caused by their own victimisation.

#### SIGMUND FREUD AND ALCOHOL USE

Although Freud did not explore the topic of alcohol addiction specifically, he did explore the concept of addiction in his study of cocaine. Freud (cited in Yalisove, 1997, p. 15) published several papers on cocaine and in these papers he suggested that cocaine be used for individuals who were withdrawing from morphine. Freud tested his ideas on Fleishal, whom he gave cocaine. Due to the adverse consequences of cocaine, Freud was criticized for promoting its use, which he stopped doing in 1887. Freud also personally made use of cocaine from 1884 until 1896.

Freud's theory on addiction argues that the alcohol-dependent individual becomes fixated at the oral phase of development, which results in an orally receptive or orally aggressive personality. The oral receptive personality is preoccupied with oral gratification as the individual reduces tension through oral activity such as eating, drinking, smoking or biting nails. They are generally passive, needy and sensitive to rejection. Whereas, the oral aggressive personality is hostile and verbally abusive to others, using mouth-based aggression (Yalisove, 1997).

If the individual suffers from a phallic fixation – in that the male suffers from *castration anxiety*, whereby the son believes his father knows about his desire for his mother and hence fears his father will castrate him – he thus represses his desire and defensively identifies with his father. Girls, on the other hand, suffer from a *penis envy*, whereby the daughter is initially attached to her mother, but then a shift of attachment occurs when she realizes she lacks a penis. She desires her father whom she sees as a means to obtain a penis substitute. She then represses her desire for her father and

incorporates the values of her mother and accepts her inherent 'inferiority' in society. In this way the substance represents the repressed feelings around the penis (Yalisove, 1997).

In Freud's *Civilization and Its Discontents* (1929), he states that "the crudest, but also the most effective among these methods of influence is the chemical one – intoxication. I do not think that anyone completely understands its mechanism, but it is a fact that there are foreign substances, which, when present in the blood or tissues, directly cause us pleasurable sensations; and they also so alter the conditions governing our sensibility that we become incapable of receiving unpleasurable impulses" (cited in Yalisove, 1997, p. 22).

Freud referred to masturbation as the primary addiction and shortly hereafter, he supported the abstinence theory in order to sustain long-lasting cure from addiction. He states in *Sexuality and the Aetiology of the Neuroses* (1898, cited in Yalisove, 1997, p. 15), "these narcotics are meant to serve – directly or indirectly – as a substitute for a lack of sexual satisfaction; and whenever normal sexual life can no longer be re-established, we can count with certainty on the patient's relapse". This quotation refers to Freud's early theories in which he argued that neurosis occurs as a result of unhealthy sexual accumulation of sexual excitation.

In *Civilization and Its Discontents* (1929), Freud shows a disregard of religion; in contrast AA is based on a spiritual programme to alleviate addiction (Yalisove, 1997).

Freud (cited in Yalisove, 1997, p. 16) suggests that intoxication is used to ward off not only disappointments but also external pressures. This implies that Freud believed external forces cause addiction, a view which is contrasted by the majority of psychoanalysts who believe that addiction occurs as a result of internal factors (Yalisove, 1997).

Howard Markel published, *An Anatomy of Addiction: Sigmund Freud, William Halsted and the Miracle Drug, Cocaine* (2012), which focused on the involvement with cocaine of two of the most significant figures in the development of modern medicine. As indicated, Freud (cited in Smith-

Pickard, 2004) connected the action of intoxication and the regulation of feelings particularly unpleasant ones. This is supported by Freud's (cited in Eckleberry, 2009, p. 69) statement that, "the freedom in drugs is that the pressures of reality can be evaded and consequences ignored".

Specifically, Freud makes reference to alcohol, in his writings in the years before 1900, however he does this in relation to hysteria and hypnosis in the form of subjection, which according to Freud (cited in Descombey, 2005) is a habit caused by a spectrum ranging from organic affections to the disorders of the imagination. Descombey (2005) argues that Freud referred to the concept of alcohol usage in two instances – firstly, in letters that he wrote to Wilhelm Fleiss (especially that of December 22, 1897); and secondly, and to a greater degree, in his text titled *Sexuality in the Aetiology of the Neuroses* (1898). As highlighted by Descombey:

Freud writes, that habit is a mere form of words, without any explanatory value, and success will only be an apparent one, so long as the physician contents himself with withdrawing the narcotic substance from his patients, without troubling about the source from which their imperative need for it springs (1989/2005, p. 276).

Freud and Abraham (Descombey, 2005; Loose, 2002) believed initially that alcohol was not the cause of symptoms in an alcoholic, but rather it was used to remove unwanted symptoms, such as inhibition and sublimation. In this way, Freud referred to the relationship between the alcohol-dependent individual and alcohol as non-conflicting or, in Freud's words, as the purest harmony and an example of a happy marriage (1912).

Levin (1986) furthers the link between Freud's work and alcohol dependence, stating that Freud indicated that rejection and/ or disappointment of the "object love" can lead to withdrawal and redirection of interest (libido) from the world and into the self, which is labelled as secondary narcissism and is distinguished from primary narcissism, which is stated to occur in the initial stages of life. Secondary narcissism is stated to result from the individual's psychotic withdrawal from the

world, as is the case in Alcohol Use Disorder, where the individual emotionally withdraws from the world (Levin, 1986, p. 124). This is particularly pertinent for alcoholics, who can emotionally withdraw to a point of psychosis.

Descombey (1994) cautions that Freud's views on alcohol misuse disorder were somewhat blinded by his own relationship with cocaine and tobacco.

Melanie Klein (cited in Yalisove, 1997) opposed the view of Freud; she argued that fixation-points of the psychoses are pregenital sadistic fixations and that individuals experience paranoid anxiety in the early anal phases when they have phantasies about attacking the mother's body. Aggressive tendencies are transferred to the excretory system, urine and faeces, being sadistic properties, the projection of which gives rise to anxieties. However, controversy exists in respect to detailing the sadistic phantasy-systems and defenses (Yalisove, 1997).

According to David Rappaport's formulation (1967, cited in Yalisove, 1997), a regressive state develops when the ego is unable to maintain relative autonomy from the id or the external environment. In such a state the barriers differentiating ego and id processes become fluid. Ideas and fantasies based on primary process thinking rise to consciousness, and the individual develops a reliance on more primitive defenses. These individuals suffer constantly from doubts and their ability to maintain relationships, and they cling to stereotyped views about themselves. These impaired autonomies result in the ego being forced to make do with insufficient or distorted input from both id and the external environment. The ego must then modify its structures to conform to this new, more restricted and primitive pattern (Yalisove, 1997).

#### LATE GENITAL ANXIETIES

Current psychoanalytic literature views drug addiction in terms of late genital anxieties. Rado argues that a type of basic fixation occurs on which a "pharmacotoxic orgiastic system is built up" (Yalisove,

1997, p. 29) and he attaches no specific content to the psychic system. Simmel supports the fixation theory, which occurs in a phase antedating psychic structure. He furthermore related drug addiction to melancholia as a secondary regression, in following a primary obsessional mechanism, and like Rado he supports the idea of a fixation factor in a phase antedating psychic structure. Although attempts are made to establish deeper roots for fixations of addiction, the tendency is to look for them in phases of development when psychic structure must be of the most rudimentary order. Rado likens drug addiction and abstinence to manic-depressive sequences; he looks for the basic fixation in a phase of “alimentary orgasm” on which a pharmacotoxic orgiastic system is built up. The oral and anal worlds are among the concentration points of the body-world of the earliest phase of development. The pleasure of this phase has been termed “alimentary orgasm”, because it is an inner pleasure attaching to the entire alimentary tract which begins at the mouth and ends at the anus. These theorists believe that psychic hunger is created in this phase (Neuman, 1988, p. 28).

Glover (cited in Yalisove, 1997) states that these ideas are reactionary or represent a stage of primal intestinal narcissism. Pre-structural factors of this type can be considered to be predisposing, without using the term fixation. Glover (cited in Yalisove, 1997, p. 30) also states that he cannot find any adequate explanation of drug addiction which does not assume “an active Oedipus situation at a stage when object relations are developing and when sadistic and libidinal functions overlap considerably”.

Furthermore, drug addiction is stated to imply a fixation to a transitional Oedipus system, which lies between the more primitive Oedipus nuclei that produce paranoid/ melancholic anxieties and the Oedipus nucleus that is responsible for later obsessional reactions. An addiction is also thought to be a defensive reaction to control sadistic charges, which are suggested to be less violent than the sadistic charges associated with paranoia, and more severe than the sadistic charges in obsessional formations. Drug addiction is also stated to be a protection against psychotic reaction in states of regression (Yalisove, 1997).

Unconscious homosexual phantasy-systems are not considered a direct aetiological factor, but are representative of a defensive system – due to their libidinal cathexis (both narcissistic and genital), homosexual systems act as a protection against anxieties of the addiction type. Therefore, the close association of homosexual interests with drug addiction implies either the persistence of a defensive system or the ruins of a defensive system (Yalisove, 1997).

SANDOR RADO

Rado (cited in Yalisove, 1997) states that the psychoanalytic study of addiction begins with the recognition of an impulse that releases a craving, as opposed to a substance, and that it is the impulse which forms an addict. Cravings of all drug types are suggested to be varieties of one disease. Rado states that although the etiology of drug addiction has been focused on erotogenic oral zones and a relationship to homosexuality, he rather places an emphasis on the pleasure principle, in which the focus is on the drug, in this case alcohol, removing pain and creating pleasure.

An addiction occurs as a result of intense depression and the addict's "craving for magic" (Yalisove, 1997, p. 53). Once the individual consumes a substance, their ego shrinks and they are left with guilt because they are ignoring their real needs and they struggle with increased fear of reality. These occurrences result in the ego becoming more irritable, which increases anxiety levels and results in greater ego deficits and the craving for elation.

RONA KNIGHT

According to Knight (cited in Yalisove, 1997), alcohol enmeshes with the individual's entire emotional life and soon the alcoholic feels betrayed, as they did in infancy by their mother, as it becomes increasingly difficult for the individual to attain the right sense of well-being, freedom from psychic distress and narcissistic self-esteem, but this individual nevertheless continues to attempt to reach the right sense of self being with one more beverage. This individual then falls into a drunken stupor and the next day they feel guilty and condemn themselves. This results in a vicious neurotic



cycle, which according to Knight is caused by childhood experiences that result in a personality characterised by excessive demands for indulgence. These demands are doomed to frustration in the world of adults, which causes the individual to feel rage and disappointment and react in self-destructive and hostile acts. The individual then feels guilty and punishes themselves masochistically. As reassurance against these feelings, this individual feels excessive need for affection and indulgence as proof of affection. Again these needs are doomed to frustration, and the neurotic vicious cycle is complete. Overall, the alcohol acts as a pacifier (Yalisove, 1997).

During the 1970s drug epidemic, psychoanalysts built upon the theoretical concepts introduced by Rado and Glover regarding the importance of premorbid psychopathology in creating a vulnerability to addiction and the adaptive function of drugs and moved away from the drive theory of addiction. Two trends developed: (1) Wurmser and Krystal focused on a traditional conflict-theory approach; (ii) Gustafson and Khantzian followed the deficiency theory of Kohut and viewed addiction as a variant of Narcissistic Personality Disorder. Both of these trends focused on premorbid personality factors of the addict as the cause of addiction. Other psychoanalysts began to consider factors outside the traditional view of psychoanalysis to understand addiction (Yalisove, 1997).

Wurmser is suggested to be one of the modern pioneers in addiction treatment. He posits that addicts are predisposed to addiction because of significant narcissistic disturbances in early childhood; these individuals experience a narcissistic crisis that propels an addictive search relieved by the use of the drug, and addiction is rapidly established. Krystal is a psychoanalyst with interests in both addiction and survivors of trauma, more specifically Holocaust survivors. He, as with Wurmser, assumes addicts have severe premorbid psychopathology that predisposes them to addiction. He states that addicts have suffered early infantile trauma, which created difficulties in their affect development and led to alexithymia. He feels addicts are blocked from exercising self-control in several areas because they cannot integrate the ambivalently held mother introject. He argues persuasively for a conflict

explanation of this problem. Zinberg (cited in Yalisove, 1997) challenges the assumption that the premorbid personality problems are a primary cause of addiction. He argues that the lack of stimulus nutriment in addicts' lives causes their egos to regress and interferes with ego autonomy, applying important concepts of Rappaport.

#### LEON WURMSER

Wurmser (cited in Yalisove, 1997) states that although the majority of drug users are inaccessible to psychoanalysis, a few studies have been done that have explored the topic of psychoanalysis and compulsive drug use (Wurmser, 1974, 1978). The contributions of Chein et al., (1964), Krystal and Raskin (1970), Wieder and Kaplan (1969), Dora Hartmann (1969), Savitt (1963), Panel (1970), Zinberg and Robertson (1972), and Khantzian et al. (1974) are stated to be notable examples.

Wurmser (cited in Yalisove, 1997) points out that individuals primarily use drugs to relieve themselves of what is missing or bothering them. He supports his statement by suggesting that this is why the individual will engage in other substances or behaviours if the drug is removed. The problem as such is the individual's disturbed emotions. This view, he argued, is supported by the link between borderline or even psychotic conflicts with compulsive drug use.

Furthermore, Wurmser states that it is important to distinguish between a psychological hunger, which presents in the form of an addictive search as opposed to social experimentation. According to Wurmser, the addict would fall into the addictive search and range along a continuum in terms of severity, which is linked to the severity of the individual's emotional disorder (Yalisove, 1997).

#### HENRY KRYSTAL

Similarly, Krystal (cited in Yalisove, 1997) found an affective disturbance in drug-dependence. He describes the affective disturbance in drug dependent individuals as consisting of affect dedifferentiation, deverbalsation, and resomatisation (Krystal, 1977, 1978; Krystal & Raskin, 1970).

It is possible to prepare some substance-dependent individuals for psychoanalytic psychotherapy by offering them a preliminary stage of the treatment in which the patient's affective functions are dealt with (Yalisove, 1997).

According to Krystal and Raskin (1970, cited in Yalisove, 1997), the addict is not able to self-soothe in the way that an ordinary person does. Krystal (cited in Yalisove, 1997, p. 124) states that the drug-dependent individual has "a type of self-disregard in which impairment of a multitude of functions is related to proper self-care and self-regulation". Intrapsychic blocks/ repressions develop at various times in the individuals' childhood and prevent them from being able to adequately care for themselves.

Zinberg (cited in Yalisove, 1997, p. 124) has also commented on the drug addict's severe impairment in self-care. He suggests that these individuals are not only self-destructive, but also "manage almost never to do well for themselves in the simplest life transactions".

Drug-dependent individuals are not free to take care of themselves unless under the "order" of transference objects or under the influence of a placebo. These patients can make use of an external object that can act like a symbolic object and thus repair the psychic gap (Yalisove, 1997, p. 125).

Substance-dependent and psychosomatic patients alike experience their self-caring functions as reserved for the maternal object representation and psychologically inaccessible to them (Yalisove, 1997).

Krystal (cited in Yalisove, 1997, p. 126) placed particular emphasis on the nature of the infantile experiences that interfere with the child's development of a freedom for self-soothing. In situations where a mother's need for a narcissistic unity with the child is so great that she becomes jealous of the child's other objects, even a transitional object, and prevents the use of it, the child fuses their perceptions of the mother and their distress and therefore the image of the "bad mother or bad self being punished" becomes merged with a myriad of other fantasies.

On the other side of the spectrum, Fain (cited in Yalisove, 1997) places an emphasis on the child engaging in a type of autoeroticism, which eliminates the mother as an object. In such a case, McDougall (cited in Yalisove, 1997) states that instinctual aims and autoerotic activity run the risk of becoming autonomous and detached from any mental representation of an object.

The substance/ transitional object then acts like a placebo, and it permits the exercise of functions which, from an early age, are experienced as part of the object representation. The impoverishment of the self of self-helping resources of the object representations is stated to be the most severe form of psychic crippling. According to Krystal, the kind of person who is likely to become drug dependent is one who uses the substance to help him carry out basic survival functions, which the individual otherwise cannot perform (Yalisove, 1997).

Desire is stated to appear in the transference in the analysis of alcoholics and other drug-dependent individuals due to their lack of maternal soothing, and this phenomenon and phase of the treatment has been termed by Fenichel (1954) as object addiction.

According to Krystal, transferences need to be interpreted so that the individual will discover that the characteristics that they attribute to the analyst are actually their own mental representations, which the individual first perceived as being part of their mother and now re-experiences as alienation. After all, the healing principle of psychoanalysis consists of the individuals gaining insight into their own mind, and thereby restoring conscious recognition of their own self. This presents a huge challenge for drug-dependent individuals, as they repress their rage and destructive wishes toward their maternal love object. This need manifests itself in a rigid “walling off” of the maternal love-object representation, together with an idealisation thereof and an attribution to it of most life-supporting and nurturing functions. By doing so, the patient manages (in their fantasy) to protect “the love object from his fantasied destructive powers and to assure that someone out there loves him and will take care of him” (Krystal & Raskin, cited in Yalisove, 1997, p. 130).

Krystal states that the process of withdrawal from drugs is an integral part of the process of addiction (Krystal, cited in Yalisove, 1997). He also states that the intolerance to the substance is greater in drug-dependent individuals because they have the need to deprive the drug of its power and, at the same time, the moment it does lose its force they panic.

It is suggested that the addiction revolves around the process of taking in and losing the drug as opposed to having it. The ambivalence toward the therapist in the transference is stated to be the same as the individual's ambivalence toward the drug, and this is a reliving of the severe ambivalence towards the maternal object representation (Yalisove, 1997).

According to Krystal, it is broadly accepted that alcoholics and other drug-dependent individuals cannot tolerate object losses (including the therapists) without being so threatened by their effects that relapse is unavoidable (Yalisove, 1997, p. 132).

According to Yalisove (1991), addicts make use of projections, which are impulses, feelings and wishes that are not integrated, within the individual. Projections result due to these individuals "walling off" their maternal object due to extreme aggressive impulses toward it. The intensity of the narcissistic rages and the persistence of aggressive impulses suggest that all addiction could be considered to be a "hate addiction". It is stated that some individuals will be driven to prove that their childhood misfortunes were real by attempting to provoke the analyst, while others may become so terrified of the dangerous, transference object that they set out on a frantic search for the ideal mother, which is represented in the form of objects – such as drink, love or gambling (Yalisove, 1997, p. 134).

Krystal's (cited in Yalisove, 1997, 135) theory regarding impairment in capacity for self-love is similar to Kohut's theory regarding transmuting internalisations, whereby aspects of the object image break apart as they are being internalised and in this way introjects are depersonalised and a psychic structure is formed (Yalisove, 1997, p. 135).

As such, the goal of the psychoanalysts is to deal with distortions in self-representation and object representation. Psychic blocks to functions of self-soothing are generally externalised by the individual (Yalisove, 1997). To develop adequate object relations, the individual should be encouraged to verbalise their affective states as precisely as possible. The symbolic representation of the individual's needs is directly linked with their ability to experience their narcissistic omnipotence in terms of fulfilment of their wishes. The availability of a good self-object permits the grandiosity of the child to unfold appropriately and also permits the feeling that it is proper for the individual to take care of themselves (Yalisove, 1997). The primary caregiver is the holder of external supplies and often the distressed individual loses sight of the fact that they have a role in their own soothing (Yalisove, 1997).

Zinberg (Yalisove, 1997) also suggests that it is important to understand the power of social settings in understanding drug abuse, beyond the internal image of the mother. Infantile psychic trauma has serious after-effects in that there may be regression in the genetic development of affects, which results in alexithymia, impairment in symbolisation and frequently anhedonia, and a general fear of effects as trauma screens. Another after-effect relates to the premature disruption of the symbiotic unity, which places the child with a dangerous, all-powerful external object (the traumatic experience) that cannot be satisfactorily controlled. These after-effects result in the individual attempting to magically control the object by splitting, idealisation and masochistic modifications of the self-representation (Yalisove, 1997).

According to Zinberg (cited in Yalisove, 1997), in the 18<sup>th</sup> century, alcohol was one of the most popular substances to be used and because of this many more alcoholics were created by the system. Similarly, today, heroin use has increased substantially, resulting in more heroin addicts. Zinberg suggests that the more society becomes accustomed to a substance, the less extreme cases occur. Today more is done to prevent alcoholism and people are more educated regarding the risk factors,

which according to Zinberg has resulted in more controlled drinkers as opposed to alcoholics. The statistics presented by Zinberg indicate that in the past, 75–80% of individuals who consumed alcohol would become alcoholics, whereas now there are between 6 and 8 million alcoholics and 100 million controlled drinkers of every personality type. According to Zinberg (cited in Yalisove, 1997, p. 148), our relative control over alcohol stems from inculcation of social maxims and rituals.

Zinberg (cited in Yalisove, 1997) argues that an individual's responses to a substance are determined by the individual's degree of emotional disturbance and the personality of the individual.

As can be noted, there are numerous theories regarding the cause and treatment of addictions. Drive Theory, Ego Psychology, Self-psychology and Object Relations theory all play an important role in the understanding and treatment of mental disorders, including addictions. Drive aspects of addiction theory relate to the finding that addicts often have a fixation at the oral level and have excessive aggressive impulses. From the ego aspect of addiction theory, certain ego functions are impaired in addicts. The self-disturbances in addicts are reflected in their self-destructive behaviour, their lack of capacity to regulate self-esteem, their extreme self-absorption and the fragility of their sense of self. Object relations aspects include the tendency for addicts to enact many experiences of their lives over and over again with little or no awareness of the original cause (Yalisove, 1997). In order for society to be empowered as a whole in terms of adequately treating addiction, it is important to bring these theories together in an effort to create an all-encompassing theory, which can be applied to every addiction.

#### **2.4.2. ADDICTION CONCEPTS NOT ADDRESSED PSYCHODYNAMICALLY**

Little in the way of psychodynamic literature exists that integrates results of studies on different substances, however, according to Yalisove (1997), clear links exist between all addictions. Furthermore, an addiction to any substance has specific features. The evidence that supports this commonality is the fact that polysubstance use is an extremely common phenomenon, and the pleasure-pathway theory presented in physiology is further evidence to support this.

#### **2.4.3. THEORY OF ADDICTION**

In 2006, West and Hardy published *The theory of addiction*, which endeavours to tie the different views of addiction together in an attempt to prove an all-encompassing and holistic theory. In order to do this, West and Hardy (2006) emphasise the role of the motivational system in an addiction and then go on to explain themes that are pivotal in an addiction.

West and Hardy (2006) link their theory to that of the psychoanalysts in that they state that there are various forces at play promoting addictive behaviour. They also consider social and cultural factors. The goal of these authors is to “develop a synthetic theory of addiction” (West & Hardy, 2006, p. ix).

West and Hardy (2006) propose different themes that form the various pillars of their theory.

The first theme revolves around the structure of the system, which according to West and Hardy (2006) consists of different levels, namely impulses/inhibitory forces, motives (desires), beliefs, responses and overarching plans. These levels are constantly challenged by an individual’s internal and external experiences.

The second theme refers to the moment to moment control of behaviour (West, 2006, p. ix). West and Hardy (2006) suggest that beliefs, wants and needs are fleeting entities, such as memories. However, motivation is stated to be caused by the structure of the brain and the neural connections that get



passed down genetically from one generation to the next. According to West and Hardy (2006), too much emphasis is given to individual attitudes such as self-efficacy.

The third theme refers to the changeability of the motivation system, which again refers to genetics influencing the motivational system; for instance, what occurs in the case where responses are lowered or heightened due to sensitisation or associative learning (West & Hardy, 2006).

The fourth theme refers to the identity of the individual, in which West and Hardy (2006) argue that our motivation is fundamentally influenced by mental representations. Self-control is based on what we choose to be part of our sense of self. The way we think about ourselves in terms of self-labels influences our emotions and then our behaviour, which is the same when it comes to self-protection or self-harm. Again, an individual's belief in their own ability also influences the actions they take and what they commit to doing.

The last theme refers to the mind, which according to West and Hardy (2006) is unstable. Our minds are constantly exposed to triggers, to which a stable mind reacts and rebalances. However, in some situations this rebalancing does not transpire and West and Hardy (2006) state that this is when addiction occurs. These authors believe this is due to environmental events that influence switches within an individual, and in this way the individual becomes addicted. This forms the basis of the chaos theory (West and Hardy, 2006).

## **2.5. OBJECT RELATIONS AND ALCOHOL USE**

In traditional psychoanalytic literature, the word object refers to a person, however in Object Relations terms, an object can be many things, including objects of desire and fear, rather than simply only a person. Object is differentiated from the subject, and as such the object is outside of the self and is perceived by the self in a number of ways including desire, fears and rejection, or is otherwise

internalised. Object can also be breasts, music, art, the weather, or else substances can become objects; in these cases the objects are deeply and symbolically connected to powerful object experiences in the internal world. Substances may function as medication and also as a “symbol of care”. When taken by the mouth they also resemble feeding and nurturance (Flanagan, 2011, p. 120). This study will focus more on the later psychodynamic theorist, namely the Object Relations theorist.

According to Flanagan (2011), there are several theories within the Object Relations field, which are divided into the British and the American traditions. Main proponents of the British School are Melanie Klein, Ronald Fairbairn, Harry Guntrip, Donald Winnicott and John Bowlby. Chief among the Americans are Margaret Mahler, Otto Kernberg, Thomas Ogden, and James Masterson.

Rather than looking to the influence of the ‘id’, Object Relations theorists look to the influence of external objects such as parents and other significant people in a child’s world. In contrast to Freudian theory, more recent psychodynamic theory (since the 1970s specifically) looks at the human person in the context of their lived experience. For Object Relations theorists, including Melanie Klein, W. D. Fairbairn, D.W. Winnicott, Margaret Mahler, Otto Kernberg and Heinz Kohut, “the self is not a hypostasized essence, but conceived as the locus of experience” (Flanagan, 2011, p. 120).

The object, in relation to the Drive Theory, refers to the target of the drives and hence the target becomes the object by which the drive can be satisfied or frustrated. In relation to the Object Relations theory, the object refers more to the person, real or internalised, with their qualities and the individual’s contribution to interaction. Another distinction between Object Relations theory compared to Drive Theory and Ego Psychology is that Object Relations looks more closely at needs being met by relationships, rather than by satisfaction or frustration of particular impulses. As such, Object Relations make a clear distinction between need and impulse (Flanagan 2011).

Object Relations theory refers to the work of a group of psychodynamic theorists, both in England and the United States of America. Object Relations is not one theory, but rather refers to the works of

many psychoanalytic theorists who did not identify with a particular school of thought and who often disagreed with one another. Nevertheless, their theories revolve around the same central themes, which are different from the Drive Theory, Ego Psychology and Self-Psychology. The core belief that these Object Relations theorists share is that all human beings have an internal, generally unconscious world of relationships that influences the individuals more than what happens in the individual's external world with interaction with real people (Flanagan, 2011).

Object Relations theorists emphasise the importance of an individual's fundamental and primary need for attachment and the harm that results if this need is not met. John Bowlby states that attachment is a primary, biological and absolute need and, as such, the primary caregiver is important to the child's psychological existence. He also suggested that when the child's needs are not met, true mourning occurs due to the absence of a caregiver, rather than merely frustration because wishes were not gratified. Donald Winnicott recognised the importance of distinguishing between needs and wishes that are either met or gratified – real needs for object relations are either met or not met. Furthermore, Bowlby conducted studies across cultures and concluded that attachment is pivotal in terms of an absolute need (cited in Flanagan, 2011).

Before Bowlby, Spitz (cited in Flanagan, 2011) stressed the importance of adequate emotional care for children to prevent psychological harm, as without appropriate attachments a lack of soothing introjects taken in from the people around them makes the child vulnerable to psychopathology. Attachment fundamentally influences the fullness and quality of a person's inner world and this is greatly influenced by the quality of the individual's early relationships.

The focus of Object Relations theory is on the process whereby people come to experience themselves as separate and independent from others and at the same time needing attachment to others throughout their lifetime (Flanagan, 2011).

Melanie Klein (cited in Flanagan, 2011) states that Object Relations form the centre of emotional life. Object relations theories focus on two main areas: firstly, the interaction between people and the process by which individuals internalise those interactions is prioritised; secondly, Object Relations focuses around the influence that the internalisations have on an individual's psychological life. The term *object relations* then refers to relationships with others, internal mental representations of others, and to internal images of self. In this way, Object Relations theory argues that human beings incorporate physical and psychological experiences into the psyche and these experiences with others become part of the person's psychological self. Furthermore, Object Relations make use of external relationships with others, to understand the internal world between self and other, and the way in which the other becomes part of the self (Flanagan, 2011, p. 119). Depending on each person's psychological strengths, vulnerabilities, past experiences and social and cultural influences, each person's body reacts differently to experiences and, in this way, the person is affected by both nature and nurture.

### **2.5.1. DONALD WINNICOTT AND ALCOHOL USE**

Donald Woods Winnicott was born in England in the 20th century and was a paediatrician and psychoanalyst who studied child development. Winnicott (cited in Flanagan, 2011) argues that impulses and drives can be fulfilled in the individual by a relationship with a meaningful other over time (Flanagan, 2011). Object Relations theorists believe that for development to take place, the need to be seen and valued as a unique separate individual, "to be accepted as a whole with both good and bad aspects, to be held tight and to be let go, and to be cared for, protected and loved" is essential (Flanagan, 2011, p. 120).

Winnicott (cited in Wood, 1987) argues that the more the parent's needs impinge upon the child, the more the child withdraws aspects of their true self from the parent or the environment and the child is suggested to do this to protect their core from destruction. Winnicott (cited in Wood, 1987, p. 26) said

the false self is actually an aspect of the true self that may be “conveniently society-syntonic”, but he believed it to be inherently unstable and incapable of experiencing life or feeling real. In this way the individual “organises an illness” as opposed to collapsing in chaos. As such, the false self is a pathological formation that serves a critical function in protecting the individual’s core being. In this way the individual’s true self remains unconscious until the individual is able to work through some object-related failures of childhood and in so doing the original parent-child situation is “frozen” in the individual’s psyche. Kohut and Winnicott both emphasise the importance in applying the therapeutic approach of unfreezing traumatic experiences, such as those experienced by individuals with Alcohol Use Disorder.

Specifically, in relation to alcohol misuse, Winnicott (1947) further states that intolerance to alcohol can be interpreted as a reaction formation to the excitations that alcohol promotes, or to the frequently negative attitudes toward individuals with alcoholism, sometimes as extreme as hatred, or even to the most primitive issues of the individual with alcoholism that are stirred in the therapist. Winnicott’s treatment focused on detoxification and social prohibition and requires of the individual to draw strength from the libido’s current as opposed to the involvement of the superego. The effectiveness of the individual’s ability to stop drinking is suggested to be associated with dysfunctional libidinal investments that have been formed as a result of alcohol. According to Winnicott, these libidinal investments are often then expressed by the alcohol abuser in the form of exhibitionism and/ or homosexual and/ or narcissistic masochism (Wood, 1987).

### **2.5.2. OTTO KERNBERG & EDWARD KHANTZIAN AND ALCOHOL USE**

Otto Friedmann Kernberg is a psychoanalyst and professor of psychiatry in New York, USA who is most widely known for his psychoanalytic theories of borderline personality organisation and narcissistic pathology. Kernberg's views (cited in Bean et al., 1981, p. 171) are similar to Edward Khantzian, a professor of psychiatry at Harvard Medical School in Boston, USA. He is the originator of the self-medication hypothesis related to drug abuse, which argues that individuals abuse drugs in an attempt to self-medicate feelings of distress and suffering.

Both Kernberg and Khantzian focus on pathological self-structures within the individual. Kernberg, however, applies them to the borderline personality organisation, which he links to alcoholism. He also argues that alcohol-dependent individuals make use of primitive defense mechanisms, such as splitting, denial and projection in order to split off a part of the self, and alcohol is used to reactivate the grandiose all-good self and object image. In this way the all-bad internalised object within the individual's psyche is denied (Levin, 1987).

Kernberg (cited in Levin, 1987, p. 226) built on Jacobson's concept of self and object representations to delineate four stages in the development of Object Relations. It is argued that individuals suffering from alcoholism are generally found at Stage 3. Stage 1 consists of positive (libidinally cathected) self-object representations; Stage 2 consists of negative (aggressively cathected) self-object representations (no differentiation between self and world). Fixation at either of these stages results in psychosis.

In Stage 3, the self and object representations are differentiated, resulting in four structures, namely: positive self-representation, negative self-representation, positive object representation, and negative object representation. Fixation at this stage or regression to it is suggested to result in borderline pathology. According to Kernberg, many alcoholics regress to a borderline character structure, whereas some have never developed beyond this stage (cited in Levin, 1987).

Stage 4 refers to attainment of object constancy, which is the ideal state of ego structures in terms of integration of the negative self with object representations resulting in stable self-representations. The attainment of object constancy indicates that there is a cathexis of the constant mental representation of the object and there is also a firm sense of identity. According to Alfred North Whitehead (cited in Levin, 1987), most alcoholics in the early stages of recovery are not functioning at this psychological level.

Kernberg (cited in Levin, 1987) theorised that in normal development the ego and the id are structured separately and have affectively differentiated complex self and object representations. When an individual is emotionally healthy, the self and object representations integrate the gratifying aspects of experience and are differentiated from each other. Hereafter, the superego develops, the formation of which involves the differentiation from the ego and a series of identifications with parents and other mentors. The superego represents the conscience and the ego-ideal of the individual; it comprises of the internal parent and is vitally involved in self-regulation and the maintenance of self-esteem (Levin, 1987, p. 227).

Kernberg (cited in Levin, 1987) conceptualises normal narcissism as the libidinal investment of the self. This self is a structure in the ego which integrates good and bad self-images. Levin (1987) states that particularly relevant to and illuminating of alcoholic psychopathology is Kernberg's concept of pseudo-dependency in the narcissistic personality and his description of the grandiose self. According to him, the pathologically grandiose self defends against the investment in others, more specifically against dependency on others. This characteristic may manifest itself as a pseudo-self-sufficiency, whereby the patient denies any need for nurturance while at the same time attempting to impress others and gain approval, as found in the narcissistic personality.

### **2.5.3. HEINZ KOHUT AND ALCOHOL USE**

Object Relations theorists such as Krystal, who specifically explored alcohol in relation to Object Relations, focused more on internal family representations and the dynamics of how these representations influence an individual. On the other hand, proponents of Self-Psychology, such as Khantzian and Kohut (cited in Bean et al., 1981) state that alcohol is used in an attempt to correct structural deficits that have resulted from traumatic incidences with the individual's maternal figure. Alcoholics are suggested to suffer from pathological self-formations, which occur due to pathological internalisations, identification and self-structures.

Heinz Kohut was an American psychoanalyst who formulated about the way in which individuals develop from a narcissistic position. As a result, he was shunned from the psychoanalytic community and instead started the Self-Psychology tradition (Watts et al., 2009).

Kohut (cited in Bean et al., 1981) provides support for Kernberg's theory. He states that substance abusers use substances to feel soothed, when the self-esteem resurges. Krystal and Raskin (1970) also refer to the defenses, specifically to denial and splitting in alcohol-dependent individuals. They suggest that these defenses suppress feelings in relation to the self and other. Krystal argues that alcohol-dependent individuals use alcohol to give them a feeling of safety.

Kohut contradicts Freud's (cited in Watts et al., 2009) view, which stated that primary narcissism occurs between the auto-eroticism and object-love stages, during which Freud suggested that the infant experiences itself as being omnipotent. Freud then argues that secondary narcissism is a pathological state in which the narcissistic individual's libido is withdrawn from the outside world, thereby resulting in these individuals being unable to maintain mature relationships because they are completely self-absorbed. In opposition, Kohut described narcissism as an indispensable defense that has its own course of development. According to Kohut, self-love is a prerequisite for mature



relationships. In this same vein he argued that it is healthy for an individual to enjoy their successes in a healthy manner (Watts et al., 2009, p. 184).

One of Kohut's central features of his theory of narcissism relates to the process whereby an individual moves from conceiving objects to be purely external to internalising certain qualities that the individual perceives the object to possess, and in this way making these qualities his own. Wolfe (1989) explains the contrast between Freud's understanding of the terms "self" and "object", which referred to objectively existent objects as opposed to object relations theorists who focus on inner experience. Kohut (cited in Levi, 1987, p. 12) also viewed addictive behaviour as an attempt to deal with narcissistic disturbances; he also viewed alcoholics as individuals who become self-absorbed to make sure that they are still alive. Their sense of self is weak, which results in them living on the edge of constant psychic annihilation and their barely cohesive selves may fragment at any time.

Kohut (cited in Levin, 1987, p. 13) states that addiction is an attempt by the individual to repair developmental deficits in the self and, as such, treatment of these individuals should focus on the repair of these deficits. Such deficits result in a lack of what Kohut called "psychic structure", as in internal resources for maintaining self-esteem. Self-Psychology also proposes that the centrality of control for an alcoholic is their attempt at trying to exercise omnipotent control over self-objects and this includes the world being experienced as part of themselves. AA places a large amount of focus on treating the addicts need to control.

Kohut (cited in Levin, 1987, p. 13) sees narcissistic disturbance as central to the psychopathology of the addict. The core difficulty of narcissistic personalities is the absence of internal structure; explicitly, there are deficits in the self's capacities for tension regulation, self-soothing and self-esteem regulation. The alcoholic's pathological drinking is an attempt to make up for this "missing structure", and in this way alcohol serves to reduce tension and reinsulate self-esteem in the absence of adequate intrapsychic resources to achieve such regulation.

## **2.6. ALCOHOL USE DISORDER AND CO-MORBID DISORDERS**

### **CO-MORBID PSYCHIATRIC DISORDERS**

On the international front, a number of research studies were carried out using the BORRTI. In 1991 Bell and Steins (1991, p. 72) conducted a pilot study in which they assessed the way in which ego-functioning changed through rehabilitation. The BORRTI and Symptoms Checklist-90 (SCL-90) administered to a sample of twenty-five psychiatric in patients who had been in the rehabilitation centre for six months – these individuals were reassessed a year later again. The results from the SCL-90 show that although somatisation, paranoia and hostility symptoms increased, no changes occurred in relation to distress symptoms. In the BORRTI, a significant improvement in the Object Relations dimension of social competence was found.

According to Edwards, Marshall and Cook (2003, p. 110) alcohol problems and psychiatric disorders are both common and some degree of overlap should be expected in any population. In the Epidemiologic Catchment Area (ECA) study, which took place in America in 2003 (Edwards, Marshall & Cook), 37% of individuals in the general population with an alcohol disorder also experienced other psychiatric disorders. The most common co-morbid disorders were stated to be anxiety disorders (19%), antisocial personality disorder (14%), affective disorders (13%), and schizophrenia (4%). Another American survey, the National Co-Morbidity Survey (NCS), reported a slightly higher level of co-morbidity. The evidence for lifetime co-morbidity was more likely to occur in women than in men. Anxiety and affective disorders were the main contributors to co-morbidity in women. The predominant co-morbid disorders among men were substance use disorders, Conduct Disorder and Antisocial Personality Disorder.

The national British Psychiatric Morbidity survey (2007) found heavy drinking and alcohol dependence to be associated with higher rates of psychological morbidity, which is supported by the BORRTI results of the participants in this study. In the USA, a National Epidemiologic Survey on

Alcohol and Related Conditions (2004) argued that 14.79% of all Americans have at least one personality disorder (cited in Ekleberry, 2009, p. 11). Hasin, Stinson, Ogburn and Grant (2007) also suggest a high level of co-morbidity between alcohol dependence and depressive, bipolar, anxiety, and personality disorders. Furthermore, Hasin et al. (2007) state that the level of co-morbidity increases with the severity of substance-related disorders.

Hasin, Stinson, Ogburn and Grant (2007) state that co-morbidity of alcohol dependence with other substance disorders appears due in part to unique factors underlying aetiology for each pair of disorders, while co-morbidity of alcohol dependence with depressive, bipolar, anxiety and personality disorders appears more attributable to factors shared among these disorders.

In 1988, Tyrer, Casey and Ferguson presented studies which indicate that 69% of individuals with alcohol dependence meet the diagnosis of a personality disorder. In 1993, Weissman (cited in Ekleberry, 2009) stated that between 13% and 18% of the population in America have personality disorders. In 1995, Dowdon and Grouds studied alcoholic individuals in outpatient settings and indicated that 64% of these individuals had personality disorders. In 1996, Benjamin (cited in Ekleberry, 2009, p. 4) argued that half of the populations in mental health treatment have personality disorders.

Merikangas et al. (1998) also indicate a strong association between mood and anxiety disorders. In particular, conduct disorder and antisocial personality disorder were also found to be strongly associated and all these disorders were strongly associated with substance-related disorders (including Alcohol Use Disorder). The level of co-morbidity was found to increase with the severity of substance-related disorders.

Evans and Sullivan (1990) supported these findings and they suggest that individuals with a psychiatric disorder are at an increased risk for having a substance abuse disorder. Furthermore, it is stated that individuals with severe Alcohol Use Disorder, especially those with co-morbid Antisocial

Personality Disorder, are associated with the commission of criminal acts. Suicide attempts and completed suicides are also highly correlated with individuals with severe Alcohol Use Disorder.

Epidemiological studies conducted in Beaverton, USA have suggested that the prevalence rates for alcohol and substance abuse or dependency are around 7% in the general population. However, individuals with a history of major depression or anxiety disorder appear to have double the risk for later substance misuse. Among young, chronically mentally ill patients, reported chemical abuse rates approach or exceed 50%. Other data suggest a 20% alcohol abuse rate for persons with a Bipolar Disorder and 70% rate for persons with an Antisocial Personality Disorder. These numbers are indicated to be conservative as clinicians often fail to diagnose substance abuse in psychiatric patients and it has been reported that by using urine drug screening on psychiatric inpatients, it shows that patients underreport their substance use (Evans & Sullivan, 1990).

Tyrer, Casey and Ferguson cite British studies indicating that 69% of individuals with alcohol dependence and abuse also have a personality disorder. Similarly, Dowson and Grounds (1995) note a study of alcoholic outpatients in which it was determined that 64% had a personality disorder. Edward, Marshall and Cook (2003) suggest that psychiatric disorders often pre-date the alcohol problem and that co-morbidity could be due to the individual attempting to self-medicate with alcohol in an attempt to alleviate psychiatric symptoms (cited in Edward et al., 2003, p. 114).

With regard to co-morbid mood disorders, depression has also been found to be common amongst individuals with drinking problems and in most cases the depression is secondary to the alcohol problem. Depression is stated to pre-date alcohol abuse or dependence in 66% of the women in the Epidemiologic Catchment Area (ECA) study, and depression was found to be more prevalent in women drinkers as well as in problem drinkers who have a family history of alcohol-related problems. A history of negative life events and a family history of depression appeared to be risk

factors for secondary depression in male alcohol-dependent individuals (cited in Edward et al., 2003, p. 114).

According to Edward et al. (2003), hypomania is not as common a condition as pathological depression, and when it occurs does not carry a particularly high risk of being associated with drinking. Occasionally, hypomanic patients may, however, find that alcohol relieves unpleasant elements in their feelings and as a result these individuals engage in binge-drinking (Edward et al., 2003).

Higher rates of co-morbid SUD and psychiatric illnesses have been found to be linked to medication non-compliance, relapse and re-hospitalisation, work-related issues, financial problems, homelessness, HIV infection and an increased prevalence of suicide (Weich & Pienaar, 2009). More regular treatment is needed for these individuals, which is costly but assists in lowering the individual's tendency to experience major impairments in terms of social isolation and interpersonal conflicts.

Eckleberry (2009) presents a detailed analysis of the disorders that are most likely to be co-morbid for all the disorders presented in the DSM; he also describes the drugs of choice that are most likely to be linked to the different disorders.

#### PERSONALITY DISORDERS AND ALCOHOL MISUSE

Eckleberry's (2009) findings will be overviewed below in the different personality clusters A, B and C. Cluster A and C are least likely of the three categories to be linked to alcohol problems.

In relation to Cluster A Personality Disorders, Eckleberry (2009) states that individuals suffering from Schizoid Personality Disorder (SPD) have deficits in responding to others in an emotionally meaningful way. These individuals are generally impervious to feelings of joy, anger or sadness and as a result they make use of defense mechanisms such as intellectualisation, conflict avoidance and

withdrawal, which they use to detach and form emotional barriers. Individuals with SPD are most likely to have: Schizotypal, Paranoid and/ or Avoidant personality disorders as co-morbid disorders. Their drug of choice is stated to be alcohol, which assists the individual in collapsing all their needs into one object of attachment (Walant, 1995, cited in Eckleberry, 2009).

Individuals with Schizotypal Personality Disorders (StPD) suffer from an intense amount of social anxiety and struggle with an inability to achieve interpersonal safety (Eckleberry, 2009). Slight or soft delusions are often employed by these individuals, which are used to assist them in living in the past or in a fantasy. These individuals use alcohol or other substances to regulate their needs and to connect to a social environment.

According to Eckleberry (2009), Cluster B Personality Disorders are the most likely to be co-morbid with substance and alcohol abuse. Antisocial Personality Disorder (ADP) individuals are generally deceitful, aggressive and socially vindictive. This disorder is suggested to be caused by a basic failure of human attachment (Eckleberry, 2009). Defense mechanisms employed include projection and acting out. The inability of individuals with Antisocial Personality Disorder to connect negative consequences with behaviour, contempt for authority, laws and social norms, as well as the inclination toward impulsive action, their need for high level of stimulation and their failure to self-regulate result in these individuals engaging in polydrug use (Eckleberry, 2009).

Borderline Personality Disorder (BPD) is characterised by marked impulsivity, a pattern of unstable interpersonal relationships, self-image and affect. Eckleberry (2009, p. 79) suggests that such individuals are caught between their feelings of shame, which are caused by their dependence, fear of abandonment, and their need to be assertive. These feelings result in an explosive anger which generally elicits the rejection that these individuals fear (Million & Grossman, 2007; cited in Eckleberry, 2009, p. 79). These individuals make use of dysregulation in terms of self-injurious, self-mutilating or suicidal behaviour, as well as through dysregulation including depersonalisation and

dissociation and self-dysregulation in the form of an incomplete sense of self and feelings of emptiness. Other defense mechanisms employed include regression, denial and/ or minimisation of the consequences of their behaviour.

As diagnosed, individuals with histrionic personality disorders suffer from a pervasive and excessive pattern of emotionality and attention seeking behaviour; they are lively, dramatic and flirtatious. These individuals fail to view others realistically and this influences their ability to develop satisfactory relationships. HPD defenses include denial and dissociative and repressive defense mechanisms. According to Eckleberry (2009, p. 101), “the incidence of co-occurring substance use disorders is so high for these individuals that it is imperative to assess drug and alcohol use when they enter mental health treatment”. Drugs of choice for these individuals are suggested to include antianxiety agents and stimulants; however, they also often use what is fashionable in their environment.

Individuals diagnosed with Narcissistic Personality Disorder are grandiose, lack empathy and have an extreme need for admiration. They have fragile self-esteem and are hypersensitive to criticism. Their entitlement and disregard for others results in impaired relationships (Eckleberry, 2009). McWilliams (1994, cited in Eckleberry, 2009) suggests that these individuals take one of two stances – the grandiose or depressive posture, depending on their ideals. Substances are suggested to support these individuals’ grandiose ideals, which is supported by Freud’s statement: “drugs can give immediate pleasure and provide a greatly desired degree of independence from the external world and the pressures of reality” (Khantzian cited in Eckleberry, 2009, p. 117). These individuals’ drugs of choice are generally the ones that support the inflated sense of self, such as cocaine and methamphetamines; however, they may use alcohol to ward off unwanted intrusions of unpleasant reality.

According to Eckleberry (2009), individuals with Cluster C Personality Disorder do not abuse alcohol as much as Personality disorders in cluster B. Individuals with Avoidant Personality Disorder struggle

with a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation. They have pathological self-images of being socially inept, unlikeable and inadequate, and they struggle to adapt to adversity. They use fantasy and dysphoria in an effort to escape their emotions, which they struggle to self-regulate. They also make use of activities and addiction to distract themselves from negative thoughts and feelings and in this way they engage in self-soothing. Sedatives and anti-anxiety agents are the drugs of choice for these individuals (Eckleberry, 2009). Individuals with a Dependent Personality Disorder have a pervasive and excessive need to be taken care of which results in submissive and clinging behaviour. These individuals are pessimistic, characterised by self-doubt and often live with someone who is controlling, domineering and infantilising. These individuals make use of defenses such as minimisation, denial or distortion; however, their primary defense mechanism is introjection of a more powerful other than themselves. These individuals fail to self-regulate and therefore increases their inclination to use prescription drugs and alcohol (Eckleberry, 2009).

According to Eckleberry (2009), individuals with Obsessive-compulsive Personality Disorders (OCPD) have a preoccupation with orderliness, perfectionisms and control at the expense of flexibility and openness, which results in these individuals experiencing an ongoing conflict between obedience and defiance. It is also stated that at least 50% of people who meet the diagnosis for OCPD also meet the criteria of at least one other personality disorder, especially avoidant or dependent personality disorders. They have extremely high expectations of themselves and others, which results in them being vulnerable to a range of affective disorders. They make use of defense mechanisms that assist in controlling their anxiety, such as intellectualisation, isolation of affect, undoing reaction formation, displacement and regression. Some individuals with OCPD may be intolerant to disruptive feelings created by intoxication, dependence and/ or withdrawal; however, they may make use of



substances to control their internal discomfort and negative feelings. It is suggested that no specific drug of choice has been linked to this disorder (Eckleberry, 2009).

Individuals with Paranoid Personality Disorders, part of Cluster A are more likely to stay away from substances that may break their paranoid defense down, which will make them feel weak and inferior. However, alcohol for some may help to reinstate their defenses, in that it may assist the individual to control feelings of despair and worthlessness (Eckleberry, 2009).

Goodwin and Stein (2013) studied the relationship between anxiety disorders and substance dependence in a population in the USA between the ages of 15 and 45. Data from the National Comorbidity Survey was used and alcohol dependence and co-morbid major depression were explored. The results suggest that substance dependence precedes anxiety disorders, particularly in the case of panic disorders. Furthermore, a history of past substance dependence was found to be a precursor to current panic disorder, social phobia and agoraphobia. Anxiety disorder was found to be the first onset in approximately 30% of Generalised Anxiety Disorder cases (GAD), around 40% of post-traumatic stress disorder (PTSD) cases and more than 50% of substance abuse disorders. It was also found that a lifetime history of GAD, PTSD or Social Phobia significantly predicts lifetime substance dependence. Thus substance use disorders and anxiety are often co-morbid as the individual self-medicates the anxiety symptoms (Goodwin & Stein, 2013).

Quello, Brady and Sonne (2005) studied the co-morbidity between mood and substance use disorders and suggest that mood disorders are the most common psychiatric co-morbidity in patients with substance use disorders. Data from the National Institute of Mental Health Epidemiologic Catchment Area (ECA) Study (Regier et al., cited in Quello et al., 2005) was used to ascertain these results.

It is stated that diagnostic issues are complex when assessing mood and substance use disorders as co-morbid disorders. This is due to the fact that abstinence from substances including alcohol can cause a

temporary depression, which could result in patients who are withdrawing being incorrectly diagnosed with a mood disorder (Quello et al., 2005).

Numerous theories have been proposed which explain the high rates of co-morbidity between substance abuse and mood disorders (Quello et al., 2005). The first proposes that the pathological effects of one disorder increases the likelihood of the other disorder developing. The second theory revolves around affect regulation that results in exacerbated mood degradation, which leads to increased use and dependence (Quello et al., 2005). The third theory relates to self-medicating of the individuals and suggests that individuals select drugs based on medicating their specific psychiatric symptom. The self-medicating theory proposes that mood disorders increase the likelihood of substance use dependence, though the converse is also true: chronic substance use may unmask a mood disorder as a trigger to the excessive substance abuse.

Two studies, the National Co-morbidity Survey (NCS) (1991) and the ECA (1994) study mentioned above (cited in Quello et al., 2005) pinpoint lifetime prevalence rates for co-morbid disorders. The findings suggest that development of any non-substance use disorder in the participants of these studies is 22.5% likely and the lifetime prevalence rates for co-morbid disorders and alcohol abuse/dependence is 13.5% likely and 61% likely for other drug misuse/dependence, and 32% likely for individuals diagnosed with mood disorders who also had a co-morbid substance use disorder.

Other co-morbid findings suggest that 16.5% of individuals with lifetime major depression have an alcohol use disorder and 18% have a drug use disorder. Substance Use Disorder was found to be especially high in individuals with bipolar disorders at 56% co-morbidity of lifetime substance use dependence (Quello et al., 2005). The NCS study indicated lifetime prevalence for any mental disorder at 48%, with alcohol dependence being estimated at 14.1% and drug dependence at 7.5%. Lifetime prevalence for any mood disorder was 19.3%. In comparison with individuals with no mood disorder, those with depression were twice as likely and those with bipolar disorder seven times as

likely to have a co-morbid SUD. The ECA study also documented a high rate of co-occurrence of SUD, mood and anxiety disorders (Quello et al., 2005).

The USA studies conducted have indicated different percentages of co-morbidity. Dowdon and Grouds (1995) state that 64% of their sample had co-morbid disorders, while Benjamin (cited in Eckleberry, 2009) argued that half of their sample had co-morbid disorders. The Epidemiologic Catchment Area (ECA) study in the USA (Edwards, Marshall & Cook, 2003) state that 37% of the population have co-morbid alcohol use disorder and other psychiatric disorders, with the most common co-morbid disorders being anxiety (19%), antisocial (14%), affective (13%), and schizophrenia (4%) related disorders.

The national British Psychiatric Morbidity survey found that heavy drinking and alcohol dependence were associated with higher rates of psychological morbidity, which can be noted in the findings of the BORRTI and the Pearson's Correlation Coefficient scores. Hasin, Stinson, Ogburn and Grant (2007) also suggest a high level of co-morbidity between alcohol dependence and depressive, bipolar, anxiety and personality disorders. Furthermore, Hasin et al. (2007) state that the level of co-morbidity with other psychiatric disorders increases with the severity of substance-related disorders.

#### SOUTH AFRICAN LITERATURE

According to Stein et al. (2008), South Africa has a particularly high lifetime prevalence of substance use disorders in comparison with data from other countries. South African lifetime prevalence of psychiatric disorders, in general, are less than the USA, with 30% and 50% of participants being affected respectively. Although the percentage of South Africans suffering from a psychiatric disorder is less than the USA, this number is considerably higher than the "majority of other countries that have participated in the first wave of the WHO World Mental Health Survey Initiative" (Stein et al., 2008, p.1).

According to Van Heerden, Grimsrud, Seedat, Myer, Williams and Stein (2011), there is limited data on substance use in South Africa and even less so with regard to alcohol use. However, most substance dependent individuals engage in polydrug use patterns, which include alcohol. Akindipe, Wilson and Stein (2014) studied the co-morbidity between methamphetamine dependence and a range of psychiatric disorders. A structured diagnostic interview was used to assess the prevalence and co-morbid psychiatric disorders in 100 individuals dependent on methamphetamine from three different rehabilitation centres. Co-morbid psychiatric disorders were identified in 36% of the sample; these included mood disorders (16%), psychotic disorders (13%) and anxiety disorders (7%). Other factors that were found to influence co-morbidity included gender and if the participant had a previous psychiatric disorder. More male participants were found to have co-morbid disorders. Mood, psychotic and anxiety disorders were identified as being common co-morbid disorders in individuals with methamphetamine dependence. These findings underscore the need for an integrated model of care addressing both substance use disorders and psychiatric co-morbidity (Akindipe, Wilson & Stein, 2014). Individuals who make use of methamphetamines often engage in polydrug use, which includes excessive alcohol use and alludes to the link between Alcohol Use Disorder and the psychiatric disorders mentioned in this study.

In 2011, van Heerden, Grimsrud, Seedat, Myer, Williams and Stein presented a study that describes patterns of substance use based on data that was collected for the South African Stress and Health (SASH) study, conducted during the time period 2002 to 2004. SASH was an epidemiological survey of mental illness and part of the World Health Organisation's (WHO's) World Mental Health (WMH) 2000 initiative. A nationally representative household probability sample of 4,351 adults was interviewed using the WHO Composite International Diagnostic Interview (CIDI). The results indicate an estimate for cumulative occurrence of alcohol as being 38.7%, of tobacco smoking 30%, of cannabis use 8.4%, of other drug use 2%, and of extra-medical psychoactive drug use 19.3%. Some

findings related to ethnic orientation suggested that White and Coloured individuals were more likely than African individuals to use alcohol, tobacco and other drugs. This study referred to these findings as providing a foundation for future epidemiological work on drug use patterns across birth cohorts and population subgroups in South Africa.

Van Heerden et al. (2011) suggest that economic and political issues also influence substance use. These authors suggest that due to the fact that South Africa was relatively isolated from the rest of the world during the apartheid era, substances used during those times were produced locally, notably alcohol, tobacco and cannabis. However, after the social and political transformations of the 1990s and early 2000s, links and trade with the rest of the world opened and with this substance related problems have increased dramatically, which has also resulted in an increase in mental illness (van Heerden et al., 2011).

In the past, substance abuse data in South Africa has been limited (van Heerden et al., 2011). More recent studies have however been conducted, with the most notable being the South African Community Epidemiology Network on Drug Use (SACENDU) project, which meets biannually to discuss substance abuse patterns (van Heerden et al., 2011). Alcohol has been identified as the most abused substance in South Africa, with cannabis being the most common illicit drug used. These findings also indicate that different areas of the country are affected by different patterns in substance misuse. The primary substance of abuse in Cape Town is crystal Methamphetamine (aka Tik). In Gauteng and Mpumalanga, Caucasians were found to be the highest users of substances, followed by Africans, Coloured and Indians. In Port Elizabeth and Cape Town, Coloureds were found to be the highest users. In East London, African individuals far outnumber any other group (Stein et al. 2008). Although there are few differences in lifetime prevalence by ethnic group, an increase in lifetime prevalence of substance use disorders in the Coloured group, according to the authors, is due to this group of individuals being given a distinct status under the Apartheid government as well as resulting

from the Coloured workers on wine farms being paid according to the 'dop' system (Stein et al., 2008). Although there are clear differences between ethnic groups and their access to health care in South Africa, other aspects between ethnic groups and psychiatric disorders may be more complex, one being the heterogeneity of the construct of ethnicity (Stein et al., 2008).

In 2009, Herman, Stein, Seedat, Heeringa, Moomal and Williams compiled research based on the data collected in the SASH study. Their focus was to provide data on the 12-month and lifetime prevalence of psychiatric disorders. They made use of weighted cross-tabulation methods and logistic regression analysis to estimate correlates of 12-month and lifetime prevalence. Results indicated that the lifetime prevalence for any disorder was 30.3% and that the most prevalent 12-month and lifetime disorders were the anxiety disorders. The Western Cape had the highest 12-month and lifetime prevalence rates, and the lowest rates were in the Northern Cape. The high prevalence in the Western Cape could be due to being the first region in South Africa to be colonised and also because it is now fairly urbanised. In contrast, lower rates of mental disorders were identified in rural areas such as the Eastern Cape.

Weich and Pienaar (2009) researched substance use disorders (SUD) among psychiatric inpatients in the Western Cape, South Africa. The sample comprised of participants from Stikland Hospital as well as three state acute psychiatric hospitals in the province. Over a three-month period, a survey was administered to 298 participants who were hospitalised in the acute psychiatric wards. Co-morbid Substance Use Disorder was diagnosed in 51% of the patients, substance-induced psychiatric disorders at 8% and 1% were diagnosed with substance-induced mood disorders. A total of 7% of the sample was diagnosed as having a substance-induced psychotic disorder. The findings of this study indicate that SUD's are prevalent amongst psychiatric inpatients and contribute to their co-morbidity. Weich and Pienaar's (2009) study supports the fact that the abuse of methamphetamine is highly

prevalent in the Western Cape and is the preferred drug of choice for patients in substance treatment programmes in the province.

Fabricus, Langa and Wilson (2007) conducted a study to assess the prevalence rates of co-morbid substance-related and psychiatric disorders. They used the Statistical Analysis System (SAS) where 419 individuals were interviewed and 57.1% of the sample had one or more co-occurring psychiatric disorders, along with substance-related disorder. Of the 239 individuals who were diagnosed with co-morbid disorders, 155 had a mood disorder, 40 had an anxiety disorder, 39 had ADHD, 35 had an eating disorder, 8 had a conduct disorder and 5 had schizophrenia. Statistically significant relationships were found for ADHD with cannabis-related disorders and polysubstance dependence; anxiety-related disorders with alcohol-related disorders; and mood disorders with cocaine-related disorders and substance-induced disorders. These high rates of co-morbidity indicate that there is a large need to have individually tailored and detailed treatment plans; this is as result of the array and complexity of disorders that they present with. A total of 52% of the sample presented by Fabricus et al. (2007) was diagnosed with an alcohol-related disorder. According to Sadock and Sadock (2003), alcohol is the most frequently abused substance internationally. Watkins et al. (cited in Fabricus et al., 2007) found that 69% of the sample reported using alcohol and that the rate of alcohol abuse was between 10 and 20% higher than in the co-morbid sample as opposed to the non-co-morbid sample. Pluddeman et al. (2005, cited in Fabricus et al., 2007) cited statistics by SACENDU which indicated that 38% of the sample of individuals seeking treatment for substance abuse in Gauteng also reported abusing alcohol. It is suggested that the higher rates of alcohol abuse in the co-morbid samples may be because of the statistically significant relationship found between anxiety and alcohol related disorders.

Fabricus et al. (2007) found that there was no statistically significant relationship between alcohol and mood disorders, which could be due to the fact that the percentages of individuals with a mood

disorder and the percentages of individuals with an alcohol related disorder are extremely high, which could suggest that these disorders may simply co-occur by chance. Mood disorders, however, were found to be highly associated with cocaine-related disorders. Gold (1997) indicates that at least half of individuals seeking treatment for substance abuse also meet the criteria for a mood disorder. According to Sadock and Sadock (2003), this could be due to the fact that mood disorders are most likely to follow the onset of cocaine-related disorders (Little, Krolewski, Zhang, & Cassin, 2003, cited in Fabricus et al., 2007).

Eckleberry (2009) states that approximately 13–18% of the general population have personality disorders. This is based on the USA National Epidemiological Survey on Alcohol and Related Conditions, which cites an overall prevalence of 14.79% of adult Americans with at least one personality disorder. Benjamin states that over half of the adults in mental health treatment in the USA have a personality disorder. The relationship between alcohol problems and personality factors is complex. From a British viewpoint, Edward, Marshall and Cook (2003) emphasise the importance of identifying the personality disorder of the person who has a drinking problem, in order to treat the individual adequately.

## **2.7. GENDER DIFFERENCES AND ALCOHOL ABUSE**

### **GENDER DIFFERENCES**

In the Dasis report (2002), gender prevalence rates for the co-morbid and non-co-morbid sample were also compared; there was a more equal distribution of males and females in the co-morbid sample. A total of 71% of the non-co-morbid samples were males, with 29% being females. However, the co-morbid sample comprised of 55% males and 45% females. A chi-square test of association revealed that a statistically significant proportion of women versus men were diagnosed with a COD. This



theme has been found in other studies, whereby the admission of people with co-morbid disorders into American prisons were more likely to be female than substance abuse only admissions (Dasis, 2002, as cited in Dolan, Kolthoff, Schreck, Smilanich, & Todd, 2003). In a study conducted in Los Angeles, USA in a public outpatient substance abuse treatment facility, Watkins et al. (2004) found that the non-co-morbid sample comprised of 75% were male and 25% were female. Their co-morbid sample, however, comprised of 52% males and 48% females.

In terms of South African studies, a study within the Western Cape indicated the prevalence rate of the gender of people admitted to psychiatric hospitals in terms of overall psychiatric admissions were more likely to be female, whereas more males were admitted for substance-related disorders (cited in Fabricus et al., 2007). Fabricus et al. (2007) indicate that 57% of inpatients admitted to the rehabilitation centre had a substance-related disorder and one or more co-occurring psychiatric disorders. The results support international research, which found that co-morbidity rates are between 50 and 90% (Fabricus et al., 2007). Thus, research has shown high levels of co-morbidity of substance use disorders and other psychiatric disorders globally.

Fabricus et al. (2007) argue that strong gender differences exist with regard to mental illnesses and substance abuse. Females internalise their problems and as a result suffer more from depression and anxiety. Males, on the other hand, were found to externalise more, resulting in delinquency, aggression and substance abuse (Rosenfield, Phillips, White, 2006). Social stigma has also been indicated to play a role in these statistics as well as women being less likely than men to seek treatment due to limited finances resources and domestic responsibilities. Blume (1999) and Green (2006) suggest that this could be due to there being a greater stigma associated with female substance abuse; furthermore, women have trouble accessing treatment because they fear retribution from the social welfare system. This system often assumes child rearing to be the female's domain.

However, a study conducted in the Western Cape opposes these findings. Strebelt et al. (2004) found that women were admitted more frequently than men, indicating that non-substance psychiatric disorders are more commonly treated in women and substance related disorders are more commonly addressed in men.

Gender prevalence rates were compared in two samples and the findings indicated that the amount of males and females who had co-morbid disorders was more closely correlated than the amount of males and females with one disorder only, with the co-morbid group comprising of 55% males and 45% women; whereas the single diagnosis sample comprised of 71% males and 29% females. These findings are supported by a study by Watkin et al. (2002, cited in Fabricus et al., 2007), in which they found that the co-morbid sample was comprised of 52% males and 48% females and their non-co-morbid sample was comprised of 75% males and 25% females.

According to Fabricus et al. (2007), the results of their study indicated that 57% of the people admitted to the rehabilitation centre had a substance-related disorder, as well as one or more co-occurring psychiatric disorders. These statistics concurred with international research, which found that the co-morbidity of substance-related disorders and other psychiatric disorders is between 50 and 90% (Alverson et al., 2000; Beeder & Millman, 1997; Strathdee et al., 2002; Weaver et al., 2002). The statistics of this study also indicate that males are more highly represented than females in studies related to substance abuse, with the males comprising 55% of the sample and the females 45% (Pluddeman et al., 2005 cited in Fabricus et al., 2007). Another reason is related to the fact that pregnant women or women with their children are not accepted into treatment facilities.

## **2.8. METHODS USED TO ASSESS OBJECT RELATIONS**

In London, within the United Kingdom, Hadley, Holloway and Mallinckrodt (1993) used the BORRTI to assess the Object Relations in offspring from dysfunctional families, to determine whether the Object Relations of adult children of alcoholics' were damaged in different ways

compared to adults whose family dysfunction was not due to substance abuse. The sample consisted of 97 individuals from both a clinical and community setting. The results of this study indicate that family dysfunction was found to be high in the majority of cases, but no significant differences were found between adult children of alcoholics (ACOA) and adults from non-substance-related dysfunctional families. It was found that dysfunction in the family was related to shame, emotional problems, addiction and Object Relations deficits. Furthermore, family dysfunction was negatively correlated with goal instability and superiority in the form of narcissism. Importantly, the study suggests that clinical interventions based on Object Relations and attachment theories may be particularly useful with adult children from dysfunctional families.

In 1995, Hardwick, Hansen and Bairnsfather (cited in Li & Bells, 2008) studied ACOA with the goal of discerning whether ACOA are unique in terms of their Object Relations and Reality Testing utilising the BORRTI. This study was conducted in California, USA. The sample was made up of 49 adult children of alcoholics (ACOA), 55 adult children of normal families (CAN) and 48 children from dysfunctional families (ACD). This study found that adult children of alcoholics are significantly different from CAN families on more than half of the BORRTI's variables, namely Hallucinations and Delusions, Reality Testing, Alienation, Egocentricity, Social Incompetence, Uncertainty of Perception and Insecure Attachment. Differences were also found between ACOA and ACD families, however in this instance differences were observed on the Reality Testing scales of the BORRTI. Both ACOA and ACD families differed from CAN families with regard to insecure attachments and perceived quality of maternal and paternal caregiving.

In the USA, Altonji (1996, cited in Li & Bell, 2008) studied the way in which the Object Relations of adult daughters of alcoholics influenced their reaction to stress in their own parenting role. A total of 38 ACOA mothers and 50 non-ACOA mothers completed the Parenting Stress Index (PSI) and the BORRTI. Results indicated significant differences between the two groups on the following scales:

Alienation, Insecure Attachment and Social Incompetence. For each significant result, the non-ACOA mothers demonstrated significantly healthier Object Relations score means. No significant differences were noted in relation to parenting stress or Egocentricity. The level of Object Relations were also found to account for the increase in the level of variance in parenting stress beyond that explained by the adult children of alcoholic status alone. These results suggest ACOA status in conjunction with Object Relations development is more useful than ACOA status alone in understanding variations in parenting stress for this population.

Strand and Wahler (1996) analysed the role of maternal Object Relations in predicting maladaptive parenting. In this American study, 34 mother and children pairs participated in two testing sessions. In the first session, the mothers and children were observed in their homes having natural interaction and, in the second instance, the mothers completed several questionnaires related to their child's behaviour, their own dysphoria, the socioemotional climate, and their own Object Relations. These predictors were then regressed against two criterion variables, namely maternal compliance with child disobedience, and mother's childcare behaviours acted out without careful judgment. Results indicated that deficits in Object Relations variables accounted for mothers acting without careful judgment; however, there did not seem to be a correlation between deficits in Object Relations and a mother acting in a compliant manner when their child was misbehaving or not having the courage to discipline their children.

The situational confidence, affect intensity and Object Relations in alcohol and cocaine-dependent men were investigated by Higgins (1997). The sample comprised of 47 alcohol-dependent and 46 cocaine-dependent male veterans in the USA. Three testing instruments were used: The Affect Intensity Measure (Larsen & Diener, 1987, cited in Li & Bell, 2008), a measure of emotional reactivity, the BORTTI (Bell, 1991, cited in Li & Bell, 2008), and the Situational Confidence Questionnaire-39 (Annis & Graham, cited in Li & Bell, 2008). The SCQ-39 measured self-efficacy

regarding situations with potential to induce relapse. The Addiction Severity Index to assess substance use was also administered. Results indicated that the alcohol group was more confident than the cocaine group in their capacity to resist heavy use of substances in response to unpleasant emotions, social problems at work, or when experiencing urges to use. No differences between the groups were found on affect intensity or Object Relations scores. For the cocaine group only, higher egocentricity was associated with lower situational confidence in negative situations, so the cocaine using individuals' level of egocentricity/self-awareness and paranoia increased in negative situations resulting in lower levels of confidence.

Snyder (1999) explored the relationship of psychopathy and Antisocial Personality Disorder to the Object Relations and Reality Testing of alcoholic men in the USA. The BORRTI was used to evaluate the differences in the Object Relations and Reality Testing of participants. The Psychopathy Checklist-Revised was used to measure the level of psychopathy and the Personality Disorder Examination was used to measure Antisocial Personality Disorder. More than half of the 151 male alcohol-dependent samples had elevated BORRTI scores, indicating general Object Relations and Reality Testing disturbances. Results also indicate that individuals with specific psychopathy in the alcoholic sample did not exhibit greater impairment than alcoholic patients without psychopathy. Men diagnosed with Antisocial Personality Disorder demonstrate the greatest impairment on the BORRTI's scales. The reason for this finding is related to the idea that those individuals diagnosed with Antisocial Personality Disorder demonstrate more borderline-type of pathology than men with psychopathy. Another reason could be related to the fact that Object Relations and Reality Testing problems in psychopathic individuals may not be evident in self-reports.

In the USA, Santina (1998) compiled a study titled, *Object Relations, Ego Development, and Affect Regulation in Severely Addicted Substance Abusers*. This comparative study assessed the Object Relations, alexythymia, ego development, psychopathology and experienced level of childhood

trauma of two groups, namely, an experimental group – 50 severely addicted substance abusers – and a control group – 50 non-addicted individuals. The BORRTI, the Sentence Completion Test for Ego Development, the Toronto Alexythymia Scale, the Symptom Checklist-90, and the Childhood Trauma Questionnaire were administered to all participants. Results showed that individuals with substance abuse displayed significant difficulties in several areas, namely, the ability to recognise and differentiate emotions, difficulty in forming secure relationships, chronic feelings of alienation, and egocentricity. Individuals with substance abuse also reported significantly greater levels of childhood trauma and psychopathology than did control subjects. Object Relations deficits, alexythymia and experienced level of childhood trauma were highly correlated across the entire sample. Ego development was weakly correlated with some measures and not with others. Santina concluded that Object Relations theories on addiction are empirically supported, and thus that the deficits of individuals with substance-related disorders should be addressed in the treatment approach adopted.

In 2002, Bladt performed an exploratory study of the psychodynamic understanding of binge-drinking behaviour in 181 male and 196 female first-year students, in their first-semester attending university in Northeastern USA. Four assessment measures were administered to this sample: the Toronto Alexithymia Scale, the Rosenberg Self-Esteem Scale, the BORTTI, and the College Alcohol Survey. Results found clear differences in the relationship between ego-functioning and drinking behaviour for men compared to women. Findings indicate that the meaning of alcohol use may differ for male and female students. These findings suggest that the meaning of alcohol differs in terms of gender.

## **2.9. TREATMENT METHODOLOGIES**

### **TREATMENT METHODOLOGY**

Bean, Khantzian, Mack, Valliant and Zinberg (1981) state that making the diagnosis of alcohol misuse is the beginning of the treatment process. Bean et al. further state that the usual professional approach has been to treat alcoholism as a psychological problem. That said, the research literature

focused on the treatment of Alcohol Use Disorder is notably diverse and often conflict in terms of understandings and treatment approach. Treatment programmes can range from AA-orientated programmes (as described by Valliant, 1984) to the direct psychiatric treatment approach such as those described by Khantzian and contemporary authors (Yalisove, 1997).

Although psychoanalysts started treating addiction in the 20th century, the views around addiction in the 19th century occurring as a result of an individual having weak morals and therefore discouraged individuals with Alcohol Use Disorder from seeking help. According to Yalisove (1997), during the Temperance Movement in the USA the effort to treat addicts stopped and this continued into the 1940s and 1950s although psychiatric services continued to expand. Alcoholics were discouraged from admission into mental health hospitals; this was due to the fact that they were viewed as having a lack of motivation and poor prognoses.

During this same time period, AA was formed in the year 1935. They were separate from the mainstream movement indicated above, but they provided help for alcoholics. AA is described as a non-professional, spiritual, self-help fellowship and the movement was popularised by the National Council on Alcoholism in the USA. The majority of individuals working as addictions counsellors have been in recovery themselves for alcohol misuse. This movement had a great impact on alcoholic treatment models.

The fundamental belief of AA is that alcoholism is a disease; this concept has been incorporated into the views of professional and non-psychiatric treatment. In the 1970s, treatment for other addictions became the focus in America. Again, mostly non-professionals were used as counsellors and, although this has changed somewhat, residues of this attitude remain (Yalisove, 1997).

Treatment for addiction is stated to have grown tremendously and treatment programmes for alcoholism now include inpatient detoxification, inpatient rehabilitation programmes and outpatient treatments (Yalisove, 1997).

To date, Cognitive Behavioural Therapy (CBT) is still the most applied means of treating alcoholism, due to the fact that it is cost and time effective. CBT is incorporated into the Minnesota Model and the AA. CBT was first applied to the treatment of alcohol-dependent individuals in 1988 by Brown, Peterson and Cunningham. The founder of Cognitive Behavioural Therapy, Aaron Beck also supported the use of CBT in treating alcoholism. His theory behind the CBT model involves treating the problem by setting goals for the user, addressing beliefs and schemas and managing life problems and deficits in coping skills that may influence alcohol use. The idea is that by addressing these beliefs, the individual who uses alcohol develops better and more efficient coping skills. In essence, by changing the individual's cognitive beliefs, their behaviours are changed and thereby the individual has healthier coping skills (Beck, Wright, Newman & Liese, 2001).

Khan (2002) supports Beck's views, arguing that three meta-analyses rank CBT coping skills training as the most important training, and they based these findings on evidence of effectiveness, as compared to a variety of other treatments for alcoholism. Nevertheless, assisted by the Department of Psychiatry, Mount Sinai School of Medicine, New York, USA and Centre for Alcohol and Addiction Studies, Brown University, USA, Longabaugh and Morgenstern (2000) have questioned whether the analysed research studies provide adequate grounds for concluding that CBT coping skills training is superior to other forms of treatment. In the meantime, coping skills training does receive strong support, being widely employed in substance disorders treatment programmes (Beck, Wright, Newman & Liese, 2001).

Walant (1995), a self-psychologist, argues that the 12-steps of AA are based on behavioural theories and techniques and can be likened to the process that results from Object Relations and Self-Psychology informed therapy. She explains this concept in detail in terms of Bill Wilson (cited in Walant, 1995, p. 133), the cofounder of AA, who places a large amount of emphasis on the "disturbances in the self as central to the etiology of alcoholism".



The first step of the 12-step programme requires the alcoholic to transcend their current state of being, by admitting that they are not alone in the world, and in this way the alcoholic manages to attain “moments of oneness” with other people as opposed to alcohol. These moments of oneness can be likened to the Object Relations process referred to as Immersion. Walant (1995) furthers her argument in terms of the rest of the 11 steps of the 12-step programme and argues that the behavioural approach of these steps facilitates a process that results in the individual, with Alcohol Use Disorder, shifting their object of attachment away from the alcohol and back into the real world. In this way, the 12-step programme of AA is suggested to correct transference distortions by introjecting a transformational object that is available and soothing and the individual therefore starts to feel connected to a safe and soothing world. This entire process is referred to as the immersive process in which alcoholics learn to immerse themselves with a powerful other and to reflect back as separate beings (Walant, 1995).

According to Yalisove (1997), Cognitive Behavioural Therapists (CBT) and psychoanalysts alike, “remained outside the realm of specialised addiction treatment programs”. However conditioned therapy has been applied to addiction since the 1940s, and like the majority of specialised addiction programmes, their treatment techniques focuses on the behavioural issues related to addiction. From this viewpoint addiction is considered to be a habit, which can be influenced by learning new habits. Furthermore, addiction is viewed on a continuum of severity, as opposed to the view supported by AA which states that addiction is a disease that an addict has or does not have. It is stated that in the 1970s the CBT methodology focused on teaching the addict control. However, this view was strongly opposed by the supporters of the disease concept, who suggest that abstinence from all mood and mind-altering substances is essential. Yalisove (1997) indicates the CBT theorists have over time modified their views and support the movement; they too argue that abstinence is the only acceptable goal for treating addiction. Some controlled-drinking training programmes are nevertheless stated to

still be offered. Furthermore, CBT theorists have developed a number of behaviourally focused techniques that have been empirically tested and are focused on relapse prevention.

According to Yalisove (1997), one of the successful psychoanalytic treatment centres was Simmel's Schloss Tegel Clinic in Germany. Simmel was concerned with the alcoholic's tendency to self-punishing ideas and suicide attempts after withdrawal. Krystal (1997) further indicates that it has been his observation that when highly ambivalent patients have a therapeutic team available they will use it for the purpose of "splitting" of the transferences and, in such cases, they generally exhibit aggressive wishes toward one member of the team while presenting a basically loving relationship toward another, especially in the case of the chief therapist. In order to demonstrate to the patient the splitting or idealisation involved in his transference, it is necessary to bring his projections together and show that all of these transferences represent various object representations, which he needs to experience towards the one therapist.

This type of patient has a characterological disturbance which necessitates that he "externalise" (that is, fail to integrate) his superego function in having others enforce controls for him, and is a clear indication that these transferences cannot be left out of the treatment (Marigolis, Krystal, and Siegel, 1964, cited in Yalisove, 1997, p. 114).

The 'last drop' becomes virtually impossible to give up because it contains the symbolic expression of the fantasy of taking in the love object. The external object which is experienced as containing the indispensable life power that the patient wants to, but cannot, "internalise" illustrates the basic dilemma dominating his psychic reality. The alcoholic has a failing impulse control. All patients showed evidence of guilt and anxiety over gaining control over vital functions and over parts of themselves which they assume to be beyond their control.

Knight (cited in Yalisove, 1997) stated that the individual should be in treatment for an extended period of time. The immature personality and the neurotic behaviour must be corrected. Re-education

of and developing appropriate insight must also be included so that the patient may grow up emotionally. The viscous neurotic cycle of guilt and masochistic self-punishment must be broken. The rapport that must be established between the patient and physician must be focused on the patient's extreme need for indulgence. The physician must be kind and consistently indulgent, granting requests that are harmless in their consequences.

The first tasks in developing insight are created by skilful questioning, which make the individual aware of all the emotional tensions that previously caused them to crave a drink. This is done by the investigation of the life history of the person and pointing out maladjustments, childish behaviour, neurotic traits and fear, so that the patients may come to realise that his cure is much more than a matter of developing sufficient will power to stop drinking. At this point it is important for the individual to understand why such a long period of treatment is necessary.

A second goal of treatment is for the patient to begin to accept the physician as a caring surrogate and to test the physician by making increasing requests for indulgences and privileges; this is said to be the most difficult stages of treatment. The physician must focus on not spoiling or frustrating the patient as both of these will lead to experiments in drinking (Yalisove, 1997, p. 83).

Psychoanalysis is based on repressed unconscious infantile wishes, which result in adult neurosis. Freud developed psychoanalysis to explain these conflicts. He stressed that if an individual could gain insight into such conflicts, the conflict would abate. Freud made use of specific techniques including free association, transference, resistance and interpretation of dreams to bring insight to the individual. Yalisove (1997) refers to the fact that Freud developed a technique in which the analyst refrained from gratifying many of their patients' wishes; this technique is referred to as abstinence.

Yalisove (1997, p. 6) states that CBT therapy starts from the opposite, outer levels of the addict's psyche. The analyst provides inner exploration and insight, whilst the CBT therapist gives advice, education and makes use of persuasion. The addiction counsellors in specialised treatment facilities,

often addicts themselves, disclose information in an attempt to identify with the patient. This technique contrasts sharply with the 'blank screen' (high non-self-disclosure) of the psychoanalyst.

According to Yalisove (1997, p.6), the fact that psychoanalysis was developed to treat neurosis suggests that it could be used to successfully treat addiction. Wurmser (cited in Yalisove, 1997, p. 6) argues that the addict could benefit from the exploration of unconscious factors which could assist in dealing with otherwise untraceable symptoms, and in this way assist the addict in becoming and remaining abstinent.

Addiction specialists criticise psychoanalysis as it places an emphasis on the fact that addiction is a mental condition, whilst addiction specialists view it as a body phenomenon. Dependence and withdrawal symptoms are stated to not be understood by early psychoanalysts as being physiologically based (Yalisove, 1997).

With the newly acquired authority, an educational approach was propounded. The patients were encouraged to begin to recognise experience and accept their feelings. At the same time however, feelings were clearly differentiated from actions (Yalisove, 1997).

Through this approach, some of the super-ego's primitiveness and punitiveness is migrated, and a better appreciation of reality is enhanced by making explicit the differences among feeling, thinking and doing. The same approach was followed with masochistically provocative behaviour which stems from the wish to be punished because of one's aggressive impulses (Yalisove, 1997).

This positive educational effort also helped to diminish the severity of the superego's demands and strengthened the ego's ability to control. The differences between inner and outer reality were promoted as these patients were helped to separate and differentiate feelings from actions (Yalisove, 1997).

Over a period of years, it became more apparent that the attitudes that the therapist harboured toward both the alcoholic patient and his symptomatology frequently had a more significant affect upon the course of treatment than the particular technique employed by the therapist (Yalisove, 1997).

Other autonomous ego functions affecting judgment, anticipation, thinking, object comprehension, recall, language, capacity for self-observation, delay of action and mobility can all in a similar way lose their autonomy as they are embroiled in a conflict. The manner in which the patients' ego will be able to handle operations dependent upon optimal ego autonomy is thus affected. Moreover, one psychological consequence of the ingestion of alcohol is frequently the illusion that the impaired autonomous functions have been restored to optimal functioning as a consequence of the drinking. The loss of ego autonomy has an immediate effect upon any kind of psychotherapy (Yalisove, 1997).

These elements are all specifically emphasised so that the therapist will not initially concentrate all interest upon the drinking per se, but will begin to recognise that the drinking itself represents and attempts to deal with many conflicting ideas and impulses, as yet unknown both to the therapist and the patient (Yalisove, 1997).

The significance of the family constellation in the aetiology of alcoholism has been stressed by many authors, including Knight and Simmel. Knight (cited in Yalisove, 1997) states that both parents affect the development of an illness in their offspring and Simmel described the mothers of an addict as seductive and manipulative (Litin et al., Johnson & Szurek (cited in Yalisove, 1997).

The therapist supplies a new psychological matrix in the form of intact ego functions that are lent out to the patient to make up for those functions that are found to be developmentally deficient because of the instances of parental pathology. In therapy, the parent's deficiencies are clearly highlighted so as to help the patient separate his attitudes, ideas and function from theirs (Yalisove, 1997).

In support of Walant (1995), Khantzian, who conducted studies in Boston, USA (cited in Levin & Weisser, 1996, p. 163) provides support for psychoanalytic treatment for alcohol dependent-

individuals. He states that treatment of alcoholism should address the individual's difficulty with regulating their own feelings, behaviour and self-esteem. Khantzian further acknowledges that psychoanalysis is often not the favoured treatment of choice for individuals with alcoholism, but it does provide a "special understanding of many of the alcoholics' problems and a rationale for the treatment choices and decisions that must be made to help the individual with alcoholism".

#### OBJECT RELATIONS TREATMENT

Object Relations based treatment approaches differ slightly from the psychoanalytic views mentioned above. These differences are explored below.

Levin (1987) states that the aim of psychological treatment is to replace addiction with relationships and to use emotional bonds to promote integration and growth. Bean et al. (1981) state that it is important to broaden our knowledge base about alcoholism, which in the long run will result in the development of better prevention and treatment programmes.

Walant (1995) contrasts psychoanalytic literature in favour of an Object Relations view. She argues that the fusion state is not regressive and is more closely linked to the separation and individuation process that takes place in ego development, as stressed in Object Relation focused literature. Furthermore, Walant (1995) also disagrees with the psychoanalytic perspective that a baby feels omnipotent and grandiose, as was suggested by the Freudian idea of "His Majesty the Baby"; rather she agrees with Miller and Bowlby who focus on the wounds that occur in childhood. Clinebell (cited in Walant, 1995, p. 133) supports this view and draws attention to basic trust disturbances in the mother-child dyad in which basic trust cannot be established. Rinsley, on the other hand, provides support for Kohut's theory; however, Rinsley's view differs slightly – Rinsley argues that the child does not infuse early omnipotence into his parental figures, which then leads him to distrust their own power and all authority.

Miller (cited in Walant, 1995, p.8) argues that the wound created in childhood results from parenting that is considered to be “normal” and acceptable by society. Normal parenting refers to parenting styles and techniques that generally meet the norms of society, yet according to Miller, this kind of parenting is inadequate in terms of meeting the child’s attachment needs and in this way generation after generation passes down their hurt. This hurt creates wounds in each individual’s ego structure with regard to attachment needs of the child being sacrificed, and the parent not providing the child with the right amount of empathy because of their cultural norm and importance associated with the separation and individuation being the goal.

Walant (1995) refers to this kind of parenting as “normative abuse” and she suggests that it fundamentally affects the overall development of the child’s personality. In this way individuals never really feel connected to others and Walant (1995) states that this pain they tend to carry from the experience across the lifespan of their lives and the fear of the pain of separation leaves the person unattached and using defense mechanisms such as minimisation and schizoid defenses. The issue of separation anxiety is supported by Bowlby, who dispels the traditional notion of oedipal anxiety.

According to Walant (1995), the alcoholic wears a grandiose mask of the false self and therefore these individuals pretend to be self-confident and self-assured. In this way, the individual detaches from the real feelings of inner helplessness. Buxton, Smith, and Seymour (cited in Walant, 1995, p. 134) indicate that the addict becomes their own higher power, resulting in them being unable to truly connect to others or accept external support.

To prevent the primal wounding, Walant (1995) suggests that the caregiver must provide the child with adequate immersion in terms of allowing the child to immerse themselves in their attachment figure in order to meet their attachment needs, and in this way the child will develop a healthy sense of competence and self-esteem. According to Walant (1995), in the case of an alcoholic, immersions do not take place in infancy, which results in the individual staying stuck in a state of infantile

helplessness. The individual with an alcohol use disorder will then use alcohol to immerse themselves with an internal power. Alcoholics are also theorised by Walant (1995) to stay stuck in their false mask of self-reliance, which results in their core being hidden in helpless shame.

The individual suffering from Alcohol Use Disorder merges with alcohol and in this way they are seduced into believing that they are powerful, omnipotent and in control. Intoxication results in the melting of social inhibitions and emotional repression (Walant, 1995).

As indicted by Walant (1995), the immersive approach requires as much connectedness as possible between the patient and the therapist. The therapist must take on the role of a subjective object, where the patient can place his emotional and intellectual being. In this immersive process the therapist indicates that they will enter the world of the client and take care of their needs. In this way the client becomes immersed with omnipotence and the alcohol-dependent individual is able to break through the alienating, empty space that has surrounded him since infancy and he can form a link between his inner world and the world around him (Walant, 1995).

Co-morbid disorders with substance use disorders complicate treatment methodology. Ruegg and Frances (cited in Eckleberry, 2009) suggest that substance misuse by individuals with a personality disorder results in a poorer treatment outcome; whereas, long-term abstinence is associated with remission of the personality pathology. Furthermore, personality disorders increase vulnerability to substance use disorders. The individuals with both use defenses to sustaining maladaptive pattern of preferred behaviour and seek a way to escape from the pain in life. They dread the loss of their illusions and often seek others to either exploit or receive care and protection from. Their relationships are marked by a lack of reciprocity. Drugs and alcohol also provide this kind of protection and such substances allow the individual to remain in denial regarding their expectation, behaviours and attitudes to the demands of reality.



The 12-step groups present a philosophy of living which mirrors the same goals that would be most helpful for persons with personality disorders, namely: responsibility for self, honesty in dealing with feelings, sensitivity to both the needs and the feelings of others, avoidance of impulsive actions, and the ability to tolerate stress and painful feelings (O'Malley, Kosten, & Renner, 1990, cited in Eckleberry, 2009).

## **CHAPTER 3: METHODOLOGY**

In this section the research design is explained, followed by a description of the sample and the research procedure, the ethical considerations and a description of the psychometric instruments administered in the current study. The way in which the data was analysed is also described.

### **1.1. Current Study Methodology Outlined**

An exploratory research design is employed in this study, in which different instruments are used to assess the object relations of individuals who use alcohol. A snowball sampling technique was applied to a group of individuals who had been admitted to a psychiatric institution. Two instruments were administered to each participant, namely, the AUDIT and the BORRTI. This information was then used to assess areas of pathology amongst the participants and the Pearson's correlation coefficient was applied to assess any possible correlations between alcohol use and dysfunctional object relations.

### **METHODS USED TO ASSESS OBJECT RELATIONS**

Currently, internationally studies have focused on Object Relations and the alcohol use as well as the alcohol abuse of individuals. Specifically, internationally studies have been conducted which explore different aspects of Alcohol Use Disorder by using the Bells Object Relations and Reality Testing Inventory (BORRTI), however this is not the case in South Africa. In South Africa, far fewer studies have been carried out which explore the relationship between alcohol use and Object Relations.

The international studies that have been conducted which relate to excessive alcohol use and the BORRTI were used. The same cannot be said for South African research, as no known studies have been carried out in South Africa that have used the BORRTI to study excessive alcohol use.

Furthermore, no studies have been conducted internationally that assess the Object Relations of individuals who use alcohol excessively and who are in the early stages of recovery. Neither have classifications for normal and abnormal or addicted and non-addicted individuals been established. There is also a lack of literature focusing on individuals in the early stage of recovery from excessive alcohol use.

Furthermore, little research has been conducted in the South African context that explores substance and alcohol related disorders and how treatment may be impacted by the personality structure of the individual who misuses alcohol. The objective of this study is to provide more information in order to fill some of these gaps.

## 1.2. Current Study Methodology Outlined

An exploratory research design is used in this study, in which different instruments are used to assess the object relations of individuals who use alcohol. A snowball sampling technique was applied to a group of individuals who had been admitted to a psychiatric institution. Two instruments were administered to each participant, namely, the AUDIT and the BORRTI. This information was then used to assess areas of pathology amongst the participants and the Pearson's correlation coefficient was applied to assess any possible correlations between alcohol use and dysfunctional object relations.

### 3.1.1. RESEARCH DESIGN

This study was prompted by gaps in the current knowledge regarding the Object Relations of alcohol-dependent individuals, and a quantitative research design, which is a formalised and explicitly controlled research design, was used in which natural observations were made and no variables were manipulated (De Vos, 2000).

This is an exploratory study in which data was gathered and analysed. The theoretical Object Relations framework, as employed by the BORRTI, provided a deductive framework within which the data was analysed inductively to allow for unexpected results to come to the fore.

Object Relations describe internalised relationships within the individual's psyche. As object relations are complex, abstract and difficult to identify, this study employed the quantitative instrument of the BORRTI assessment tool to tap into the Object Relations of the individual. Additionally, this study used the Alcohol Use Disorder Test to identify alcohol-dependent individuals; hereafter the BORRTI questionnaire was administered. The researcher emphasised the importance of honestly answering the questionnaire because no "correct" answer exists as the BORRTI is a self-report questionnaire. Although this self-report limitation exists, the BORRTI's strengths were its time and cost efficiency, as well as its built-in safeguard against interview bias due to it being an objective measure, not reliant on the tester's views.

The research design employed was exploratory and descriptive; exploratory in that Object Relations of alcohol-dependent individuals is not a widely studied topic (Rubin & Babbie, 2001; Strüwig & Stead, 2001), nor has the BORRTI been applied to the South African context of substance-related disorders. Due to this study being an exploratory design, the researcher remained open to possibilities. The descriptive aspect of this research related to the empirical testing methods used in this study and the research techniques used captured and measured variables (Gravetter & Forzano, 2003; Neuman, 2003).

Statistical interpretations of the data were made possible as quantitative methodology was employed (Russell & Roberts, 2001; Shaughnessy, Zechmeister & Zechmeister, 2000). The reason a quantitative methodology was employed was that the data was easy to work with and when using specific types of sampling techniques, the data could be generalised to the larger population (Dunn, 1999).

A brief biographical questionnaire was used to capture the demographics of the participants. The AUDIT and BORRTI psychological tools were used to capture information regarding the extent of alcohol use as well as for illuminating unconscious internal Object Relations of each individual, respectively (Cozby, 2004). Advantages of using questionnaires included that they allowed participants to remain anonymous as well as being easy to administer and non-threatening to participants. Questionnaires also allowed for a greater number of participants to be interviewed at one time. The disadvantage of this method of testing is the fact that there could be less one-on-one interaction. Another disadvantage related to the fact that participants could have misunderstood some of the items (Gravetter & Forzano, 2003; Jackson, 2003; Neuman, 2003; Spata, 2003).

In order to safeguard against these possible obstacles, the researcher only assessed small groups of participants at a time (Cozby, 2008), which provided the researcher with more flexibility in assisting participants and allowed for individual queries. The researcher was in control of the process to ensure standardised processes were followed with regard to setting, administration and testing circumstances. The researcher also took notes of any external factors that could have influenced the participants' testing environment.

This study was further validated due to the triangulation method that was employed. Triangulation refers to the concept of analysing something from a number of different perspectives, which is what the researcher did to ensure a more complete approach to research (Neuman, 2003).

Neuman (2003) states that there are three different ways in which triangulation can be implemented in a research study. Firstly, the most common type of triangulation involves measuring a variable or factor by using different techniques. In this case the participant's alcohol use was confirmed by their diagnosis and their scores on the AUDIT, which provided the researcher with collateral regarding the severity of alcohol (Henning, 2004; Leedy & Ormrod, 2005).

Triangulation of observers, the second type of triangulation, refers to the use of multiple scorers, interpreters or observers. In this study the data gathered was analysed by both the researcher and supervisor to ensure the results were accurate and also to ensure a more holistic understanding of the study results (Strüwig & Stead, 2001). The last kind of triangulation refers to the triangulation of theories in which different theorists are used to plan and interpret data (Neuman, 2003). Various psychoanalytic theorists were used to understand the potential psychodynamics of the participants.

### **3.1.2. PARTICIPANTS AND SAMPLING**

The initial sample for the current research comprises 45 individuals who abuse alcohol. Individuals with alcohol dependence are a sensitive and a somewhat hidden population, therefore a non-probability snowball sampling method was used. The pragmatic advantage of such a sampling strategy is one of cost and time effectiveness; however two limitations associated with this kind of sampling could occur. Firstly, errors related to chance factors and, secondly, errors due to bias in the selection process (Horner, 1990 & Dawson, 2007).

This study safeguarded against these by ensuring that three inclusion criteria were met. For starters, all participants needed to be well-versed in the English language as the BORRTI questionnaire is structured in English. Secondly, a criterion of homogeneity was applied, in that all chosen participants met the diagnosis criteria for problematic alcohol abuse, according to their psychiatric file. Finally, their scores on the AUDIT would further determine that these individuals do have problematic relationships with alcohol (Durrant & Thakker, 2003).

### **3.1.3. RESEARCH PROCEDURE**

A research proposal was submitted to a rigorous ethical review process by the Faculty of Health Sciences Ethics Committee at the University of South Africa and the University of Pretoria, as the

psychiatric hospital's ethical research boards fall within the University of Pretoria's ambit, and all ethical requirements were met.

The researcher then made arrangements with the hospital staff to organise data collection. Once permission was granted, the researcher worked closely with the head of the hospital/ person in charge of the unit to identify potential participants. Once these potential participants were identified, the staff psychologist approached each potential participant to ask them if they were interested in participating in this research study. A written letter was handed to the participants to give them an idea of the aims of the study as well as what was required of them as participants (see Appendix C). Once the individual agreed to be a voluntary participant, the staff psychologist was informed. The researcher then interviewed each of these individuals in groups of one to three participants. The groups were arranged between the staff nurses of the relevant wards and the researcher.

The researcher arranged with the staff psychologist to have an allocated testing room available and then made arrangements with the hospital staff to organise data collection. Each session took on average of two to three hours to complete and a maximum of three participants were interviewed at one time. This quota ensured that the researcher could give support and guidance to each participant. Standardised procedures were followed to avoid any errors or biases.

Each of the 45 participants was provided with an envelope that contained a copy of the two consent forms, the biographical questionnaire, the AUDIT and the BORRTI instruments. Each envelope had a number on the top right hand corner. On handing the packs to the participants, they were informed that the number would be used to identify them and in this way anonymity was ensured.

Once the participants had been seated, the researcher informed them of the nature of the study and its participation requirements (Appendix D). Individuals who were not willing to participate were given the opportunity to leave at that point. The participants who were interested in being part of the study

then completed and signed the consent forms. Whilst completing the consent forms, the participants were given the opportunity to ask questions regarding the study and the consent form.

The participants were informed that they could attain general feedback on this research by requesting access to this study in the library at the University of South Africa. The participants were also informed that they would be able to request a report to be given to their treating clinical psychologist, but only at their request.

The researcher then asked the participants to place the informed consent and letter back into the envelope and to remove the AUDIT test from the envelope, which starts off with some biographical questions that they were asked to answer (Appendix E). Once they had completed the biographical questions, instructions were given to them regarding the AUDIT questionnaire. As part of these instructions a standard drink concept was explained to them. For example: 1 can of beer; 1 glass of wine; 1 tot of spirits.

Once the participants had completed the AUDIT questionnaire, they were asked to complete the BORRTI. Hereafter they were asked to hand in their envelope (containing all their completed questionnaires and consent forms) and, once thanked, they were then requested to leave the room – this was done to ensure that they did not disturb the other participants.

The table below links the research objectives of this study with the procedure and methodology followed.

Research Objectives	Biographical Questionnaire	AUDIT	BORRTI	Pearson's Correlation
1. Explore Object Relations of individuals who use alcohol and are in a	X	X	X	



tertiary setting.				
2. Explore the individuals' Object Relations using the BORRTI.			X	
3. Explore the correlations between the individuals' BORRTI and AUDIT scores to identify similarities and differences in their Object Relations.				X

### 3.1.4 INSTRUMENTS

A biographical questionnaire was used to gain background information (Dawson, 2007). Hereafter two measures, namely the Alcohol Use Disorders Identification Scale (AUDIT) and the Bells Object Relations and Reality Testing Inventory (BORRTI) were administered.

#### 3.1.4.1. BIOGRAPHICAL QUESTIONNAIRE

A brief biographical questionnaire was used to gain identification data about the participants. The questionnaire acquired information regarding the participant's age and gender. All the questions were closed-ended in nature. The data collected from this questionnaire assisted in providing the researcher with a contextual understanding of each participant within the sample (Dawson, 2007).

#### 3.1.4.2. THE ALCOHOL USE DISORDER IDENTIFICATION TEST (AUDIT)

Babor, Higgins-Biddle, Saunders and Monteiro (1993) state that the Alcohol Use Disorders Identification Test (AUDIT) was developed by the World Health Organisation (WHO) in 1982, as a simple way to screen and identify people who were at risk of developing alcohol problems. In 1992, it was used to detect alcohol problems and it was rated as 92% effective in detecting hazardous, harmful

drinking or alcohol abuse and, as such, was suggested to be one of the most accurate alcohol screening tests available (Babor, Higgins-Biddle, Saunders & Monteiro, 1993).

Even when excessive drinkers underestimate their consumption, they often qualify on the AUDIT scoring system as positive for alcohol risk. The test contains 10 multiple choice questions on quantity and frequency of alcohol consumption, drinking behaviour and alcohol-related problems or reactions. The answers were scored on a point system; a score of more than eight indicating an alcohol problem. The results of the test allowed the researcher to categorise each participant into one of the three groups below (Babor et al., 1993):

- Hazardous drinking is defined as a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. Hazardous drinking patterns are of public health significance despite the absence of any current disorder in the individual user (Babor et al., 1993).
- Harmful use refers to alcohol consumption that has an impact on physical and mental health. Some would also include social consequences among the harm caused by alcohol (Babor et al., 1993).
- Alcohol dependence is a cluster of behavioural, cognitive and physiological phenomena that may develop after repeated alcohol use. Typically, these phenomena include a strong desire to consume alcohol, impaired control over its use, persistent drinking despite harmful consequences, a higher priority given to drinking than to other activities, increased alcohol tolerance, and a physical withdrawal reaction when alcohol use is discontinued (Babor et al., 1993).

The AUDIT was developed and evaluated over a period of 20 years and it has been found to provide an accurate measure of risk across gender, age and cultures. The advantages of the AUDIT include the test being standardised cross-nationally. It was validated on primary health care patients in six

countries (Norway, Australia, Kenya, Bulgaria, Mexico and the USA) and it is the only screening test specifically designed for international use. It identifies hazardous and harmful alcohol use as well as possible dependence and is consistent with the ICD-10 definition of alcoholism and harmful alcohol use. The test also measures recent alcohol use (Babor et al., 1993).

Buddy (2012) argues that short screening tests are popular in emergency health care situations. However, he concedes that while the shorter tests may not be as accurate as longer ones, they are nevertheless useful in terms of screening. Buddy (2012) outlines three different kinds of short tests, namely, the CAGE test, the T-ACE and the AUDIT. Although the CAGE test is considered to be one of the oldest and most popular screening tests for alcohol use, this test diagnoses alcohol problems over a lifetime (Buddy, 2012). It is also considered to be most accurate for white middle-aged men. However, Buddy (2012) states that it is not as accurate in identifying alcohol use in older people, white women, African Americans and Mexican Americans. The T-ACE, on the other hand, is found to be more accurate in both male and female samples.

Buddy (2012) supports the use of the AUDIT, a screening test developed by the WHO. Although the AUDIT takes longer to administer and score than the tests mentioned above, it is one of the most accurate tests available and is accurate 94% of the time. Furthermore, it can be used on all ethnic groups and on both males and females (Wook et al., 2012). With the initial sample in mind, the AUDIT appeared to be the best-suited screening measure for the current study.

A recent systematic review of the literature has concluded that the AUDIT is the best screening instrument for the whole range of alcohol problems in primary care, as compared to other questionnaires such as the CAGE and the Michigan Alcohol Screening Test (Babor et al., 1993; Cunety et al., 2012; MAST, 1971). Developed in 1971, the MAST is one of the oldest and most accurate alcohol screening tests available, effective in identifying dependent drinkers with up to 98% accuracy (Buddy, 2012); however, it contains 22 questions (Buddy 2012; Wook et al., 2012).

In comparison to other screening tests, the AUDIT has been found to perform equally well or at a higher degree of accuracy across a wide variety of criterion measures. Bohn et al. (cited in Wook et al., 2012. p. 27) found a strong correlation between the AUDIT (Wook et al., 2012) and the MAST ( $r=.88$ ) on a covert content alcoholism screening test. A high correlation coefficient (.78) was also found between the AUDIT and the CAGE. AUDIT scores were found to correlate well with measures of drinking consequences, attitudes toward drinking, vulnerability to alcoholism, negative mood states after drinking, and reasons for drinking. Several studies have reported on the reliability of the AUDIT, and test-retest reliability was established as well as internal consistency reliability (Babor et al., 1993; Wook et al., 2012). Peltzer and Ramlagan (2009) and Peltzer, Davids and Njuho (2011) have utilised the AUDIT with South Africans.

Total scores of eight or more are recommended as indicators of hazardous and harmful alcohol use, as well as possible alcohol dependence. Since the effects of alcohol vary with average body weight and differences in metabolism, establishing the cut-off point for all women and men over age 65 one point lower at a score of seven will increase sensitivity for these population groups. The higher the total scores on the AUDIT, the greater the sensitivity in finding alcohol-dependent individuals. On the basis of experience gained from the use of the AUDIT in research studies, it is recommended that the following interpretation be given to AUDIT scores (Babor et al., 1993; Wook et al., 2012):

- Scores between 8 and 15 are most appropriate for simple advice focused on the reduction of hazardous drinking.
- Scores between 16 and 19 suggest brief counselling and continued monitoring.
- AUDIT scores of 20 or above warrant further diagnostic evaluation for alcohol dependence.

#### **3.1.4.3. THE BELLS OBJECT RELATIONS AND REALITY TESTING INVENTORY (BORRTI)**

The BORTTI is a self-report instrument and consists of 90 items which are answered by the participants indicating if the statement is true or false. These answers are based on the individual's most recent experience. The BORRTI tests different dimensions of an individual's psyche, which can be categorised into two areas: Object Relations and Reality Testing. Each domain is represented by 45 items. The Object Relations domain tests four dimensions, namely, Alienation, Insecure Attachment, Egocentricity and Social Incompetence. The Reality Testing domain tests three dimensions, namely, Reality Distortion, Uncertainty of Perception, and Hallucinations and Delusions (Bell, 1995, p. 3). The test can be administered individually or to groups. It has been administered in clinical and non-clinical settings and has also been used to assess the pathology in individuals in "normal" populations as well as in in psychiatric hospitals, day hospitals, homeless shelters, prisons and inpatient services. This test is intended for use with individuals who are 18 years and older as well as individuals who have a reading ability of an 11–12-year-old child (6<sup>th</sup> grader). The test is scored using the WPS TEST REPORT Service Mail and norms are based on 934 individuals (Bell, 1995, p. 3).

The distinct dimensions of Object Relations and Reality Testing through factor analysis of BORRTI responses makes it possible to test specific hypotheses about how these dimensions relate to psychopathology and treatment effects. This ties in neatly with the role that this test will fulfil in this research.

In 1976, the development of the BORRTI began at Yale University in the USA and its development commenced with an understanding of the ego. Sigmund Freud's structural theory was the first to explore the concept of the ego. Important theoretical contributors were drawn from the ideas of Anna Freud, Heinz Hartmann, and David Rappaport, Ernst Kris, Rudolph Loewenstein, René Spitz, Margaret Mahler, Edith Jacobson, and Erik Erikson and Bellak, Hurvich and Gediman (1973, cited in Bell, 1995, p.47), who attempted to synthesise ego psychology by identifying 12 ego functions. Ego functions identified were as follows: Reality Testing; Judgment; Sense of Reality of the World and of

the Self; Impulse Control; Thought Processes (Cognition) – Memory, concentration and attention, Abstract vs. Concrete thinking; Adaptive Regression in the Service of the Ego (Spontaneity, playfulness to adapt, sense of humour); Defensive Functioning (Defenses) – ability to protect ego maturely (rationalisation) or immaturely (denial); Stimulus Barriers (Level of integrated response to stimuli, ability to focus, screen out distractions); Autonomous Functioning (efficiency of cognitive processes); Synthetic Functioning (ability to hold inconsistencies about situation/person within self); Mastery-Competence (subjective competence vs. actual competence); and Object Relations (pattern of relationships compared to old ones; ability to respect people as separate entities; ability to hold concept of relationship in spite of frustration) (Jayanti, Saugata, & Somnath, 2004).

The BORRTI, initially, was based on these 12 ego functions. The BORRTI's items were then limited to only assessing two ego functions: Object Relations and Reality Testing. These ego functions definitions are rooted in the psychoanalytic model of mental health and illness. Bellak argued that the quality of an individual's Object Relations can be assessed in the way in which the individual conducts relationships and experiences themselves in relation to others. His view presents a different alternative from the other Object Relations theorists such as Fairbairn, Kernberg and Mahler who proposed systematic descriptions of the process and sequential stages of Object Relations development. However, these theorists used projective interpretations to analyse individuals' Object Relations – a therapeutic method questioned due to lack of empirical validity and reliability. In order to avoid such criticism, Bellak et al. (1973) provided a conceptual framework for the BORRTI in that the dimensions of the Object Relations of the BORRTI were factor-analytically derived, therefore ensuring that reliable and valid results were produced by this test (Bell, 1995, p. 48).

Blat and Wild (1976) suggest that Reality Testing as a concept has not received the same theoretical attention as Object Relations. These authors indicate that Freud first identified Reality Testing as one of the primary and most significant functions of the ego. Ego psychologists, such as Hartmann and

Rappaport, elaborated the essential role of Reality Testing in adapting to the environment. Ego functioning is directly linked to the establishment of ego boundaries, which help the individual to distinguish the self from the not-self (Blatt & Wild, 1976). The conceptualisation of Reality Testing as a continuous variable with definable stages of functioning has been readily accepted in the assessment literature. Bellak et al. (1973) state that the majority of clinical scales that assess Reality Testing via a multidimensional continuum of the reality testing ego function have not been proven to have scientific integrity, which is not the case in the BORRTI as its subscales are derived from factor-analysis.

In 1985, Bell and Bellington presented research on the reliability, validity and factorial invariance of a scale for the assessment of Reality Testing. Factor analysis and replication factor analysis were applied and three subscales were identified, which were reassessed for internal factor consistency and in order to ensure that these factors did not have any biases due to social desirability, age or gender. These subscales form part of the BORRTI, namely, the Reality Distortion scale, the Uncertainty of Perception scale and the Hallucinations and Delusions scale.

The most common method for assessing Reality Testing up until the 1980s had been the Rorschach Inkblot Test (Rorschach, 1921/2008). However, the Bell Reality Testing Inventory was being constructed at this point according to Jackson's (cited in Bell & Bellington, 1985) recommendations, which state that empirical and rational methods of construction should use Loevinger's (cited in Bell & Bellington, 1985) three components of construct validity, namely theoretically-substantive, structural and external validity. Findings suggest that the Bell Reality Testing Inventory fared well in terms of validity and response bias. Internal consistency was also found to be high. No age or gender bias was found to be present within the test subscales. The replication study carried out indicated a reasonable amount of factorial invariance – these findings support construct validity of the test items

and the claim that these factors are relatively common features of ego functioning (Bell & Bellington, 1985).

The discriminant validity of this inventory was proven in a study of two samples of inpatients. Results correctly identified major affective disorder, mood disorders and schizophrenia, with an accuracy of 92%. Bell and Bellington (1985) further propose that the subscales in this inventory may be useful in the diagnosis of other disorders such as Borderline Personality Disorder or Bipolar Disorder with psychotic features.

Bell, Billington and Becker (1986) state that the BORRTI's items were studied by using factor analysis. Factor analysis is used in order to explore the relationship between a set of variables. The other reason is for data reduction, in which case a large number of factors are categorised into fewer variables. The factor analysis explained by Bell, Billington and Becker (1986) produced four subcategories – internal consistency was found to be high within these subscales. Furthermore, the subscales were free of age, sex or bias in response due to social desirability. Next, the scores of the Brief Psychiatric Rating Scale (BPRS), Global Assessment scale and most BPRS symptoms were compared to the subscales of the BORRTI subscales, and a low inter correlation was found. High scores are most common in the borderline community where the non-borderline community scored much lower, indicating that the borderline community had a much higher degree of deficits in relation to their ego functioning as opposed to the non-borderline community, which indicates fewer deficits and less ego dysfunction.

Bell, Billington and Becker (1986) argue that a lack of empirically based psychoanalytic literature had been produced at this point in history, therefore no measure had yet been developed which could assess Object Relations theories consistently. Bell, Billington and Becker (1986) further explain the historical position on Object Relations literature, suggesting that at this point a number of theorists had proposed systematic stages of Object Relations development (Fairbairn, 1952; Kernberg, 1975;



Mahler, Pine, & Anni, 1975; cited in Bell, Bellington & Becker, 1986), which influenced psychological testing at this time.

Blatt and Ritzler (1974) and Urist (1977) (cited in Bell, Bellington & Becker, 1986) used the Rorschach Inkblot Test (Mayman, 1968); Ryan and Bell (1984) analysed themes from early memories, and Krohn and Mayman (1974) explored the manifest content of dreams. Test developers such as Bellak, Hurvich, and Gediman (1973) (cited in Bell, Bellington and Becker, 1986) focused on the assessment of levels of ego functioning within an individual, by assessing Object Relations on a multidimensional continuum. Based on Bellak's ideas, Bell, Metcalf, and Ryan (1979, 1980, cited in Bell, Bellington and Becker, 1986) developed a true or false self-report questionnaire whose results indicated the testee's relationships and their characteristic patterns of relating. This questionnaire proved to be the forerunner of the Bell Object Relations (OR) Inventory. In 1982, Miripol (cited in Bell, Bellington & Becker, 1986) performed a comparative study of all these measures and concluded that the Bell Object Relations Inventory (early version) was the most reliable and valid (cited in Bell, Bellington & Becker, 1986).

Internal consistency in these factor scales was found to be high as no age, sex or social desirability bias was discovered. The four subscales shared many items and were found to be inter-correlated moderately. Results on studies on the subscales suggest that each bears a unique relationship to variations in psychopathology. Object Relations scores from early memories were correlated significantly with Egocentricity (cited in Bell, Bellington & Becker, 1986). A replication study showed considerable factorial invariance. This high degree of replication supports construct validity and the claim that these factors represent relatively common features of personality that are not idiosyncratic to the original sample.

The Bell Object Relations Inventory is an inexpensive and easily administered instrument that is intended to allow further empirical investigation of such issues and to stimulate inquiry into the components of the Object Relations of individuals.

This study assessed each participant in relation to the several different constructs as indicated by the Bells Object Relations and Reality Testing Inventory (BORRTI, 2005). The first four of these are Object Relations subscales, namely, Alienation, Insecure attachment, Egocentricity and Social Incompetence, whilst the other three measure the individual's reality testing ability; these being Reality Distortion, Uncertainty of perception, Hallucinations and Delusions (Bell, 2005) (Refer to Appendix I).

#### **3.1.4.4. ETHICAL CONSIDERATIONS**

According to Goodwin (2002), ethics are principles that provide moral guidelines when conducting research. These guidelines ensure that the participant's rights will at all times be considered and respected. In order to establish that the participant had voluntarily agreed to take part in the research, a consent form (Appendix B) was provided to the participant, which stipulated the processes and testing methods to be used during the interviewing process. It also stipulated that the participant's identity would remain anonymous.

The Health Professions Council of South Africa provides a detailed document of the ethical guidelines that must be adhered to when conducting research (refer to Appendix L), and this research adhered to these principles.

### **3.2. DATA ANALYSIS**

The data is organised and analysed in the following manner: Each participant was scored according to the BORRTI instrument and a T-score was worked out for each interviewee according to each criterion.

Content analysis is a technique that allows examination of data to determine whether or not the data supports a hypothesis; ‘conceptual clusters’ are already formed by the BORRTI as subscales (Dawson, 2007). Thematic analysis on the other hand refers to a process whereby the data is analysed by a theme. This type of analysis is highly inductive, meaning the themes emerge from the data and are not imposed upon it by the researcher. In this type of analysis, the data collection and analysis take place simultaneously. Even background reading can form part of the analysis process, especially if it can help to explain an emerging theme – in this regard the biographical intake form will provide further information into the background of the participants (Dawson, 2007).

The BORRTI subscales were derived from factor analysis. Calculating exact factor scores on the seven subscales for one individual involves over 800 arithmetic operations. Each individual’s scores were worked out manually in order to assess their levels within each scale. Validity was strengthened where participants answered all questions. Response patterns were analysed, specifically to attain “faking bad” or “faking good” profiles. Although the BORRTI has been shown not to correlate with favourable self-presentation response biases, it is vulnerable to purposeful positive or negative self-report.

In clinical samples it is more common to see response patterns exaggerated in the pathological than in the non-pathological direction, with the result that the respondent receives pathological elevations on six or seven subscales. The validity of such a pattern is questionable. Unusually low scores on all subscales are particularly suspect in clinical samples. The BORRTI is no more or less vulnerable to

deliberate deception than are other self-reports. It is the clinical judgment of the examiner that serves as the best guard against invalid data.

The Inconsistent Responding Scale (INC) of the BORRTI enables the detection of inconsistent response patterns and consists of 17 BORRTI item pairs. When the full 90 item BORRTI is administered and contradictory responses are given to seven or more item pairs on the INC scale, there is a substantial likelihood that the responses were given in a haphazard or inconsistent manner – this was closely monitored by the researcher in order to avoid misrepresentation. Invalid protocols were removed from the results of the research.

The validity indexes – frequency and infrequency – provided another way for the researcher to consider the consistency of a patient's response. Response patterns that violate the conditions described below for each index reflect random responding or systematically distorted responding on the part of the participant – in such cases the scores are reported and interpreted accordingly.

Items which are frequently endorsed make up the frequency index. This index provides a way to test the validity of high obtained scale scores, because a person with high scores usually endorses these items. If a patient obtains T-scores equal to or greater than 70 on any BORRTI subscale, the FREQ score should be nine or higher. If a patient with high subscale scores endorses fewer than nine of these frequently endorsed items there is a reason to question the validity of his or her responses and subsequent interpretation of the BORRTI profile was pursued with caution.

One way the validity indexes add to the simple INC score is that they can help identify false or double negative BORRTI results. This is done using the INFREQ index, which includes items that are infrequently endorsed by patients who do not also have at least one elevated subscale score equal to or greater than 70. A person without at least one markedly elevated subscale score does not usually endorse these items. If a patient obtains no subscale T-scores of 70 or above, the INFREQ score should be three or less. If a patient obtains an INFREQ score of 4 or higher, no subscale score

elevations equal to or greater than 70T, there is reason to question the fidelity of the participant's responses. These cautionary procedures were followed in the current research.

### **3.3. STANDARDISATION**

A number of procedures were followed to ensure that the data collection was standardised and ethical. All of the below procedures were communicated to the individual in the informed consent forms. In the informed consent form (Appendix B) the participant was made aware of fact that participation was voluntary; the participants were also made aware of the contact details of the researcher should any questions arise, and an offer to provide feedback on conclusion of the research was made. This information was made available to potential participants in the form of covering letters and an attached informed consent form for the participants (Appendix C). Before the participant signed this form, the exact processes and testing instruments which were used in the study were explained to them by the researcher, and in a language that was understandable to them. In so doing, all participants were able to fully comprehend the procedures in English (Cozby, 2007; Goodwin, 2002; Leedy & Ormrod, 2005).

#### **3.3.1. COERCION**

The participants were made aware of the importance of their rights being followed, in order to address the potential issue of coercion. All participants were made aware of the fact that no external pressure existed on them for taking part in this study (Cozby, 2004). To safeguard against this issue, the researcher refrained from building expectations about the participant's engagement in this study (Russel & Roberts, 2001). The researcher also emphasised the fact that the participants could withdraw from this study at any time without any consequences (Ungar & Liebenberg, 2004). Participants were then asked to sign the attached letter and consent form. Their signatures indicated the voluntary agreement of the participants to take part in this study.

### **3.3.2. CONFIDENTIALITY**

Confidentiality and anonymity were emphasised. As mentioned before, each participant was given a pack with a number on it; in this way the participant's personal identities were not revealed in this study. Furthermore, the data attained in this study is stored in a secure place in order to uphold privacy (Cozby, 2007; Goodwin, 2002; Leedy & Ormrod, 2005). In this way, the privacy of the participants was protected as advised by Mertens (1998). To further protect the participants' anonymity, the only time their details were noted was when the participants requested feedback from the researcher (Abbot & Sapsford, 2006).

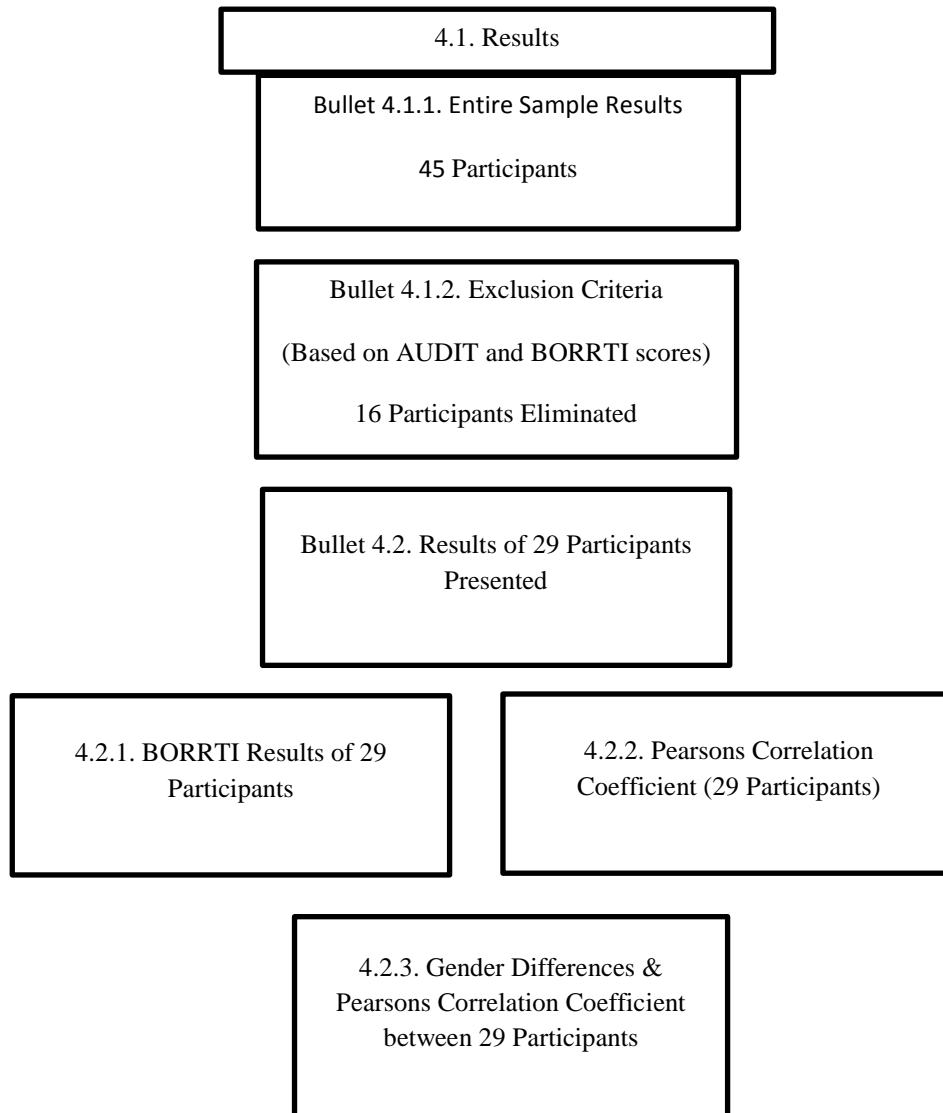
### **3.3.3. PROTECTION FROM HARM**

This study aligns itself with the protection from harm policy as suggested by Leedy and Ormrod (2005). As such, the researcher provided all participants with the contact details of a debriefing service, should the need for debriefing have arisen during their participation in this study. Participants were also protected from questions which could have elicited emotional reactions in that the AUDIT and BORRTI, as neither of these questionnaires asked the participants to elaborate or explore feelings.

This ethical consideration was also maintained in that the researcher employed culturally sensitive techniques and processes. The participants were also treated with respect at all times.

## CHAPTER 4: RESULTS AND FINDINGS

In this chapter, the results and findings of this study are presented. Under the results section, the results of the entire sample are discussed, followed by the exclusion criteria applied to the sample; hereafter the results of the 29 remaining participants are analysed. Firstly, the 29 participants BORRTI results are discussed followed by the correlation between alcohol consumption and the different BORRTI scales; initially, for the sample of 29 individuals, and then by gender specific correlations. The below diagram explains the layout of Chapter 5 in more detail:



4.3. Findings

4.3.1. BORRTI Results of 29 Participants

4.3.1. BORRTI Object Relations Profile Analyses (29 Participants) / Case Studies

Isolated and Similar Trends 29 Participants

Isolated and Similar Trends Female Participants (10 of 29 Participants)

Isolated and Similar Trends Male Participants (19 of 29 Participants)

4.3.2. Pearsons Correlation Coefficient 29 Participants

4.3.2. Pearsons Correlation Coefficient in terms of Genders

4.3.3. Trends Identified

White Afrikaans-speaking Females

White Afrikaans-speaking Males

High AUDIT score and no pathological BORRTI score



## 4.1. RESULTS

Under this section, three different categories of results will be presented. Firstly, the results of the entire sample will be presented for both the BORRTI and the AUDIT test results. Following this the exclusion criteria, which was applied to all the participant's results, will be discussed – this criterion was instilled to ensure the sample of individuals consisted of people who have an alcohol use disorder and who answered the BORRTI questionnaire with the required cognisance. By excluding the individuals who did not meet these criteria, the validity of the results were safeguarded.

### 4.1.1. Results of Entire Sample

In the table below, the scores of the entire sample of 45 participants are given. Hereafter, an exclusion criterion is applied to the sample, with only 29 participants' results being considered valid to analyse throughout the rest of the dissertation. Under the first section, 4.2.1., the BORRTI results of the 29 participants are presented.

**Table 1: Entire Sample BORRTI and Audit Scores**

Participant Number	Ethnicity	Language	Gender	AUDIT	Frequently Endorsed Questions	Infrequently Endorsed	Inconsistency Scale	Alienation Scale	Insecure Attachment Scale	Egocentricity Scale	Social Incompetence Scale	Reality Distortion Scale	Uncertainty of Perception Scale	Hallucinations and Delusions Scale
1	W	Afr, Eng	M	26	10	3	9	66	60	64	56	57	60	61
2	W	Afr, Eng	M	14	7	5	6	70	74	72	56	67	57	50
3	W	Eng	M	29	7	2	2	66	55	54	62	57	53	57
4	W	Eng	F	6	2	0	1	46	36	40	41	48	30	42
5	C	Eng	M	21	9	4	4	65	59	64	62	71	53	76
6	A	Eng, Afr	F	13	10	8	9	66	53	59	67	68	57	79
7	A	Afr	M	30	10	5	7	66	69	80	48	80	62	67
8	W	Afr, Eng	F	9	9	2	2	53	59	59	48	57	57	42

9	W	Afr, Eng	M	10	12	5	7	78	80	73	56	69	80	76
10	W	Afr, Eng	M	32	10	5	6	80	71	77	71	69	63	62
11	W	Afr, Eng	M	12	9	3	4	66	66	64	62	57	53	42
12	W	Afr, Eng	F	17	9	3	5	69	69	64	62	65	57	50
13	A	Eng	F	4	3	4	8	49	45	59	41	66	53	66
14	C	Afr, Eng	M	38	11	6	5	80	71	78	66	68	68	74
15	W	Afr, Eng	M	29	11	10	8	74	80	78	62	73	57	73
16	W	Afr, Eng	M	18	10	0	5	62	59	61	48	63	57	64
17	W	Afr, Eng	F	30	10	4	5	78	64	65	67	73	54	61
18	I	Eng	M	37	12	10	4	80	80	78	66	73	80	80
19	W	Afr, Eng	M	10	10	2	8	66	62	61	58	60	54	57
20	W	Afr, Eng	M	40	13	7	9	75	80	80	56	77	63	72
21	W	Afr, Eng	F	16	4	1	4	46	48	52	41	57	53	42
22	W	Afr, Eng	M	15	12	8	5	78	80	76	67	80	66	79
23	W	Afr, Eng, Por	F	20	12	0	9	60	64	70	56	73	68	72
24	W	Afr, Eng	M	34	3	1	5	55	51	43	41	49	51	42
25	W	Eng, Afr	F	10	10	2	5	74	69	76	66	63	63	61
26	W	Eng	M	17	8	3	5	58	66	71	41	63	57	50
27	A	Tshwa, Eng, Afr	M	0	4	0	2	50	45	56	41	52	41	42
28	A	Sotho, Eng, Afr	M	22	7	3	4	56	66	56	48	59	67	50
29	W	Afr, Eng	M	13	7	1	1	56	53	52	41	49	41	42
30	W	Afr, Eng	M	20	11	3	3	58	53	59	41	66	57	71
31	I	Roshini, Eng, Afr	F	1	9	3	3	50	59	65	48	73	57	66
32	W	Afr, Eng	M	34	12	9	5	80	62	80	62	80	78	79
33	w	Afr, Eng	M	24	12	6	5	80	71	77	66	67	68	61
34	B	Tsonga, Eng, Afr	M	31	9	9	8	62	69	76	48	73	53	71
35	W	Afr, Eng	M	9	8	0	4	65	62	52	56	48	51	42
36	W	Afr, Eng	F	40	4	0	1	47	45	43	41	42	39	42
37	W	Eng	M	14	9	0	5	62	59	61	48	55	57	42
38	W	Afr, Eng	F	14	10	4	6	71	69	70	71	60	78	61
39	W	Afr, Eng	M	40	2	7	3	58	59	59	48	60	57	57
40	W	Afr, Eng	F	10	9	6	6	66	60	64	67	63	57	76
41	W	Eng	F	9	6	2	4	62	64	61	48	48	51	42
42	W	Afr, Eng	F	1	9	3	4	65	55	61	48	67	57	50
43	B	Afr, Eng	F	24	4	7	8	66	62	54	64	60	47	73
44	W	Afr, Eng	F	31	11	3	7	44	76	71	70	66	68	67
45	W	Afr, Eng	F	32	6	10	2	45	53	62	59	56	73	57

Abbreviations: Afr - Afrikaans; Eng - English; Port - Portuguese; Tshwa - Tshwana

A total of 45 individuals participated in this sample. They were identified by the psychological team working at the tertiary psychiatric hospital as having being diagnosed by the multi-disciplinary team (on average comprising of two psychiatrists and three psychologists) with alcohol problems with co-morbid personality disorders and/ or mood disorders. Of this sample, 18 were females and 27 were males.

#### **4.1.2. EXCLUSION CRITERIA**

Of the 45 people assessed, only 29 of the participants' scores (whose interview numbers are coloured in yellow) were included in the analysis, as the other 22 protocols administered all met one of the exclusion criteria, which are now discussed.

This study contains four different exclusion criteria, which are in the form of the Alcohol Use Identification Test (AUDIT) and three of the BORRTI scales (Bell, 2005).

1. The AUDIT's exclusion criterion is that if an individual score is below 8, this indicates they have self-reported that they do not have a problem with alcohol abuse or misuse.
2. The first of the exclusion criteria picks up frequently answered questions. A participant who scores a seven or above on this scale should have at least one T-score of T70 or above. If not, their scores should be considered with caution.
3. The second scale measures infrequently answered questions. In this case, participants who score three or below should only have T-scores of below T70. Again, if this is not the case their scores should be considered with caution.
4. The inconsistency scale states that if an individual scores a 7 or above, their answers have been haphazardly answered.

The individuals whose scores were chosen to be analysed were all indicated by the AUDIT as having an alcohol problem; the five participants whose scores were below 8, namely, Participant 4, 13, 27, 31 and 42, were excluded. That brings the sample for further analysis to 40.

The scores of the individuals who fell within the “proceed with caution” score on both the Frequency and Infrequently scales were included if they did not meet any of the other exclusion criteria/scales. The only participant, who was excluded, was number 44, as the individual’s score was excluded by the Inconsistency scale. The overall sample was then on 39 participants.

The Inconsistency scale picked up haphazard answering by 12 of the participants, namely, 1, 6, 7, 9, 13, 15, 19, 20, 23, 34, 43 and 44. Number 13 and 44 have already been excluded due to their low score on the AUDIT. With these participants’ scores being excluded, the final valid sample of participants comprised of 29 individuals for the current research study.

**Table 2: Selected Sample Pathological BORRTI Scores: 29 Participants**

<b>Category</b>	<b>Pathological T-Score</b>	<b>Participants with Pathological T-scores</b>
Alienation	60 and above	19
Egocentricity	60 and above	18
Insecure Attachment	60 and above	17
Reality Distortion	60 and above	15
Social Incompetence	60 and above	14
Uncertainty of Perception	60 and above	10
Hallucinations and Delusions	65 and above	7

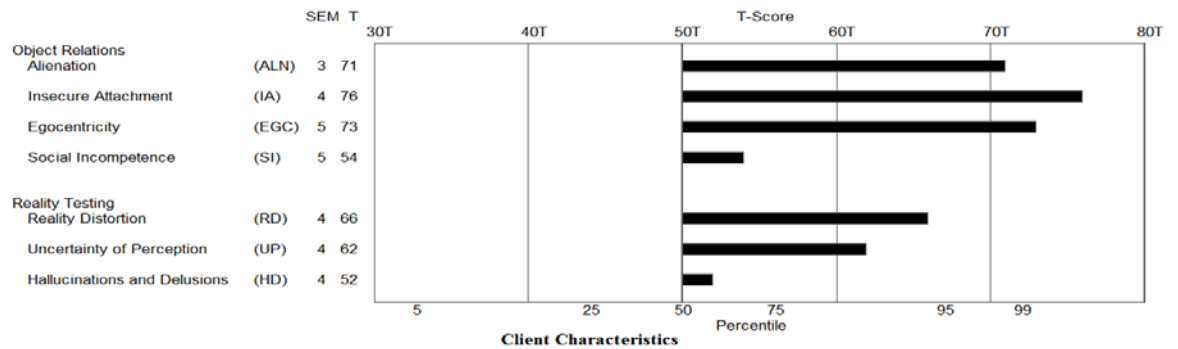
In the table above, the number of individuals who presented with pathological T-scores in the different BORRTI scales are presented. Of the sample of 29 participants, a large majority scored pathological scores in at least one category, which is indicative of severe character (personality organisation) pathology.

## 4.2. RESULTS SELECTED SAMPLE: 29 PARTICIPANTS

All participants of the initial recruitment sample who were assessed, and who met the exclusion criteria, were excluded. These 16 individuals' scores are coloured grey in Table 1. A total of 29 participants did not meet the exclusion criteria and therefore are included in the sample and their scores are indicated in Table 1 in yellow.

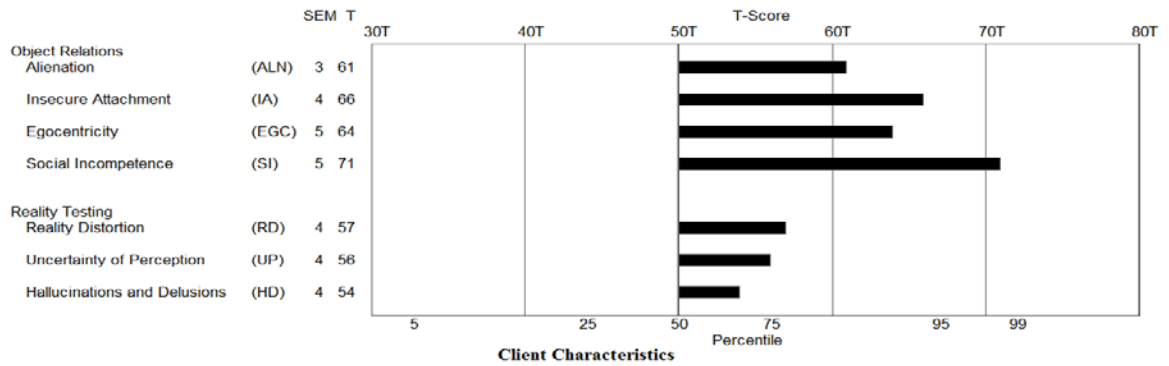
### 4.2.1. BORRTI RESULTS 29 PARTICIPANTS

Under this section, the BORRTI profiles for each of the 29 participants are presented with a brief analysis. The detailed analysis of their profiles is provided under the findings section of this study.



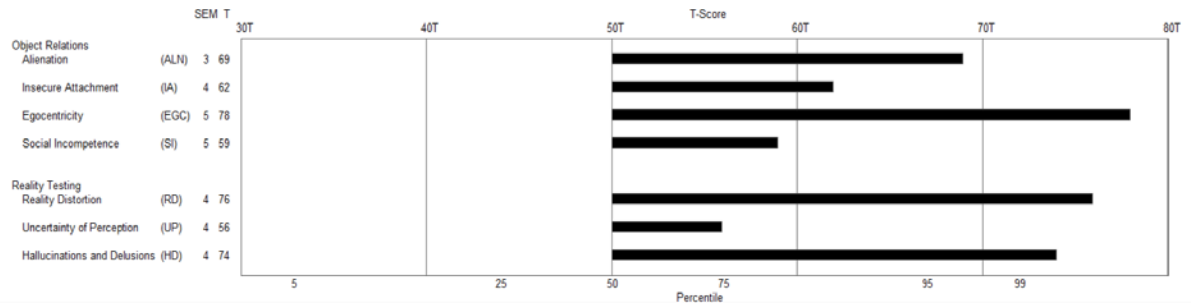
**Figure 1: Participant 2 BORRTI Profile**

Participant 2 scored high scores for the Alienation, Egocentricity, Social Incompetence, Reality Distortion and Uncertainty of Perception subcategories and a normal score for the Social Incompetence and Hallucinations and Delusions categories.



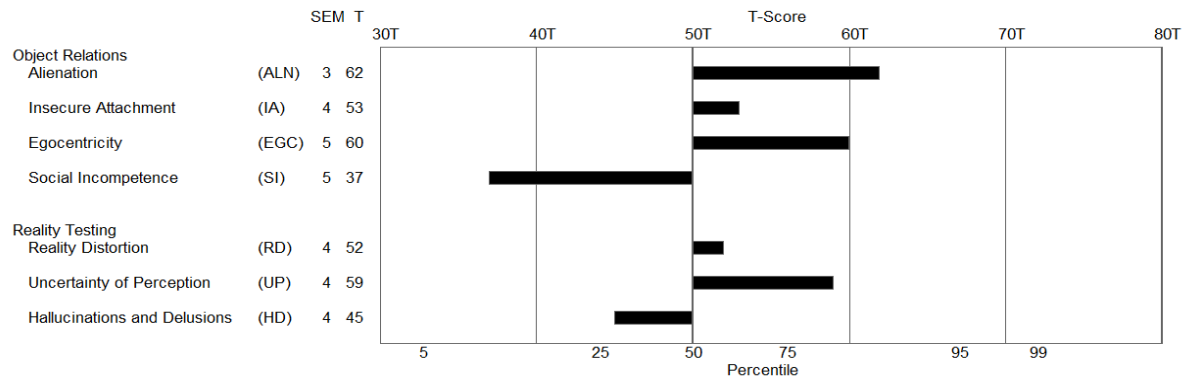
**Figure 2: Participant 3 BORRTI Profile**

Participant 3 scored pathological scores for the Alienation, Insecure Attachment, Egocentricity and Social Incompetence ego functions; however, this individual is not suffering from pathology in terms of Reality Testing, which is indicative of an easier treatment route.



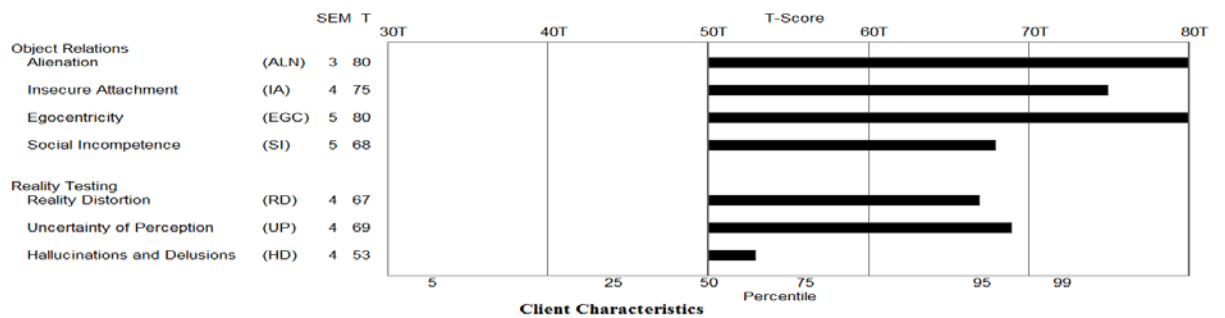
**Figure 3: Participant 5 BORRTI Profile**

Participant 5 scored extremely pathological scores for the Egocentricity subcategory as well as the Reality Distortion and Hallucinations and Delusions categories, a combination which suggests that this individual has very little insight into their current level of functioning, and because of this they may not be aware of their feelings and thoughts regarding their social incompetence and uncertainty of perceptions.



**Figure 4: Participant 8 BORRTI Profile**

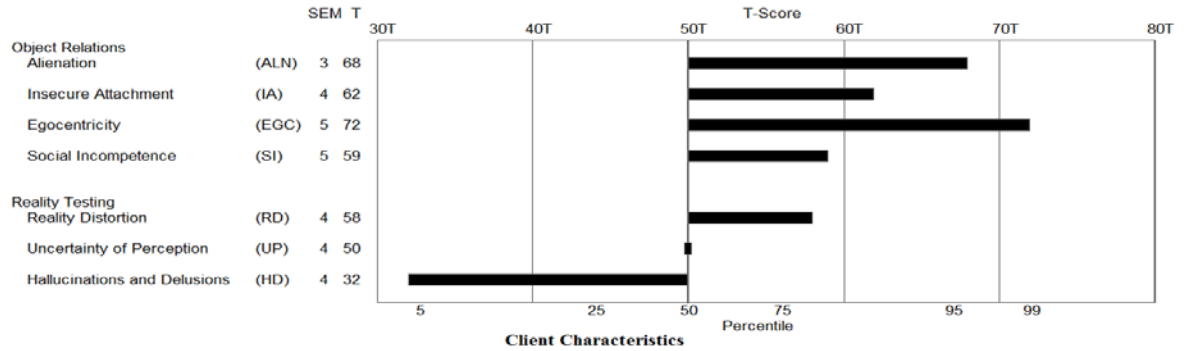
Participant 8's profile is suggestive of an individual who is higher functioning than the previous two participants. The only pathological score this individual attained is in relation to the Alienation and Egocentricity category. Although this individual scores a reasonably normal score in terms of Insecure Attachments, indicating that his attachments are not overtly dysfunctional, this person is extremely Alienated and Isolated. This is indicative of the fact that this person's functioning could improve drastically if they form a good rapport with a therapist, which will assist them in not feeling so alienated.



**Figure 5: Participant 10 BORRTI Profile**

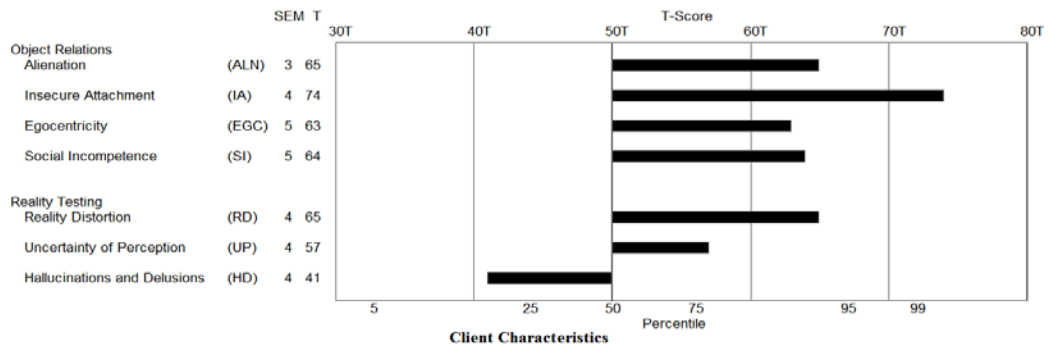
Participant 10's profile is indicative of a currently very ill individual who suffers from extreme reality distortions and uncertainty of perceptions – these would need to be treated first before work could be done on this person's ego structure. In accordance with this individual's scores, this person's ego

structure is weak, which will fundamentally influence therapy. This person has extremely high scores on the Alienation, Insecure Attachment, Social Incompetence and Egocentricity categories, which is indicative of severe character pathology.



**Figure 6: Participant 11 BORRTI Profile**

Participant 11's score indicates that this individual's Reality Testing score is normal, however the Object Relations score indicates some pathology. The main area of focus in terms of initial treatment should be related to the individual's high score on Egocentricity.



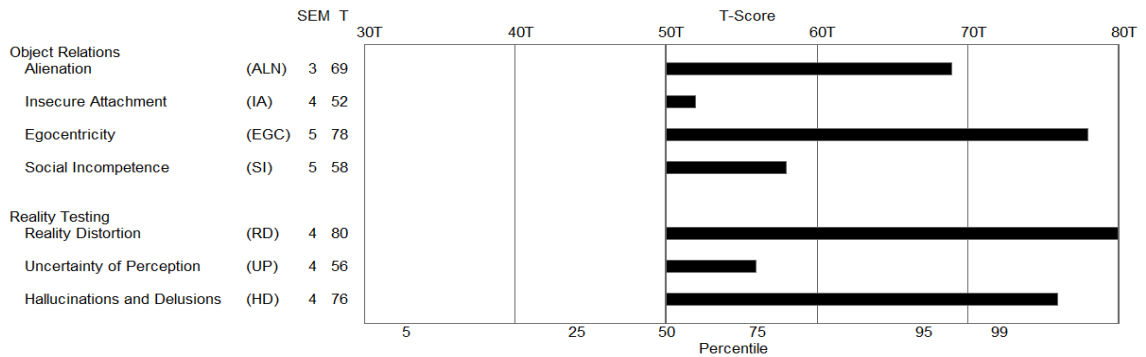
**Figure 7: Participant 12 BORRTI Profile**

Participant 12's scores indicate slight pathology in the Reality Distortion category, which could be addressed with medication or therapeutic techniques. Following this the next area of focus would be on the individual's Insecure Attachments, which is directly linked to the introjects this individual internalised in early childhood. If this individual went into long-term treatment with a consistent,



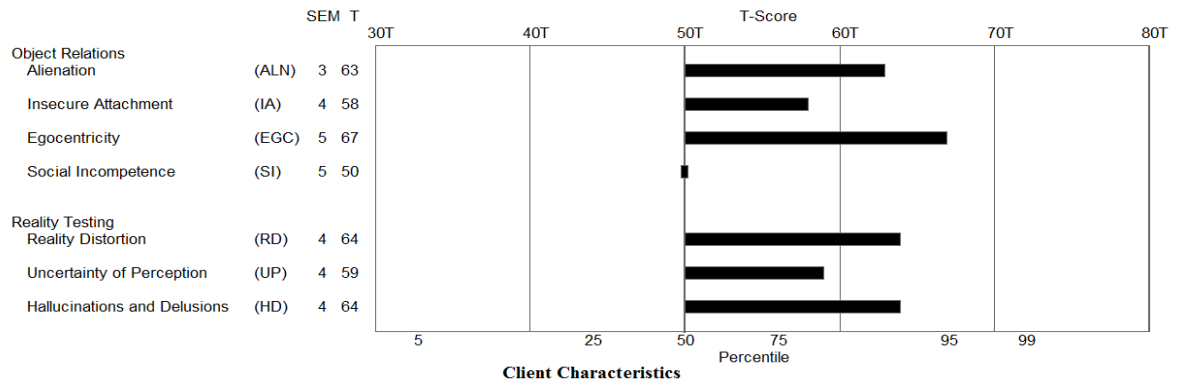
trusting and transparent therapist, the therapist would likely become their new introject/beacon of

safety.



**Figure 8: Participant 14 BORRTI Profile**

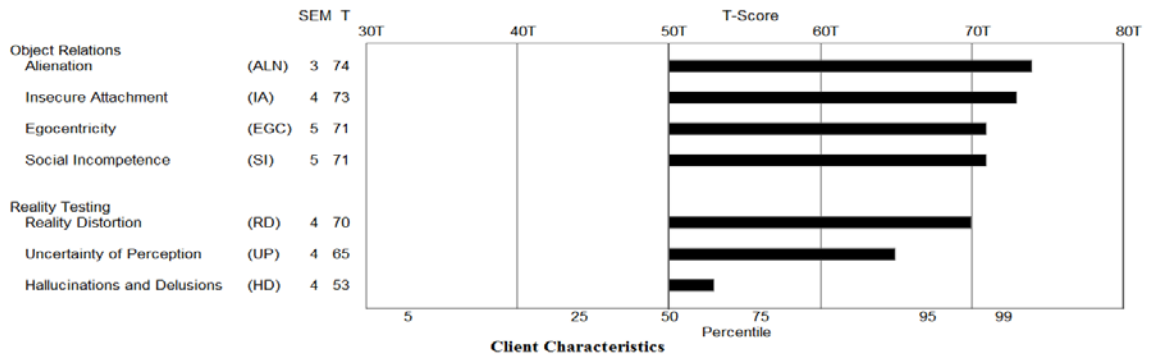
Participant 14 has severe pathology in terms of their reality testing functions. In order to assist this individual, their reality distortions, hallucinations and delusions would need to be addressed before addressing this individual’s ego weaknesses.



**Figure 9: Participant 16 BORRTI Profile**

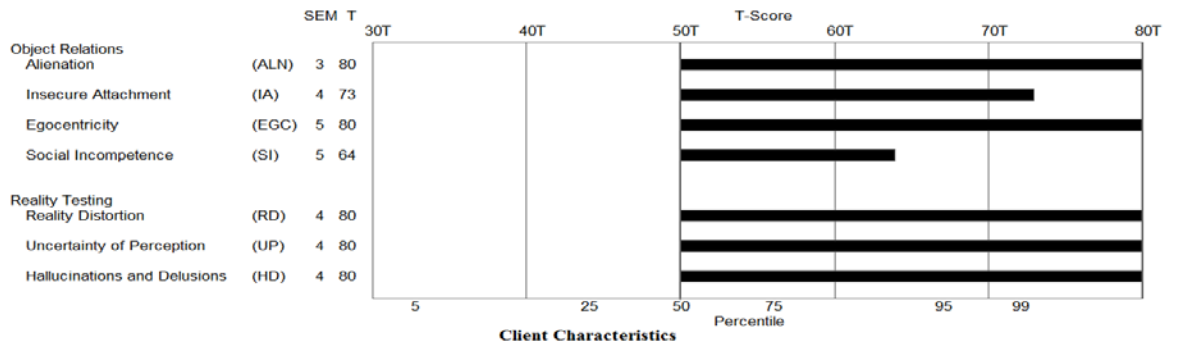
Participant 16’s profile indicates slight pathology in all areas. Some therapeutic work will hence need to be done on their hallucinations and delusions as well as reality distortions, which may be due to substance-induced psychosis, and which means these symptoms could clear up the longer this individual abstains from alcohol. Hereafter their pathology in terms of Egocentricity and Alienation

will need to be addressed, which will assist this individual in attaching to a “healthy” transitional object in the form of a therapist as opposed to alcohol.



**Figure 10: Participant 17 BORRTI Profile**

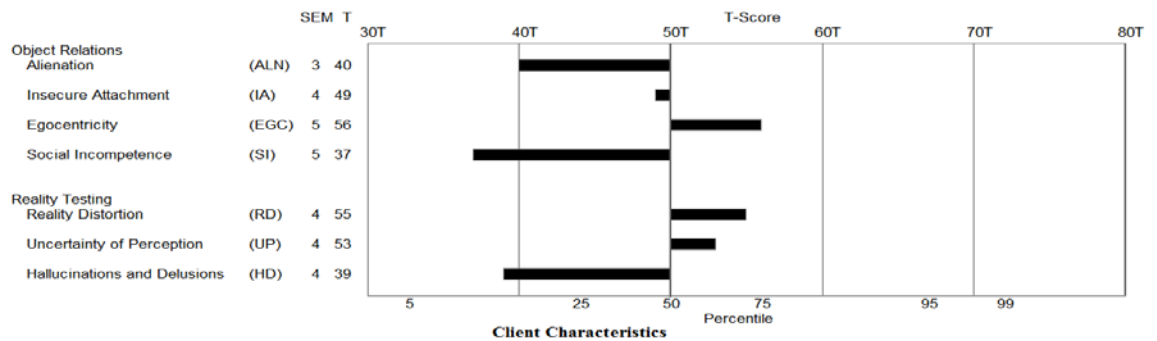
Participant 17 has a relatively unstable profile as they exhibit pathological scores in terms of most of the Reality Testing and Object Relations categories, which is indicative of a poor treatment prognosis. This individual is likely to feel threatened by therapy and therefore may drop out early from treatment and return to their “safe object” in the form of alcohol.



**Figure 11: Participant 18 BORRTI Profile**

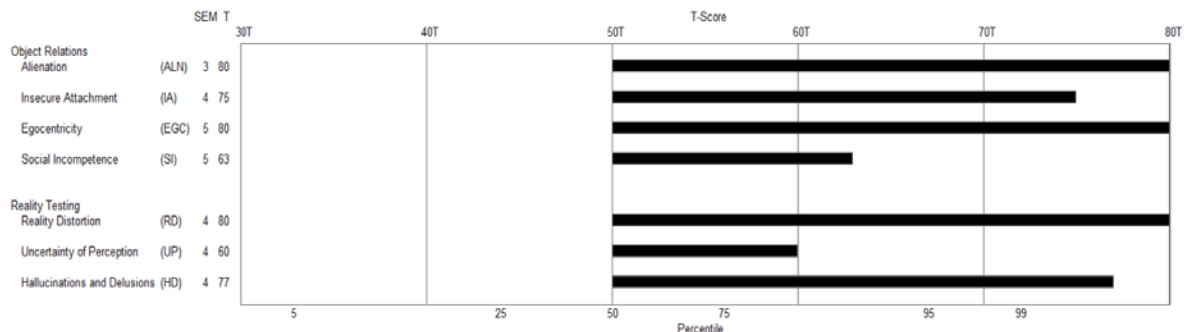
Participant 18’s scores indicate that they suffer from severe pathology. This individual is likely to have little improvement in treatment unless they remain in the psychiatric institution for an extended amount of time. The kind of pathology displayed in terms of this individual’s Reality Testing is likely to be an extreme challenge to treat; even with medication this individual’s scores suggest that their reality distortions, hallucinations and delusions are unlikely to dissipate completely. This individual

may not benefit for any form of a depth therapy approach. CBT and psycho-educational approaches are likely more helpful in this situation.



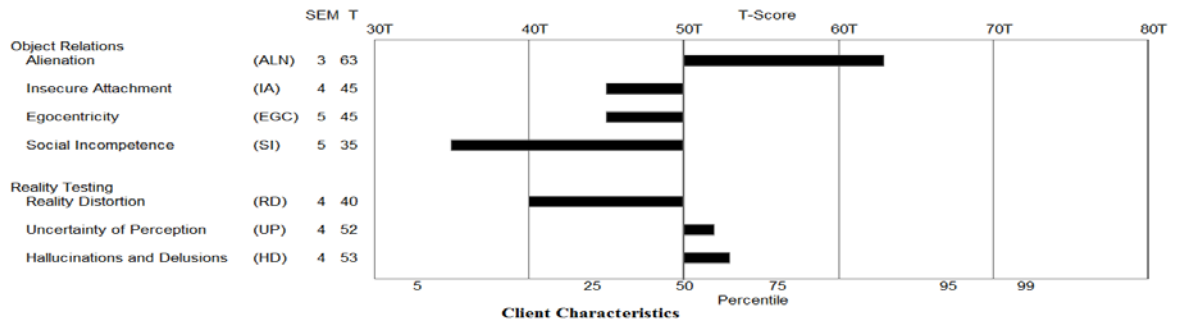
**Figure 12: Participant 21 BORRTI Profile**

Participant 21’s profile indicates that they have reasonable ego strength, as they exhibit no pathology in terms of any of the BORRTI categories. This profile is suggestive of a good treatment prognosis. However, if their alcohol abuse is not curbed, their profile is likely to deteriorate over time.



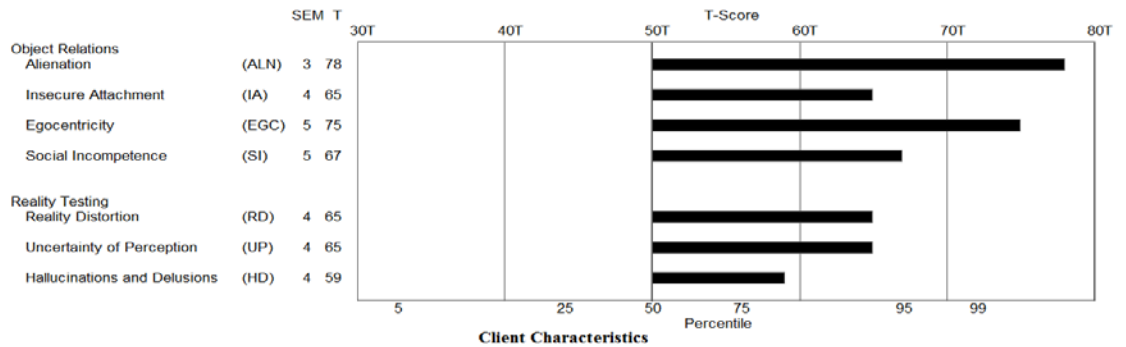
**Figure 13: Participant 22 BORRTI Profile**

Participant 22’s profile indicates severe pathology in all areas of their Object Relations and Reality Testing. This individual’s treatment prognosis is poor and the likelihood of this person becoming a healthy functioning individual is extremely low. To make progress in treatment, this individual’s reality distortions, hallucinations and delusions will need to be addressed first. Following this their defenses related to their feelings of alienation and egocentricity will need to be addressed.



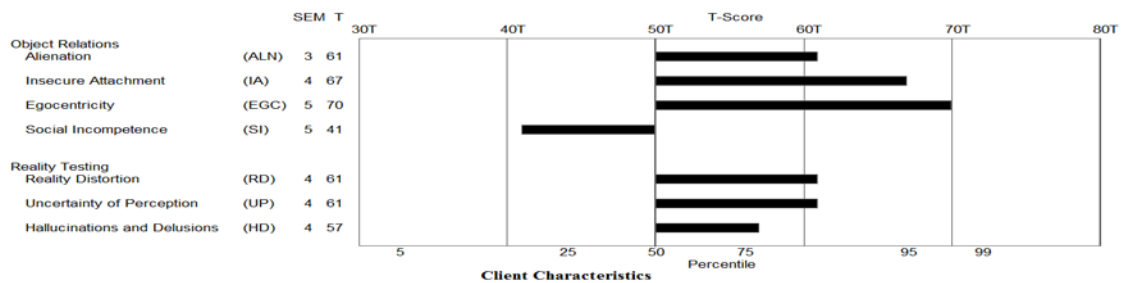
**Figure 14: Participant 24 BORRTI Profile**

Participant 24's profile is indicative of a reasonably healthy individual who experiences extreme feelings of Alienation. This is the main area that needs to be addressed in therapy.



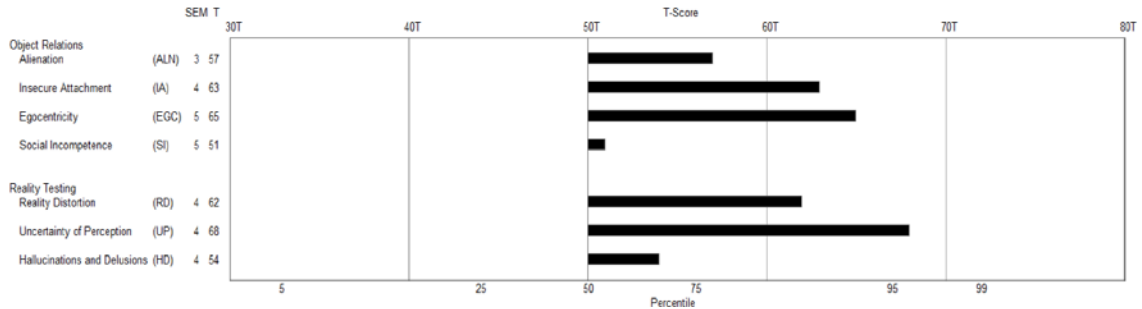
**Figure 15: Participant 25 BORRTI Profile**

Participant 25's profile is again indicative of an individual with very little ego strength. This individual has pathological scores in all areas of the BORRTI subcategories, barring the Hallucinations and Delusions subcategory.



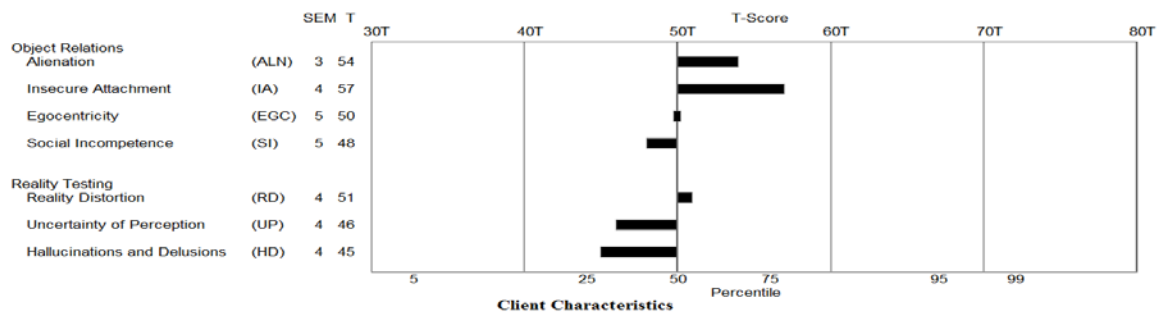
**Figure 16: Participant 26 BORRTI Profile**

Participant 26's scores indicate concern in terms of this individual's Reality Testing abilities. The scores are pathological, indicating that this individual may struggle with individual therapy; as such, group therapy and psycho-education should be focused at addressing areas of pathology in relation to their Object Relations, Egocentricity, Insecure Attachment and Alienation subcategories.



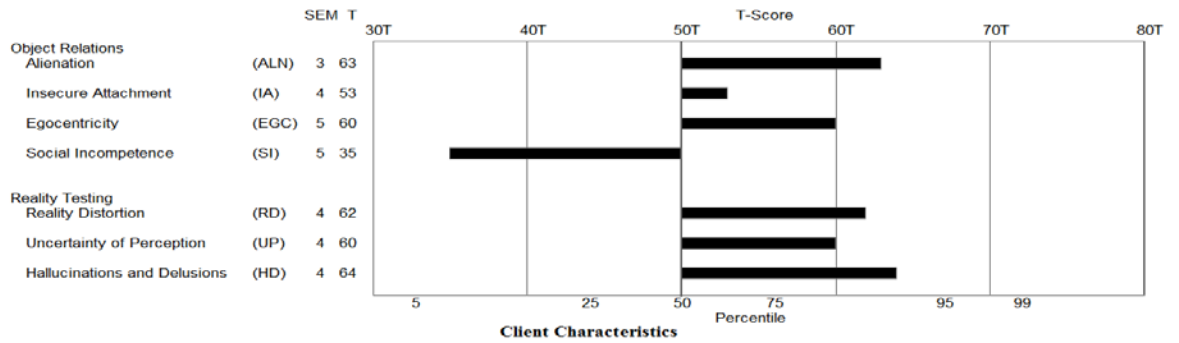
**Figure 17: Participant 28 BORRTI Profile**

Participant 28's profile indicates that they may need medication in order to manage their high level of uncertainty of perceptions together with their reality distortions, as both of these areas are indicated to be pathological in this individual. Hereafter, the individual's high level of Egocentricity and Insecure Attachments will need to be addressed.



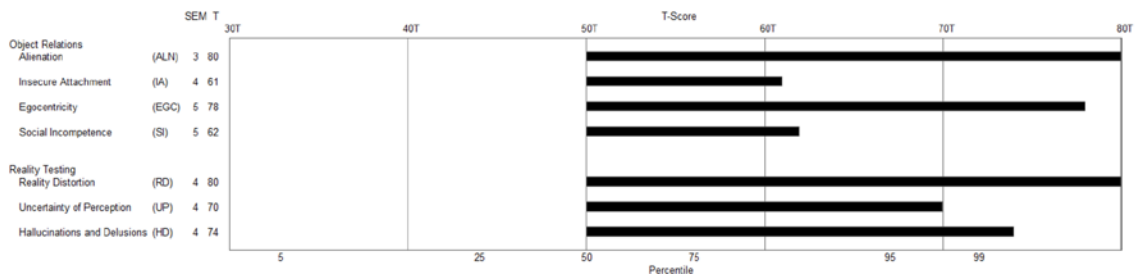
**Figure 18: Participant 29 BORRTI Profile**

Participant 29's profile indicates little severe pathology in relation to this individual's Reality Testing and Object Relations scores.



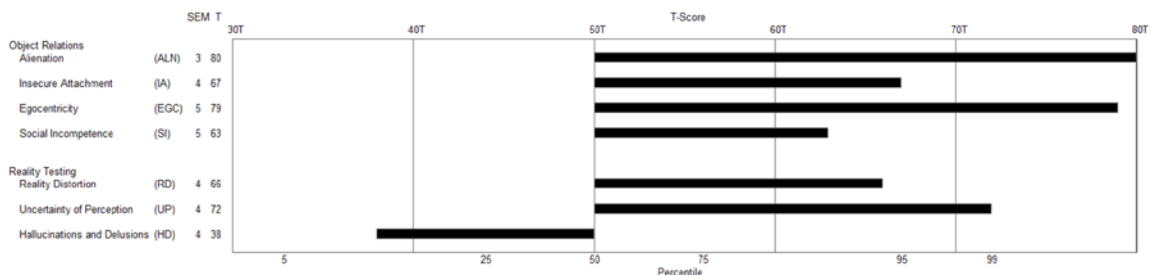
**Figure 19: Participant 30 BORRTI Profile**

Participant 30's profile indicates pathology in terms of reality distortions, hallucinations, delusions and uncertainty of perception. Pathology is also indicated in terms of this individual's feelings of Alienation and their Egocentricity subscale.



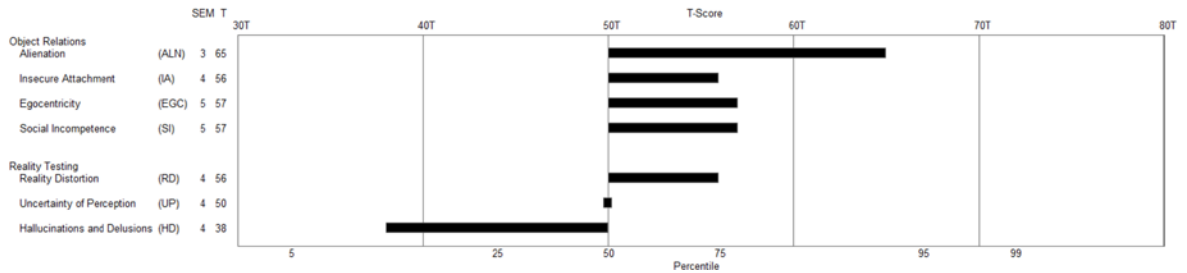
**Figure 20: Participant 32 BORRTI Profile**

Participant 32 presents with extreme pathology; the majority of this individual's scores are well above T-60, which indicate pathology in all of these areas. This individual is likely to be limited in terms of ego strength and therefore traditional psychotherapy should be avoided; CBT and more supportive forms of therapy are likely to be more beneficial. Psychoeducation will also be helpful in this situation.



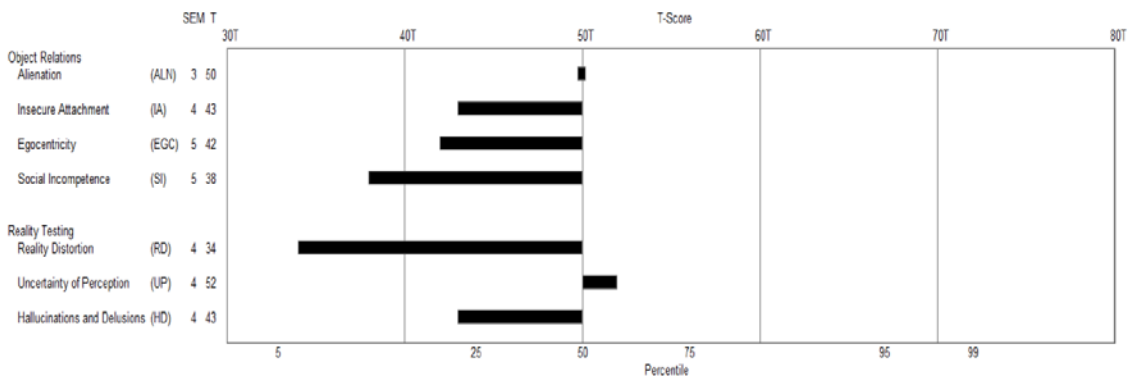
**Figure 21: Participant 33 BORRTI Profile**

Participant 33 presents with a severely dysfunctional profile; however, the fact that their score does not indicate that they are struggling with hallucinations and delusions allows for a slightly better prognosis. This individual does nevertheless present with extremely high levels of alienation and egocentricity, which will influence their relationship with their therapist.



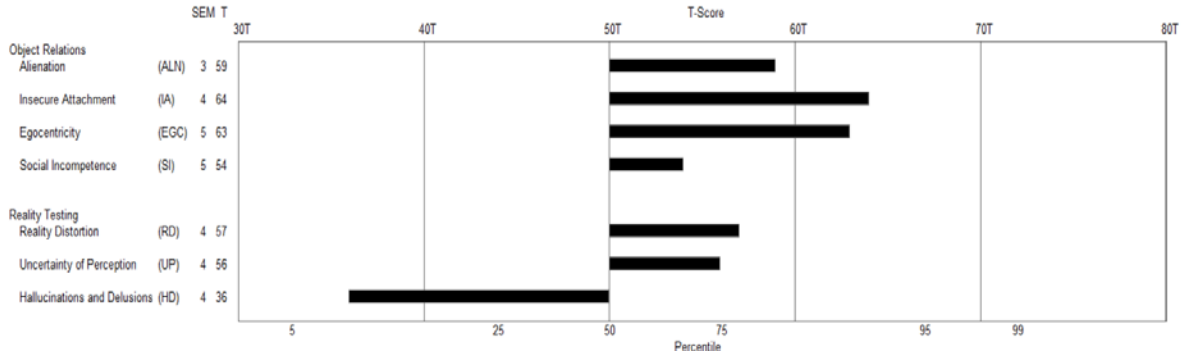
**Figure 22: Participant 35 BORRTI Profile**

Participant 35's profile indicates no pathology in terms of Reality Testing, however, this individual scores a pathological score on the Alienation category. This suggests that this person is highly isolated in everyday life, which needs to be addressed in order for this individual to be able to build a support system that will assist them to stay sober.



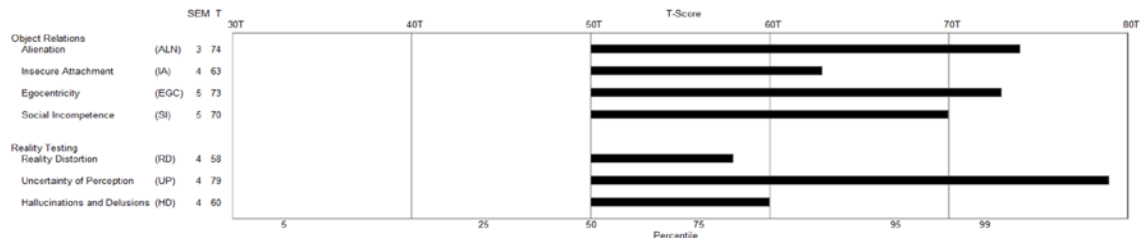
**Figure 23: Participant 36 BORRTI Profile**

Participant 36 presents with a relatively normal profile, which suggests that if their alcohol consumption is stopped they should easily be able to integrate back into society and function on a reasonably high level.



**Figure 24: Participant 37 BORRTI Profile**

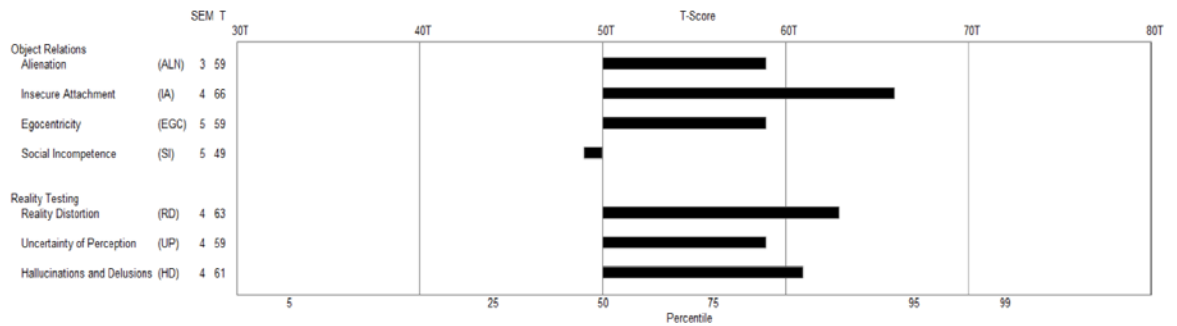
Participant 37's main areas of dysfunction revolve around attachments and egocentricity, so this individual is likely to struggle with high levels of mistrust and, possibly, display demanding, controlling and manipulative behaviour.



**Figure 25: Participant 38 BORRTI Profile**

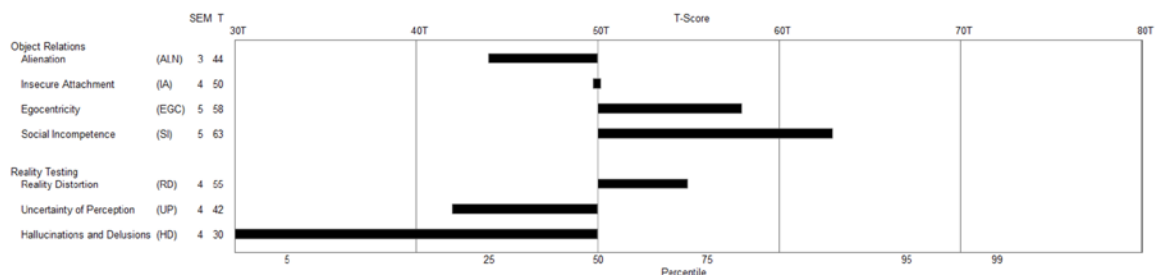
Participant 38 presents with large areas of ego weakness, specifically, related to their perceptions, feelings of alienation, egocentricity and social incompetence.





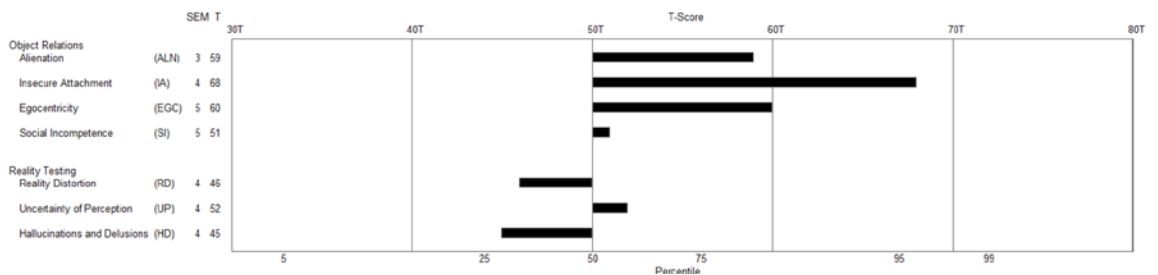
**Figure 26: Participant 39 BORRTI Profile**

Participant 39 presents with pathological scores in the Reality Distortions category as well as the Insecure Attachment category. These scores are indicative that this individual will struggle to discern reality from fantasy and to form healthy and secure attachments.



**Figure 27: Participant 40 BORRTI Profile**

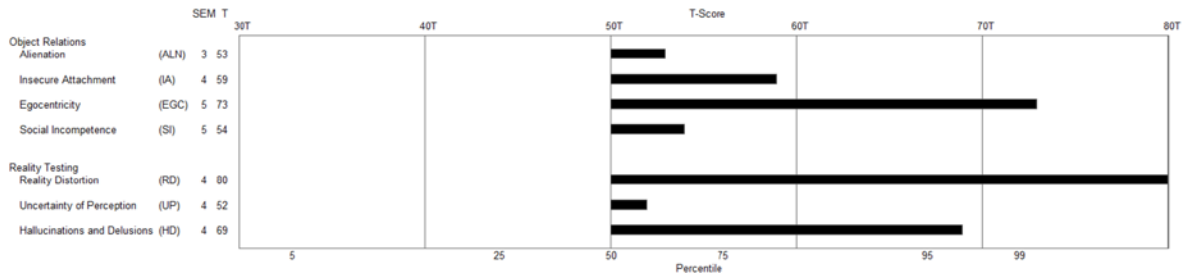
Participant 40's main area of dysfunction is indicated to be related to their feelings of social incompetence. Long-term, in-depth therapy should assist in this regard.



**Figure 28: Participant 41 BORRTI Profile**

Participant 41's scores indicate that this individual has not had exposure to secure attachments, which is leading to their main area of pathology. This is an area that can be rectified in treatment and with

their lower score on the Egocentricity scale, they should be less defended than an individual with high scores on the Egocentricity subscale.



**Figure 29: Participant 45 BORRTI Profile**

Participant 45’s profile indicates severe psychosis, which once dealt with will allow for the individual to gain more insight into their condition. At that stage the high levels of egocentricity should be dealt with in therapy.

**4.2.2. PEARSON’S CORRELATION COEFFICIENT FOR 29 PARTICIPANTS**

In this section, the Pearson’s correlation coefficient results are presented in a scatterplot figure for the sample of 29 individuals. The correlation between alcohol use and each of the BORRTI categories are presented in order of category that has the highest statistically significant correlation with alcohol consumption. A correlation percentage is considered statistically significant at the 95% level for 29 participants at 31.3% or above.

The order of categories is as follows: Hallucinations and Delusions, Reality Distortions, Uncertainty of Perception, Alienation, Social Incompetence, Egocentricity and Insecure Attachments. Although many positive correlations are indicated in these categories, the only category which presents with a statistically significant correlation is the Hallucinations and Delusions category.

**Correlation**

32.4% - statistically significant

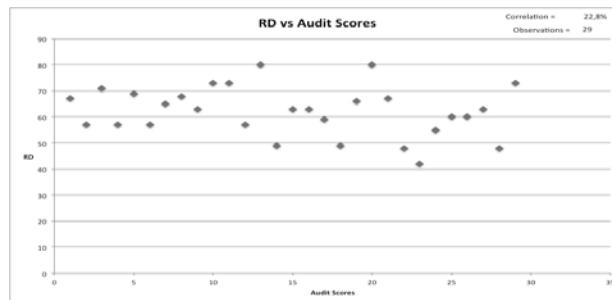


**Figure 30: Hallucinations and Delusions vs. AUDIT Correlation**

This figure indicates a statistically significant correlation between hallucinations and delusions and alcohol consumption for the entire sample, including males and females.

**Correlation**

22.8% - not statistically significant

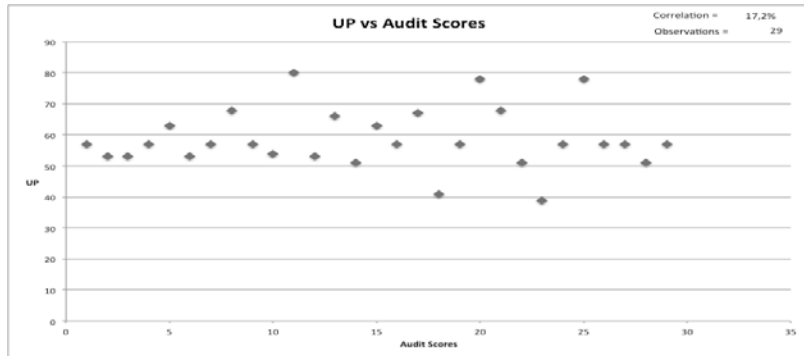


**Figure 31: Reality Distortion vs. AUDIT Correlation**

The correlation between the Reality Distortion and AUDIT scores seem to be positive, but are not statistically significant.

**Correlation**

17.2% - no significant correlation, although the correlation appears to be positive.

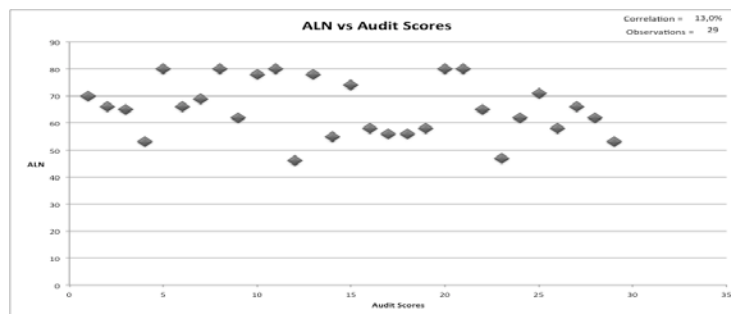


**Figure 32: Uncertainty of Perception vs. AUDIT Correlation**

No statistically significant correlation was found between the sample’s Uncertainty of Perceptions scores and their level of alcohol consumption.

**Correlation**

13.0% - no significant correlation, although the correlation appears to be positive.



**Figure 33: Alienation vs. AUDIT Correlation**

The correlation between the Alienation scale and the Audit scores seems to be positive, but no statistically significant correlation was found.

**Correlation**

5.7% - no significant correlation, although the correlation appears to be positive.

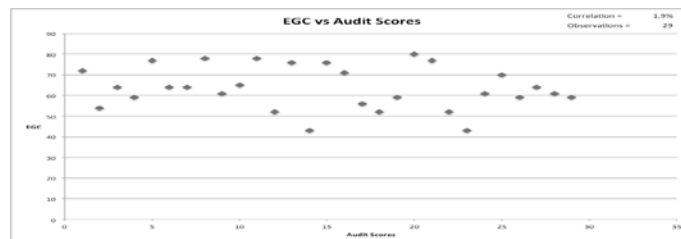


**Figure 34: Social Incompetence vs. AUDIT Correlation**

Although a positive correlation can be noted, no statistically significant correlation between the participants' scores on the Social Incompetence scale and their level of alcohol consumption are indicated.

**Correlation**

1.9% - no significant correlation, although the correlation appears to be positive.

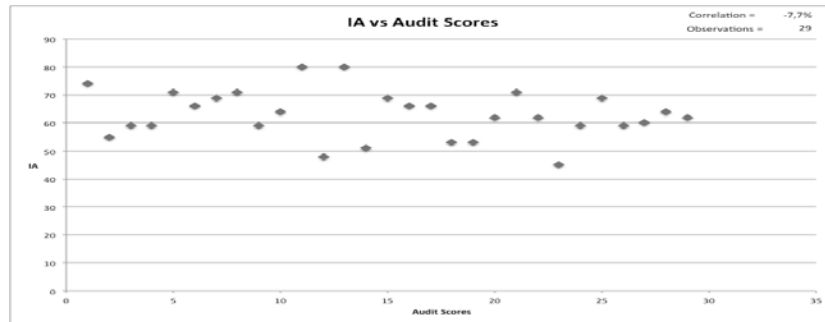


**Figure 35: Egocentricity vs. AUDIT Correlation**

Although a positive correlation can be noted, no statistically significant correlation between the participants' scores on the Egocentricity scale and their level of alcohol consumption is noted.

**Correlation**

-7.7% - negative correlation and barely any correlation



**Figure 36: Insecure Attachment vs. AUDIT Correlation**

The correlation between the participants' score within the Insecure Attachment category and the AUDIT score is negative and there is almost no correlation.

### 4.2.3. GENDER DIFFERENCES AND THE PEARSON'S CORRELATION COEFFICIENT

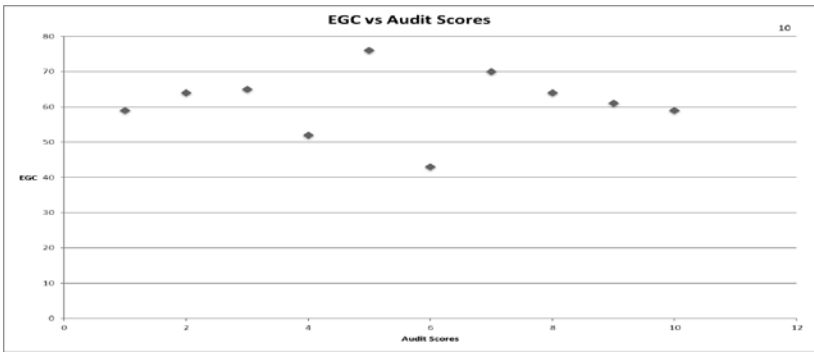
In this section, the results of the females and males in the sample were separated and the correlation between alcohol use and each gender group is presented.

#### FEMALES-ONLY PEARSON'S CORRELATION COEFFICIENT

Of the 29 participants included in the analysis, 10 were female. The figures are presented in order of the highest correlation found between ego function and BORRTI subcategory and alcohol use. A significant correlation at the 95% level, for 10 participants is 54.9%.

The order of correlation from highest to lowest in terms of BORRTI category and level of alcohol consumption is as follows for the female participants: Egocentricity, Uncertainty of Perception, Insecure Attachment, Alienation, Social Incompetence, Hallucinations and Delusions and Reality Distortions.

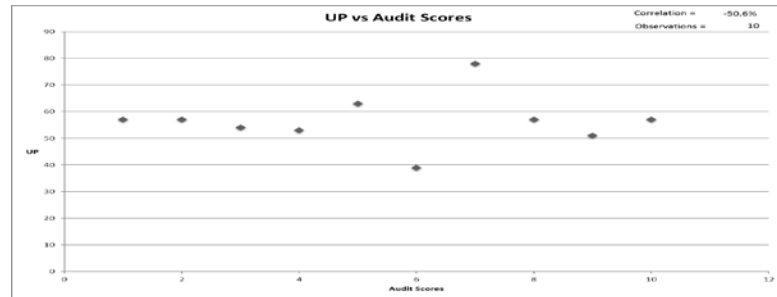
<b>Sample Size</b>	10
<b>Correlation</b>	-57.0%, statistically significant and negative



**Figure 37: Female Participants: Egocentricity vs. AUDIT Correlation**

This figure indicates a statistically significant, but negative correlation between Egocentricity and level of alcohol consumption. This suggests that the less alcohol consumed by a female participant, the more likely they are to score a higher score on the Egocentricity scale.

<b>Sample Size</b>	10
<b>Correlation</b>	- 50.6%, not statistically significant and negative correlation

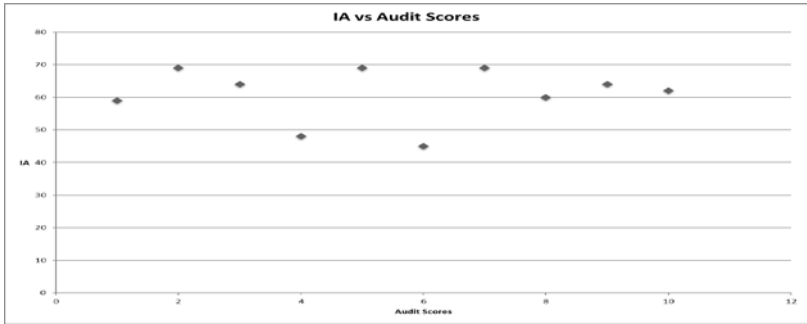


**Figure 38: Female Participants: Uncertainty of Perception vs. AUDIT Correlation**

This figure indicates a negative correlation between Uncertainty of Perception and level of alcohol consumption. This suggests that the less alcohol consumed by a female participant, the more likely they are to score a higher score on the Uncertainty of Perception.



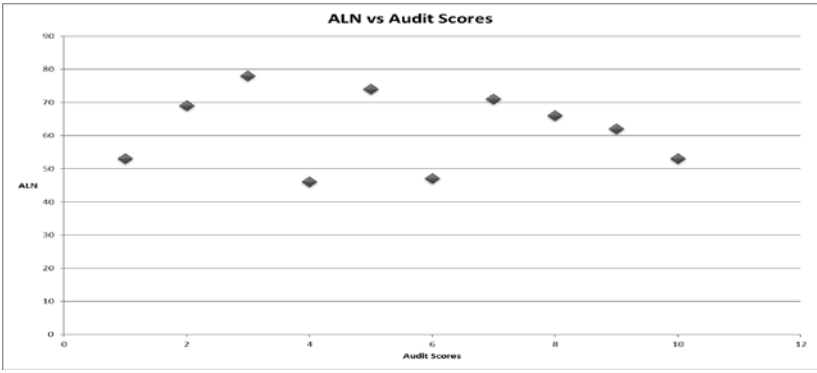
<b>Sample Size</b>	10
<b>Correlation</b>	-44.7%, high correlation and not statistically significant



**Figure 39: Female Participants: Insecure Attachment vs. Audit Correlation**

A negative correlation is indicated between Insecure Attachment and levels of alcohol consumption; however, this correlation is not statistically significant.

<b>Sample Size</b>	10
<b>Correlation</b>	-27.7%, not statistically significant, negative and slight correlation



**Figure 40: Female Participants: Alienation vs. AUDIT Correlation**

Lower levels of correlation were found between the Alienation scale and the AUDTI scores between the female participants.

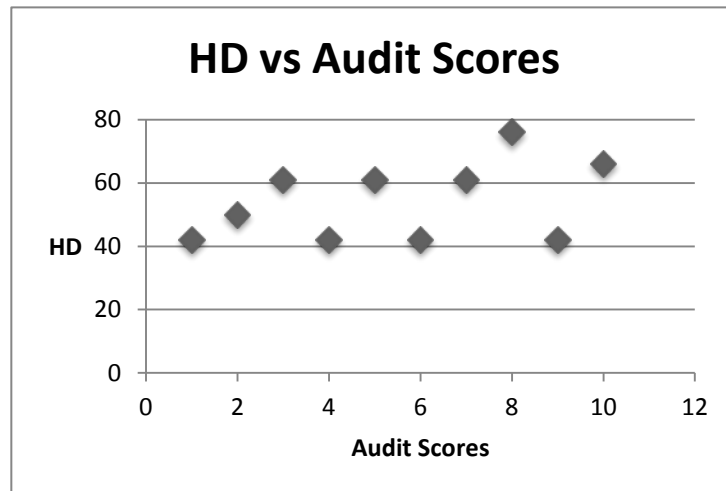
<b>Sample Size</b>	10
<b>Correlation</b>	-22.8%, slight negative correlation and not statistically significant



**Figure 41: Female Participants: Social Incompetence vs. AUDIT Correlation**

The correlation between the Social Incompetence scale and the AUDIT scale indicates a slight negative correlation, which is not statistically significant.

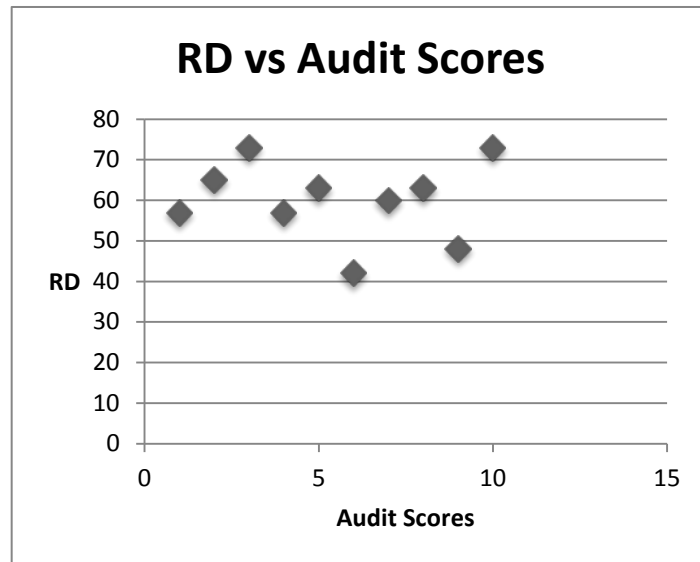
<b>Sample Size</b>	10
<b>Correlation</b>	-2.4%, not statistically significant and slight correlation



**Figure 42: Female Participants: Hallucination and Delusions vs. AUDIT Correlation**

Very little correlation was found between hallucinations and delusions and the level of alcohol consumption in the female participants.

<b>Sample Size</b>	10
<b>Correlation</b>	3.0%, slight positive correlation, but not statistically significant



**Figure 43: Female Participants: Reality Distortion vs. AUDIT Correlation**

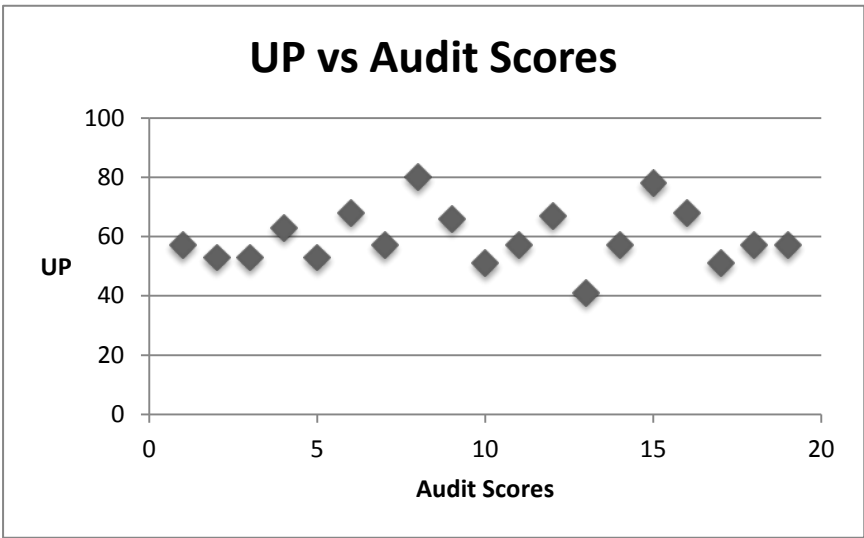
No significant correlation is found between Reality Distortion and alcohol consumption in the female sample.

**MALES-ONLY PEARSON’S CORRELATION COEFFICIENT**

Of the 29 participants included in Section A’s analysis, 19 were male. Again, the figures are presented in order of the highest correlation found between BORRTI subcategory and alcohol use. For a sample of 19 individuals to be statistically significant at the 95% level, a percentage of 38.9 must be ascertained.

The order of significance in terms of correlation between the BORRTI categories and the AUDIT scores are as follows: Uncertainty of Perception, Hallucinations and Delusions, Alienation, Reality Distortion, Social Incompetence, Egocentricity and Insecure Attachments.

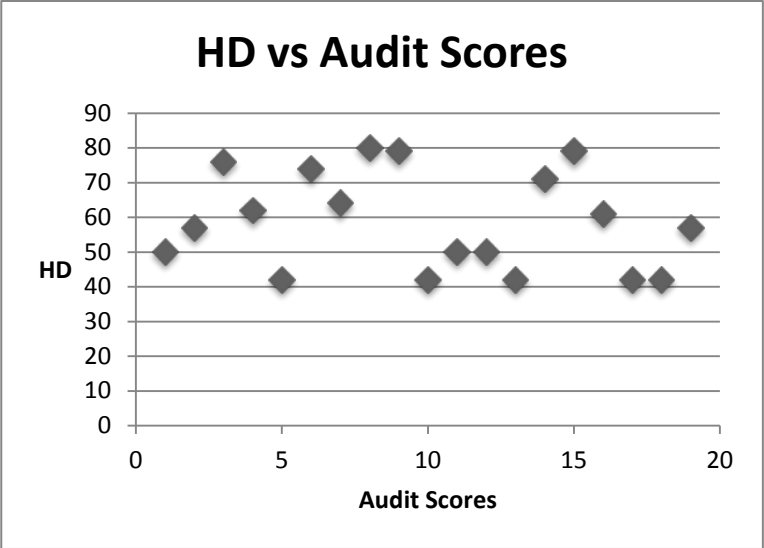
<b>Sample Size</b>	19
<b>Correlation</b>	51.6%, statistically significant and positive correlation



**Figure 44: Male Participant: Uncertainty of Perception vs. AUDIT Correlation**

The correlation between the Uncertainty of Perception and AUDIT scores have the highest correlations of all of the BORRTI subcategories with alcohol use for the male participants. The correlation is also significant.

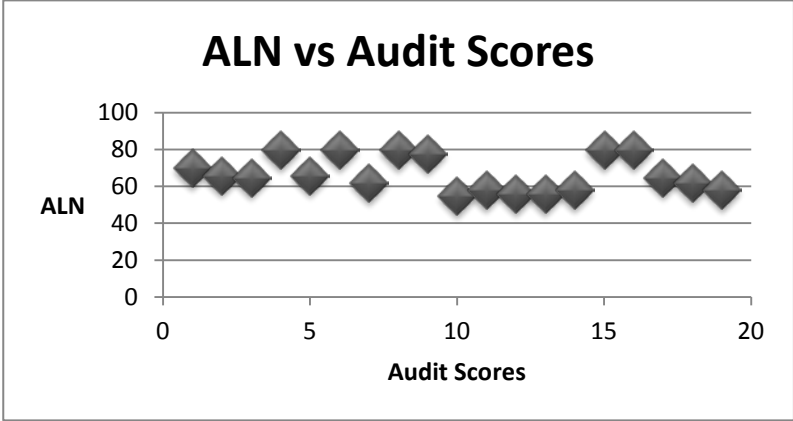
<b>Sample Size</b>	19
<b>Correlation</b>	46.0%, statistically significant and positive correlation



**Figure 45: Male Participants: Hallucinations and Delusions vs. AUDIT Correlation**

There is a statistically significant, positive correlation between the male participant’s Hallucination and Delusions scores and the AUDIT scores, which is indicative of the fact that the more alcohol these individuals consume, the more pathology they experience in terms of Hallucinations and Delusions.

<b>Sample Size</b>	19
<b>Correlation</b>	32.4%, positive, but not significant correlation

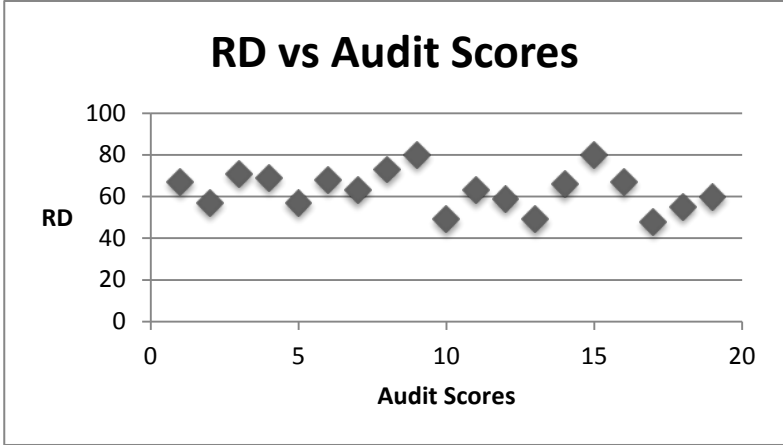


**Figure 46: Male Participants: Alienation vs. AUDIT Correlation**

The correlation between the male participants' scores on the Alienation scale and their AUDIT scores are positive and not statistically significant.



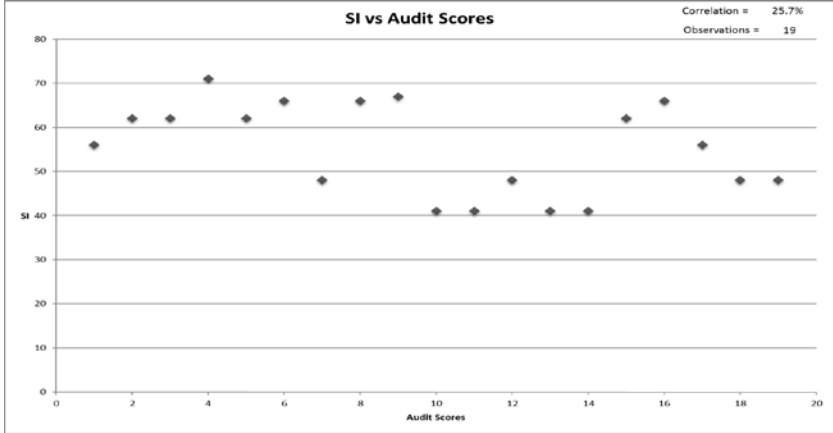
<b>Sample Size</b>	19
<b>Correlation</b>	30.1%, positive, but not statistically significant correlation



**Figure 47: Male Participants: Reality Distortion vs. AUDIT Correlation**

The correlation between Reality Distortion category and alcohol consumption is not significant, but it is positive.

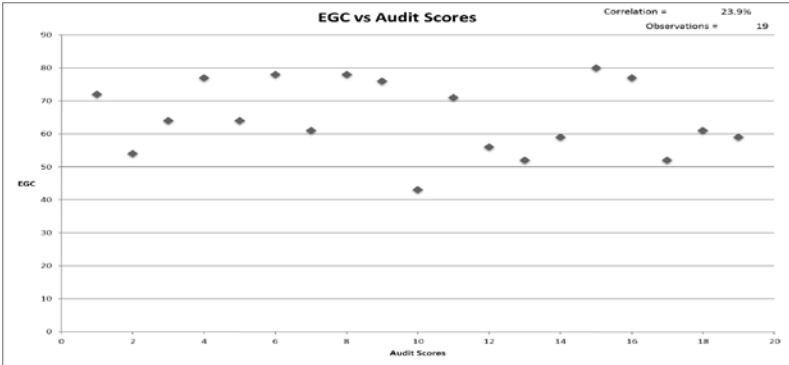
<b>Sample Size</b>	19
<b>Correlation</b>	25.7%, not statistically significant correlation



**Figure 48: Male Participants: Social Incompetence vs. AUDIT Correlation**

The correlation between the male participants' scores on the Social Incompetence scale and their AUDIT scores are positive and not statistically significant.

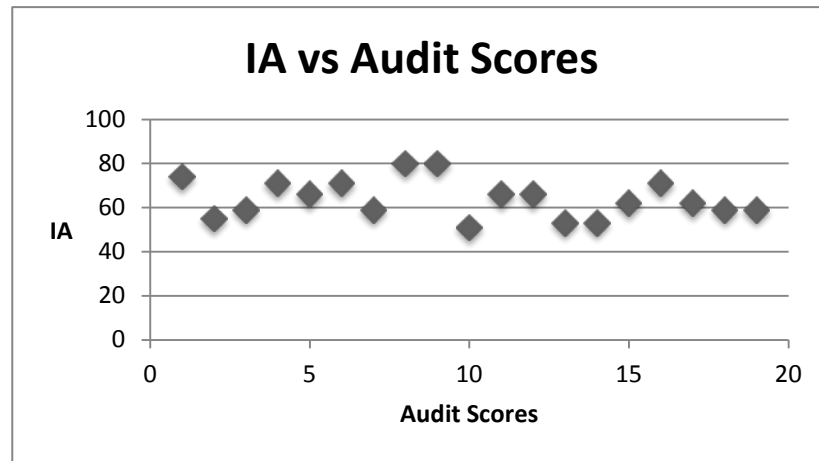
<b>Sample Size</b>	19
<b>Correlation</b>	23.9%, not statistically significant



**Figure 49: Male Participants: Egocentricity vs. AUDIT Correlation**

The correlation between alcohol consumption and increased Egocentricity scores is not statistically significant, however, some correlation is indicated in the male sample.

<b>Sample Size</b>	19
<b>Correlation</b>	5.9% slight correlation



**Figure 50: Male Participants: Insecure Attachment vs. AUDIT Correlation**

The correlation indicated between the Insecure Attachment subcategory and the Audit scores indicate that this correlation is not statistically significant, however there is a slight correlation indicating the more alcohol this group of males consume, the higher their pathology in terms of the lack of secure attachments is.

### 4.3. FINDINGS OF THE STUDY

The findings of this study will be presented here under three sections. The first section will discuss and analyse all of the BORRTI findings, including each category and profile trend analyses for the selected sample of 29 participants. This section meets objective one and two of this study, which focus on exploring and describing the Object Relations of this sample of individuals according to the BORRTI. These findings will then be linked to the literature regarding Object Relations theory related to addiction.

The second section will discuss the findings of this study in relation to the Pearson's Correlation Coefficient, which is linked to the third objective of this study. Three different samples will be analysed in this regard, namely, the selected sample of 29 participants, followed by a female-only sample and then a male-only sample. These findings will be linked back to the literature regarding gender differences and alcohol misuse.

The last aspect in this section will address all trends identified within this sample, which are presented and analysed. This information is linked back to the literature on co-morbid disorders. Following this the literature presented will be linked back to treatment plans and methodologies.

#### **4.3.1. BORRTI FINDINGS: 29 PARTICIPANTS**

In this section, the BORRTI findings will be analysed. The information to be discussed was attained from the reports provided from the BORRTI (Bell, 2005). Following this, the correlation coefficient of the sample of 29 participants will be discussed, including the gender differences that were identified in this sample of individuals. Lastly, three different trends that were identified in the data are discussed, these being white Afrikaans-speaking female participants, white Afrikaans-speaking male participants, and individuals with pathological audit scores but normal BORRTI results.

As can be noted in Table 1, only six of the 29 participants did not score any pathological scores, which suggests that their ego functioning in these categories is reasonably normal. The six participants comprise number 8, 21, 24, 29, 36 and 39. This suggests that the rest of the sample, being 23 participants, all have pathological ego functions. It could then be theorised that the 23 possibly had a premorbid psychological disorder, which assisted in the development of Alcohol Use Disorder. The six with stable ego functions could possibly have premorbid alcohol use disorder, though based on this study's findings, more support is provided for a premorbid psychological disorder.

Under this section the pathological scores of the participants on the different BORRTI scales are discussed. Each scale is discussed in terms of the participants who scored pathological scores as well as what the pathological scores are indicative of. Hereafter the possible comorbid scores will be discussed as well as the gender differences and differences in treatment plans as indicated by the individuals BORRTI results are presented.

The way in which the BORRTI is structured in the first half of the instrument analyses the individual's ego functions, which have been categorised into four subscales, namely, Alienation, Insecure Attachment, Egocentricity and Social Incompetence. The second half of the instrument measures the individual's level of Reality Testing, which is categorised into three categories, namely, Reality Distortion, Uncertainty of Perception and Hallucinations and Delusions.

The scores of the 29 participants indicate a pattern in terms of pathology in each area, as more participants scored pathological scores in all of the Ego-functioning categories, with less of them scoring pathological scores in the Reality Testing categories. The highest amount of participants (19) scored pathological scores on the Alienation scale, 18 on the Egocentricity scale, 17 on the Insecure Attachment scale, 15 on the Reality Distortion scale, 14 on the Social Incompetence scale, 10 on the Uncertainty of Perception scale and 7 on the Hallucination and Delusion subscale.

#### ALIENATION SCALE

According to the BORRTI assessment results (Bell, 2005), the Alienation scale describes an individual's ability to experience trust in intimate relationships. Of the 29 participants included in the analysis, only 10 of their scores suggest that they have the ability to experience trust in intimate relationships, these being Participant 8, 21, 24, 26, 28, 29, 30, 36 and 39. The other 19 participants, namely Participant 2, 3, 5, 10, 11, 12, 14, 16, 17, 18, 22, 25, 32, 33, 35, 37, 38, 40 and 41's scores suggest that they may struggle to have sustainable and stable relationships. These 19 participants'

scores also indicate that they struggle to regulate closeness and distance in relationships. They may be scarred by previous important relationships and therefore might be wary of others. It is also suggested by the results that these individuals are likely to struggle to demonstrate empathy and are likely to go through periods of social withdrawal. These individuals may feel disconnected and socially isolated (Bell, 2005).

#### INSECURE ATTACHMENT SCALE

Twelve of the participants have normal scores in with regards to attachments; however, the other 17 scored pathological scores. The 12 with normal scores are: 3, 5, 8, 16, 21, 24, 29, 30, 36, 37, 39 and 45. Pathological scores occurred in participant 2, 10, 11, 12, 14, 17, 18, 22, 25, 26, 28, 32, 33, 35, 38, 40 and 41. According to Bell (1995), individuals with pathological scores are very sensitive to rejection and as such are very easily hurt by others. Often neurotic concerns of being liked by others are present. Relationships are important to these individuals, but worry, guilt and anxiety as well as jealousy often lead to maladaptive patterns of self-defeating behaviour and dependency. These individuals may tend to blame themselves for things that go wrong. Separation and loss are generally poorly handled by these individuals and they may need lots of reassurance. These individuals are likely to be hyper-vigilant to potential abandonment. Extreme scores may indicate a desperate longing for closeness, as is the case for participants 2, 10, 14, 18, 22 and 33 (Bell, 2005).

#### EGOCENTRICITY SCALE

This scale measures the individual's tendency to perceive others only in relation to themselves. Of the 29 participants, 11 scored normal scores, these being Participants 3, 8, 21, 24, 28, 29, 30, 35, 36, 37 and 39. Eighteen scored pathological scores, namely, 2, 5, 10, 11, 12, 14, 16, 17, 18, 22, 25, 26, 32, 33, 38, 40, 41 and 45. Pathological scores indicate that these individuals may be mistrustful and controlling and struggle with the give and take of a relationship. These individuals view others in terms of whether they are frustrating or gratifying their emotional needs. They may have no real

awareness or concern for the feelings of others. These individuals may have little emotional energy to invest in caring about others and are likely to be preoccupied by their own self-centred aims. They may view people as being out to humiliate or defeat one another. Pathological scores are often an indication of a lack of empathy. These individuals are likely to take on a self-protective stance in a relationship and may either see themselves as powerful or omnipotent (Bell, 2005).

#### REALITY DISTORTION SCALE

Fifteen of the 29 participants scored pathological scores on this scale, these being Participants 2, 5, 10, 12, 14, 16, 17, 18, 22, 25, 30, 32, 33, 38 and 40. This is indicative that these individuals struggle with severe distortions of external and internal reality. These individuals may have delusions of being controlled externally, thought withdrawal or thought broadcasting. They are suggested to have paranoid beliefs and they may have grandiose or depressive beliefs. They are likely to distort the meaning of internal experience, leading to somatic concerns and confusion between dream and waking states. These individuals have difficulty in understanding their feelings and the feelings of others. It is stated that such people have paranoid projections of impulses, fears and wishes, which leave them feeling vulnerable and helpless. An elevation on this scale may suggest the presence of a thought disorder, however, an elevation on the RD score alone, without an elevation on the Hallucinations and Delusions subscale has not been linked by research to psychotic disorders. It is more common in schizotypal and paranoid personality disorders and the substance abuse population. Elevated scores on this subscale are commonly observed for cocaine disorders.

#### SOCIAL INCOMPETENCE SCALE

Fifteen of the 29 individuals scored normal scores, these being Participant 2, 8, 16, 21, 24, 26, 28, 29, 30, 35, 36, 37 and 39. They are likely to view themselves as socially competent. Pathological scores were attained by participants 3, 5, 10, 11, 12, 14, 17, 18, 22, 25, 32, 33, 38 and 40. Pathological



scores are an indication of their inability to engage in social activity. They are likely to be unusually shy, socially awkward and view themselves as being shy people who find it difficult to make friends. Some individuals with elevated scores may try to escape uncomfortable feelings by avoiding unnecessary social interactions. In adolescents and young adults, these difficulties may reflect social immaturity. In adults, however, these difficulties may indicate pervasive feelings of inadequacy and could include problems in sexual relations and gender identity confusion (Bell, 2005).

#### UNCERTAINTY OF PERCEPTION SCALE

Ten of the 29 participants scored pathological scores in this category, namely, Participant 10, 14, 18, 22, 25, 28, 32, 33, 38 and 45. These individuals struggle with a sense of doubt of their own perceptions about reality, both internal and external. They struggle to understand feelings, which results in them having poor social judgement. These individuals are likely to be extremely indecisive. Their key defense is denial, especially when faced with anxiety. At times these individuals may identify their misperceptions, but will remain shaken and may feel they are on the edge of becoming psychotic. They may make use of dissociative reactions. This scale reflects social desirability, so low scores on this scale in relation to psychiatric patients is suggested to reflect denial and lack of insight. The confusion and uncertainty represented by an elevation on this scale may also suggest future problems in the treatment alliance, including difficulty with medication compliance, missed appointments and attitudes of helplessness (Bell, 2005).

#### HALLUCINATION AND DELUSIONS SCALE

Seven participants scored pathological scores, namely, Participant 5, 14, 18, 22, 30, 32 and 40. Pathological scores on this subscale indicates the presence of hallucinatory experiences and paranoid delusions. This scale measures an area of ego functioning that is involved with severe breaks of reality and is most commonly found in schizophrenic and schizoaffective samples, with borderline patients also receiving elevated scores. Individuals suffering from PTSD may also score high results

due to their flashbacks and re-experiencing phenomena. Psychotropic medication should be considered for relief of target symptoms. Psychosocial interventions, including structured activities may be useful in bolstering the fragile ego functioning. Social skills training should also be considered (Bell, 2005).

### **CASE REPORT TREND ANALYSES: 29 PARTICIPANTS**

In this section, the object relations of the sample of 29 participants are discussed in terms of four categories, namely, the Object Relations Profile, Reality Testing Profile, Diagnostic Profile and Treatment Profile. Each of these categories will be analysed in terms of similar trends found within the sample and then isolated trends. This information was attained from the detailed reports provided by the BORRTI scoring guidelines designed by Bell (2005).

### **SIMILAR OBJECT RELATIONS PROFILE TRENDS: 29 PARTICIPANTS**

Based on the BORRTI report, there are no specific additional interpretations of the particular combination of Object Relations that were indicated by Participants 21, 29, 35, 39, 40 or 45 (Bell, 2005). Participants 28, 38 and 41 are likely to be mistrustful and suspicious of other people according to their results.

Participants 2, 3, 5, 10, 11, 17, 18, 25, 26, 14, 32, 33 and 38's patterns of object relations indicate that although these individuals struggle with intimacy, they continue to seek out relationships that inevitably prove unstable and painful. It is also indicated that these individuals struggle with disturbing feelings of inner emptiness and fear of abandonment and loss, which may lead to desperate attempts to establish relationships with anyone who they believe can soothe these fears and gratify their search for emotional security (Bell, 2005).

Participants 2, 3, 5, 10, 11, 17, 26, 32, 33, 37 and 38 may experience intense emotional anguish when disappointed by others and they may retreat into social withdrawal or self-defeating behaviour (Bell,

2005). Participants 2, 5, 11, 24, 26 and 30 consider themselves to be socially competent and they are generally able to manage superficial acquaintances, but may be abrasive and insensitive to social nuances (Bell, 2005).

Participants 3, 10, 17, 18, 25, 33, 32 and 38 may feel awkward around members of the opposite sex and socially inadequate in general (Bell, 2005). Participants 3, 17, 18, 25, 33, 32 and 38 struggle with shyness and find it difficult to make friends, which results in these individuals needing to hold onto whatever relationships they have developed (Bell, 2005). Participants 2, 3, 5, 8, 10, 11, 14, 16, 17, 25, 26, 30, 32, 33 and 38 scored elevated scores on the ALN and EGC scale, which indicate that they struggle with the give-and-take of relationships. They are also generally mistrustful and guarded and tend to turn on those close to them (Bell, 2005).

Participants 2, 3, 5, 10, 14, 17, 26, 32 and 33 may be coldly exploitative and believe that people are generally out to control others for self-centred aims. These individuals may have no real awareness or concern for others (Bell, 2005). Participants 2, 3, 5, 11, 17, 25, 33, 32, 28, 38 and 41 may have little genuine regard for the feelings of other people, but they may feel very vulnerable to humiliation and rejection. Their high degree of interpersonal sensitivity combined with a low degree of empathy could result in them becoming easily injured without considering what they have done to the other person. These individuals believe that they have been wronged and therefore they are entitled to be demanding, controlling or hostile (Bell, 2005).

Participants 2, 3, 8, 10, 11, 17, 26, 33 and 41 have entitled views and as such justify their hostile, manipulative and demanding behaviour (Bell, 2005). Participants 2, 3, 5, 10, 17, 28, 32, 33, 38 and 41 may experience intense emotional anguish when disappointed by another person (Bell, 2005). In participants 2, 3, 5, 10, 11, 17, 18, 25, 26, 28, 32, 33, 38 and 41, these dynamics could lead to sadomasochistic or hostile-dependent relationships (Bell, 2005).

Participants 2, 11, 26 and 33 have high levels of mistrust, which when accompanied by their high levels of emotional hunger result in intense engagement and then withdrawal when in relationships (Bell, 2005). Participants 2, 5 and 32 are easily disappointed and as such engage in manipulating and controlling behaviour (Bell, 2005). Participants 3, 5, 10, 11, 17, 26, 28, 32, 33, 37, 38 and 41 are likely to be particularly vigilant to loss and abandonment, therefore these individuals engage in manipulative, controlling and hostile behaviour (Bell, 2005).

Participants 5, 8, 11, 18, 26, 28, 33's results indicate that they are generally likely to have self-centred aims (Bell, 2005). Participants 8, 24 and 30's profile results indicate that these individuals are street smart (Bell, 2005). Participants 8 and 24 have the ability to be intensive and abrasive (Bell, 2005). Participant 8 and 30 have concern for others based on what they can get from them (Bell, 2005).

#### ISOLATED OBJECT RELATION TRENDS: 29 PARTICIPANTS

Participant 33 is likely to turn away from others rather than against them, and therefore a high level of social withdrawal is likely (Bell, 2005). Participant 24's profile indicates profound alienation. This kind of alienation and self-experience in terms of social competence is possibly an indication of a profile of a homeless individual (Bell, 2005). Participant 8 suffers with profound feelings of alienation and this individual is likely to regard him/herself as socially competent and capable of interacting superficially with others (Bell, 2005).

#### SIMILAR REALITY TESTING TRENDS: 29 PARTICIPANTS

Twelve participants (3, 11, 12, 16, 21, 24, 29, 35, 39, 37, 40 and 41) have profiles that indicate that at the time of testing, they did not experience reality-testing problems so severe as to indicate deficits in this area of ego-functioning. However, under the pressure of serious internal or external stressors, ego functioning may deteriorate (Bell, 2005).

Participants 4, 5 and 45 appear to have a lesser form of reality distortion, such as magical thinking, confusion of dream and wake states, depressive or grandiose beliefs and ideas of reference (Bell, 2005). Participants 2, 10, 25, 26 and 30 recognise inadequacy of perceptions and feel on edge of becoming psychotic (Bell, 2005). Participants 18, 22 and 32 have some awareness of the inaccuracy of their score and as a result they may be able to draw upon some observing ego that has not been wholly absorbed by a delusional system. It is likely that these individuals experience anxiety about their medical condition and they may feel very confused and frightened by it (Bell, 2005).

Participants 5, 14 and 45 may lack insight into their mental condition, with the result that these delusions or hallucinations are believed without question. These individuals may not have a sufficient observing ego to reflect on these lapses in Reality Testing and possibly experience positive symptoms of psychosis as consistent with an idiosyncratic or autistic understanding of themselves and others (Bell, 2005).

Participants 38 and 39 have profiles which indicate no specific additional interpretations for this particular combination of Reality Testing scores (Bell, 2005). Participants 5 and 45 struggle with active delusions or hallucination, and, their all-encompassing delusional system explains their unusual experiences, thus reducing internal distress. In that sense, their break with reality constitutes a preventative defense against further ego disintegration (Bell, 2005). Participants 28 and 33 recognise the inaccuracy of their perception and may feel that they are on the edge of becoming psychotic (Bell, 2005).

#### ISOLATED REALITY TESTING TREND: 29 PARTICIPANTS

Participant 8's score indicates no severity sufficient to indicate ego deficits, however under pressure of serious internal or external stressors, ego functioning may deteriorate (Bell, 2005).

Participant 14 may not have sufficient observing ego to reflect on these lapses in Reality Testing, and possibly experiences them as consistent with an idiosyncratic or autistic understanding of themselves and others. This kind of person may have an all-encompassing delusional system that explains their experiences, thus reducing internal distress. This individual's break with reality constitutes a preventative defense against further ego disintegration (Bell, 2005).

#### SIMILAR DIAGNOSTIC TRENDS: 29 PARTICIPANTS

Participants 28, 37 and 41 have profiles that are consistent with attitudes and personality traits most commonly associated with narcissistic, histrionic, dependent or passive-aggressive personality disorders, but may be so severe as to cause social dysfunction (Bell, 2005). Participants 2, 3, 5, 8, 10, 11, 12, 14, 16, 17, 18, 22, 24, 25, 26, 30, 33, 32, 35 and 38 indicate object relations deficits and severe character pathology (Bell, 2005).

Participants 32, 33 and 38 reflect an unstable character structure with a high degree of painfulness in relationships, leading to periods of social withdrawal. This suggests alienation with angry protest and retaliation for perceived hurts (Bell, 2005). Participants 2, 3, 5, 10, 11, 12, 16, 17, 18, 22, 24, 25, 26 and 30's profiles reflect an unstable character structure, painful self-experience, unmet longings and retaliatory attitude towards other people (Bell, 2005).

Participants 28, 32, 33 and 38's profiles suggest that after ruling out a psychotic disorder, this profile is most common in individuals with borderline and schizoid personality disorders and may include narcissistic, dependent and avoidant features (Bell, 2005). Participants 2, 8, 11, 14, 16, 26 and 30 display angry retaliations against the other for perceived emotional deprivation (Bell, 2005).

Eight participants (2, 5, 8, 11, 14, 16, 26 and 30) present with antisocial features as well as demandingness, dependency and grandiose defenses against feelings of helplessness (Bell, 2005). Fifteen participants' profiles (2, 3, 5, 8, 10, 11, 12, 14, 16, 18, 22, 24, 25, 26 and 30) suggest that if a

psychotic disorder is ruled out, a narcissistic, borderline or passive aggressive personality could be present. (Bell, 2005). Participants 2, 10, 12, 16, 17, 25, 26 and 30 report lapses in reality, which could be indicative of psychosis, but is not necessary an indication of a psychotic disorder (Bell, 2005).

Participant 2, 10, 12, 16, 17, 25, 26, 28, 30 and 33 report lapses in Reality Testing that are suggestive of psychosis and they may therefore have a fear of becoming psychotic, though this profile pattern is not necessarily linked to psychotic disorders. It sometimes occurs in people with history of schizophrenia and in a residual phase, commonly found in borderline, schizotypal and paranoid personality disorders and the substance abuse population (Bell, 2005).

Participants 1, 2, 10, 16, 17, 25, 26, 28, 30, 33 and 39 may have a genetic predisposition to psychotic symptoms; phenotypic experience is schizotypal rather than schizophrenic (Bell, 2005). Participants 2, 5, 10, 12, 16, 18, 25, 26, 28, 30, 33 and 39 may experience transient breaks in reality, such as those in borderline personality disorder, or may experience a dissociative state or re-experience flashbacks due to post traumatic stress disorder (Bell, 2005).

These results have particular significance for the current study as they suggest that inpatients diagnosed with Alcohol Use Disorder have underlying traits that point to Personality Disorders.

Participants 2, 10, 12, 16, 17, 25, 26, 28, 30, 33 and 39's abuse or dependence on substances such as cocaine and alcohol is likely to be a source of their reality distortions (Bell, 2005).

Participants 2, 10, 16, 17, 25, 26, 28, 30, 33 and 39's profiles suggest other types of brain function compromise – seizure disorders, sensory deprivation and traumatic insult cause elevations on this scale (Bell, 2005). Participants 3, 10, 12, 16, 17, 18, 22 and 25's profiles suggest alienation and angry retaliation for perceived hurts (Bell, 2005).

Participants 3, 10, 12, 17, 18, 22, 25, 33, 5, 32, 28 and 38 have profiles which almost never occur in high-functioning individuals who are considered to be normal (Bell, 2005). Participants 21 and 29's

profiles do not suggest presence of a specific pattern of disturbance or Reality Testing. These results do not suggest the presence of any specific serious pattern of disturbance in Object Relations or Reality Testing (Bell, 2005).

Participants 22 and 32 have profiles that are most common in people with schizophrenia and other psychotic disorders, but less common in borderline or PTSD patients (Bell, 2005). Participants 14 and 32 have profiles that are seldom found among other diagnostic groups and virtually never occur among those individuals without a diagnosis (Bell, 2005).

#### Isolated Diagnostic Trends: 29 Participants

Participant 29's results do not suggest the presence of any specific serious pattern of disturbance in Object Relations or Reality Testing (Bell, 2005). Participant 25's scores indicate that other types of brain disorders may cause elevations on this scale (Bell, 2005). Participant 14's profile is commonly found in patients with schizophrenia or other psychotic disorder. It is less common in borderline patients or patients with re-experiencing phenomena related to post traumatic stress disorder (Bell, 2005).

Participant 38's pattern of Reality Testing scores is not suggestive of any specific psychological condition, although it is associated with anxiety disorders and a lower sense of well-being. It is often an indication that the patient wishes to convey to the examiner a sense of desperation or a cry for help (Bell, 2005). Participant 39's scores indicate a single elevation on the insecure attachment score and is the most common pathological profile found among high functioning adults and students. It may indicate attitudes and personality traits most commonly associated with dependent, compulsive or passive-aggressive personality disorder and may not be so severe as to cause social dysfunction. Although this respondent may be reporting lapses in Reality Testing suggestive of psychosis, a single elevation on RD without a corresponding elevated score on HD has not been closely linked by



research to psychotic disorders. It is more commonly found in borderline, schizotypal and paranoid personality disorder and in substance abuse populations (Bell, 2005).

Participant 40's score of a single elevation on SI does not suggest severe object relations deficits and is often observed in shy or socially insecure individuals. High elevation on this scale may be associated with an Avoidant Personality Disorder. Some research has linked this profile to gender identity confusion in young adult males (Bell, 2005).

Participant 45 scored a single elevation on EGC which is consistent with personality traits most commonly associated with narcissistic, antisocial and histrionic personality disorders. This pattern of Reality Testing scores is most commonly found among patients with schizophrenia or other psychotic disorders. Less commonly, borderline patients or patients with re-experiencing phenomena related to PTSD can also have this profile. The profile is seldom found among other diagnostic groups and virtually never occurs among normal (Bell, 2005).

#### SIMILAR TREATMENT RECOMMENDATION TRENDS: 29 PARTICIPANTS

Participants 29, 28, 37, 39 and 41 are likely to have sufficient interest in relationships and enough available emotional pain to provide motivation for insight-oriented psychotherapy. This psychotherapy may be brief or long term, depending on the goals of treatment. Such individuals tend to quickly engage the therapist in complex transference paradigms and can be highly reactive to the therapist's behaviour and actions (Bell, 2005).

Participants 29, 28, 39 and 40 may be able to tolerate interpretations of defense and transference, and might be able to relate experiences within the therapy to other relationship issues in their life (Bell, 2005). Participant 29, 28 and 39's scores support the group norms, which encourage emotional investment and cohesiveness in the group (Bell, 2005).

Participants 28, 37 and 41 could be so reactive to perceived slights and so anxious about growing dependency that they might flee the intensity of the treatment relationships. Therapist's vacations, cancelled sessions or absences may be poorly tolerated and experienced by the client as abandonment. The client may then become demanding and manipulative in response to the frustrations inherent in psychotherapy. Firm boundaries and limit setting might be necessary if the individual attempts to transform therapy into a place for getting their emotional needs gratified rather than a place to understand those needs. The client may become mistrustful and rageful when interpretations of narcissistic defenses are made, and they will be very sensitive to feelings of shame and humiliation. Respect for the patient's defenses, along with slow and careful clarifications of therapeutic reactions, may be necessary to prevent a disruption in treatment. However, they may lack empathy for other group members and have difficulty with the give-and-take of a group (Bell, 2005).

Participants 28, 37, 39, 40 and 41 may benefit from the sense of belonging and intimacy found in traditional group therapy (Bell, 2005). Participants 2, 37 and 41 may respond well to transactional interpretations that can assist in understanding the way in which they disregard the emotional needs of others, sabotage relationships with mistrust or turn others against them (Bell, 2005).

Participants 8, 14 and 35 may stop treatment early, but if they continue, it is likely that breaches in rapport and tests of trust will occur (Bell, 2005). Fourteen participants (2, 3, 5, 10, 11, 12, 17, 18, 22, 25, 26, 32, 33 and 38) have profiles which suggest that the therapeutic alliance will be threatened by a lack of trust, and excessive expectations, neediness, rejection and sensitivity of the individual towards the therapist. The therapist may be idealised and then devalued as the vicissitudes of the therapeutic relationship unfold – individuals with this profile may perceive the therapist principally as a need-gratifying object (Bell, 2005).

Eighteen participants (2, 3, 5, 8, 10, 11, 12, 14, 16, 17, 18, 22, 25, 26, 30, 32, 33 and 38) do not easily tolerate frustration inherent in traditional psychotherapy and these individuals often have the need to

repeatedly disappoint those who trust them and get significant others to turn against them (Bell, 2005). Twelve participants (2, 3, 5, 10, 11, 12, 17, 18, 22, 32, 33 and 38) are likely to handle directive and supportive counselling with clear boundaries more effectively than individual and group therapy (Bell, 2005).

Seventeen participant (2, 3, 5, 10, 11, 12, 16, 17, 18, 22, 24, 25, 26, 30, 32, 33 and 38) may tend to have difficulty with the give-and-take of traditional group therapy and have problems tolerating demands for self-disclosure and intimacy. These individuals may do better in highly structured groups (activity, psycho-educational skills training or the 12-steps programme of Alcoholics Anonymous) where little intimate transaction is required (Bell, 2005).

Eighteen participants (2, 3, 5, 8, 10, 11, 12, 14, 16, 17, 18, 22, 25, 26, 30, 32, 33 and 38) are likely to benefit from a specialised milieu as in drug rehabilitation centres, halfway houses and other therapeutic communities especially effective to maintain behavioural control and opportunity of relatedness and belonging outside the complexity of a dyadic relationship (Bell, 2005). Importantly, this has implications for discharge procedures for individuals who are hospitalized for drug addiction within the South African context; as such more long-term treatment facilities need to be made available for patients once they have completed their acute hospitalisation.

Participants 32, 33 and 38's profiles indicate that these individuals can increase their sense of social competence by participation in psychosocial activities group programmes, social skills training, or activity-oriented milieu or day treatments (Bell, 2005). Participant 2, 10, 12, 16, 25, 26, 28, 30 and 33's profiles indicate that a further assessment of the reality distortion and uncertainty of perception is needed as they can cause a variety of psychological conditions (Bell, 2005).

Participant 2, 10, 12, 17, 25, 26, 28, 30 and 39's scores do not suggest the need for psychotropic medication (Bell, 2005). The profile results of 10 participants (2, 10, 12, 17, 25, 26, 28, 30, 33 and 39) indicate elevated scores on the RD scale. Bell (1995) states that if these individuals report making

use of mind-altering substances they should be strongly encouraged to stop their drug use and to commit to their substance abuse treatment.

Participants 2, 10, 17, 25, 26, 28, and 33's profiles suggest that a neuropsychological evaluation should be considered due to the possibility of substance abuse or organic pathology in these individuals. Their elevated scores on the Uncertainty of Perception scale suggest that these individuals may believe something is wrong with their mental functioning and therefore may be motivated to seek treatment; however, an elevation on the UP does not necessarily indicate a willingness to proceed with treatment beyond being a cry for help (Bell, 2005).

Thirteen participants (2, 10, 11, 16, 17, 18, 22, 25, 26, 28, 30, 33 and 38) appear to make use of denial and other rigid defenses, which make any form of treatment that utilises self-reflection and uncovering difficult (Bell, 2005). Participants 2, 10, 11, 16, 17, 18, 22, 25, 26, 28, 30, 33 and 39 may benefit particularly from reality-orientated psychotherapy, with an emphasis on excusing distortions as they occur in the therapeutic relationship (Bell, 2005).

Participants 2, 10, 11, 12, 16, 17, 25, 26, 30, 33, 28 and 39 may benefit from group therapy (Bell, 2005). Participants 2, 10, 12, 16, 17, 25, 26, 28, 30, 33 and 39's profile scores indicate that the therapist should avoid being passive or ambiguous as it may confuse or make the patient anxious and disrupt the therapeutic alliance (Bell, 2005).

Participants 2, 10, 17, 25, 28 and 33's profiles indicate confusion and uncertainty represented by evaluated uncertainty of perception, which suggest problems with medication compliance, missed appointments and attitudes of helplessness, which could further complicate treatment (Bell, 2005).

Participant 16, 24 and 30's profiles indicate a strong likelihood that they may drop out early from traditional therapy (Bell, 2005). Participants 8, 14, 16, 24, 29, 30 and 35 may benefit more from behavioural correcting as opposed to insight-oriented psychotherapy. The behavioural correcting

should address good boundaries and limit setting, in the form of directive counselling or milieu treatment (Bell, 2005).

Participants 18, 22 and 45 may find self-help group and psycho-educational programmes helpful (Bell, 2005). Participant 8, 14 and 35's profiles indicate that these individuals have difficulty with the give-and-take of traditional group therapy and have problems tolerating the group's demands for self-disclosure and intimacy. They may do better with highly structured groups, such as psycho-education or 12-step groups, where participation does not require intimate transactions with other members (Bell, 2005).

Participants 5, 14, 32 and 45's scores suggest that a further evaluation for the presence of a psychotic disorder is warranted. Psychotropic medications should be considered for relief of target symptoms suggested by the items (Bell, 2005). Participant 14, 32 and 45's scores indicate that a reality-oriented treatment with emphasis on practical problem solving may be helpful (Bell, 2005).

Participants 5, 32 and 45 may benefit from self-help groups and psycho-educational programmes; this is due to the fact that their results indicate that they may continue to experience psychotic phenomena over a long period of time. Skills training groups that emphasise reality checking could also be helpful (Bell, 2005).

Participants 40 and 45 may benefit from social skills groups that focus on learning specific social skills, behavioural rehearsal, and role playing and problem-solving. Social interactions may also be helpful, particularly in overcoming shyness, learning to initiate and sustain conversation, and learning to read complex social situations better (Bell, 2005). Participant 39 and 40 may become 'good' group members who supports the group norms, invests emotionally in the group and encourages cohesiveness (Bell, 2005).

Participant 18 and 22 may benefit from group skills training, in which they identify the reality of the situation (Bell, 2005). Participant 14 and 35 may be guarded in individual therapy and might have

difficulty in forming a therapeutic alliance. There is a strong likelihood that these individuals may drop out early from traditional therapy (Bell, 2005). Participant 5, 14, 18, 30, 32 and 45's results indicate that psychosocial interventions, including group activities may be useful in bolstering fragile ego and reducing isolation (Bell, 2005).

Participant 16 and 30's profiles suggests that if they do not drop out of treatment early, breaches in rapport are likely and these individuals are likely to engage in tests of trust. Their likely narcissistic defenses will probably result in them being mistrustful of the therapeutic alliance (Bell, 2005).

Participant 21 and 36's results do not indicate particular patterns of serious Object Relations deficits or Reality Testing deficits that would present obstacles to treatment (Bell, 2005).

#### ISOLATED TREATMENT RECOMMENDATION TRENDS: 29 PARTICIPANTS

Participant 40's results indicate that this individual may be reluctant to engage emotionally with the therapist and might have difficulty experiencing the therapist's interest as genuine. They may act remote and distant, but should eventually become invested in the relationship. They can benefit from interpretations of transactions in a group setting and they may encourage cohesiveness. They can benefit from interpretations of transactions in the group that reveal underlying feelings of jealousy, competition, sexuality, loss and so forth as well as the accompanying group defenses of fight-flight, dependency and paring (Bell, 2005).

Participant 8's profile suggests that this individual's initial engagement with the therapist may be superficial, which may cause this individual to drop out of traditional psychotherapy early (Bell, 2005). Participant 39's profile suggests that a further assessment of reality distortion phenomena may be needed as it can be caused by a wide variety of psychological conditions (Bell, 2005). Participant 33's profile suggests the need for psychotropic medications (Bell, 2005).

Participant 38's profile indicates an elevated UP scale score, which suggests that the individual believes that there is something wrong with their mental functioning, which may result in them appearing motivated to seek treatment. However, an elevation on UP does not necessarily indicate a willingness to proceed with treatment beyond being a cry for help. Difficulty with treatment compliance and attitudes of helplessness may further complicate treatment (Bell, 2005).

Participant 18's results suggest that an evaluation for the presence of a psychotic disorder is warranted (Bell, 2005). Participant 21's results do not indicate a particular pattern of serious object relations deficit or reality testing deficits that would present obstacles in treatment (Bell, 2005).

Participant 29 is likely to be sufficiently interested in relations and possesses enough available emotional pain to provide motion for insight-oriented therapy. Such individuals are likely to engage the therapist in complex paradigms and be highly reactive to therapist behaviour. Defense and transference in therapy may be tolerated and these individuals may benefit from the sense of belonging and intimacy found in traditional group therapy. They may be good group members in terms of being emotionally encouraging through their own investment in the group (Bell, 2005).

Participant 14's profile indicates that interpretations of narcissistic defenses will probably be met with hostility and mistrust (Bell, 2005). Participant 8 may benefit from accurate social feedback, as can sometimes be provided in social skills training or therapeutic communities and may be helpful in correcting this individual's abrasive or off-putting social behaviour (Bell, 2005).

Participant 38's profile indicates that a further evaluation is needed in order to determine whether the respondent's doubts about their ability to perceive internal and external reality may include disorientation and other indicators of organic pathology. If this individual has a history of brain function problems, neuropsychological testing is recommended (Bell, 2005).

SPECIFIC CLINICAL THEMES

In this section, the specific clinical themes that were identified for each of the 29 participants are indicated.

**Table 3: Specific Clinical Themes: 29 Participants**

PARTICIPANT	2	3	5	8	10	11	12	14	16	17	18	21	22	24
<b>Hostility and Self-Centeredness</b>														
I usually end up hurting those close to me	T	T		T	T	T	T	T	T	T	T		T	T
I can deal with disagreements at home without disturbing family relationships			T	T	F		F			F	F		T	T
People do not exist when I do not see them	T		T			T		T	T		T			
When I am angry with someone I am able to talk it through	F				T		F		T				T	T
I believe a good mother should always please her children		T	T		T		T	T	T			T	T	
<b>Mistrust and Humiliation</b>														
I have no influence on anyone around me			T		T	T		T			T		T	
My people treat me more like a child than like an adult	T	T	T		T		T			T	T			T
Others frequently try to humiliate me	T		T		T					T	T		T	
I am usually sorry that I trusted someone	T	T	T		T	T	T		T	T	T		T	



People are never honest with each other	T			T	T	T			T	T	T		T	
<b>Shyness, Sexual Problems and Social Awkwardness</b>														
My sex life is satisfactory		F	F			F			F	F	F		F	F
Relationships with people turn out the same way with me	T	T	T		T	T	T	T		T	T		T	
I often feel nervous when I am around people of the opposite sex		T			T	T				T	T		T	
Making friends is not a problem for me		F		T	T		T			F	T			
I do not know how to meet or talk with members of the opposite sex	T		T		T			T		T			T	
I feel shy about meeting or talking to people of the opposite sex		T	T		T	T	T	T		T	T		T	
<b>Appeasement and Dependency</b>														
If someone dislikes me, I always try harder to be nice to that person		T	T		T			T	T	T	T		T	
I tend to be what others expect me to be	T	T	T	T	T	T	T	T	T	T	T			T
No matter how bad a relationship may get, I will hold onto it	T	T	T	T		T	T	T		T	T	T	T	
I yearn to be completely "at one" with someone	T	T	T		T	T	T		T	T	T	T	T	T
I generally rely on others to make decisions for me		T			T			T		T	T		T	

I feel I need to please everyone or else they may reject me	T	T	T		T	T	T	T		T	T		T	
<b>Alienation, Social Withdrawal, and Isolation</b>														
I have at least one stable and satisfying relationship	F				T		F	T		F			T	F
I would like to be a hermit forever			T	T	T	T		T			T		T	
I may withdraw and not speak to anyone for weeks at a time	T		T	T		T			T		T		T	T
I am a very good judge of other people		F					F				F		F	
I shut myself up and don't see anyone for months at a time	T			T				T			T		T	
<b>Manipulation and Demandingness</b>														
Exercising power over other people is a secret pleasure of mine	T												T	
At times I do almost anything to get my way			T		T		T				T		T	
In relationships, I am not satisfied unless I am with the other person all the time	T		T		T	T	T	T			T		T	
Manipulating others is the best way to get what I want					T			T		T	T			

When I cannot make someone close to me do what I want, I feel hurt or angry.	T	T	T		T						T	T		T	
The most important thing to me in a relationship is to exercise power over the other person					T	T	T	T						T	
<b>Interpersonal Sensitivity, Self-Blame and Worry</b>															
I am extremely sensitive to criticism	T	T	T	T	T	T	T	T	T	T	T	T		T	
When a person close to me is not giving me his or her full attention, I often feel hurt and rejected	T	T	T		T		T		T	T	T	T	T	T	
If I become close with someone and they prove untrustworthy, I may hate myself for the way things turn out	T	T		T	T	T	T	T	T	T	T	T	T	T	
I have been hurt a lot in life	T	T	T	T	T	T	T		T	T	T	T	T	T	T
No matter how hard I try to avoid them, the same difficulties crop up in my most important relationships	T	T		T	T	T	T			T	T			T	
I often worry that I will be left out of things	T	T	T		T		T	T		T	T			T	
I am sensitive to possible rejection by important people in my life	T	T	T	T	T	T	T	T	T	T	T			T	

**Lack of Mutuality and Intimacy**

If someone I have known well goes away, I may miss that person				T					T							F
It is hard for me to get close to anyone	T		T		T	T	T		T	T	T		T			
I have someone with whom I can share my innermost feelings and who shares their feelings with me	F				F	F			F			F		F	F	
It is my fate to lead a lonely life			T		T			T		T	T			T		
I put a lot into relationships and I get a lot back		F			F	F	F	F	F	F	F			F		

PARTICIPANT	25	26	28	29	30	32	33	35	36	37	38	39	40	41	45
<b>Hostility and Self-Centeredness</b>															
I usually end up hurting those close to me	T	T			T	T	T	T	T		T	T	T		T
I can deal with disagreements at home without disturbing family relationships	T		T	T		T						T	T	T	
People do not exist when I do not see them	T	T			T	T	T								T
When I am angry with someone I am able to talk it through	T		T		T	T					T			T	
I believe a good mother should always please her children	T		T			T				T	T		T		

**Mistrust and Humiliation**

I have no influence on anyone around me	T						T	T			T		T	T		
My people treat me more like a child than like an adult		T	T	T	T	T	T				T					
Others frequently try to humiliate me		T					T	T								
I am usually sorry that I trusted someone	T	T					T	T				T	T		T	
People are never honest with each other	T	T	T			T	T	T			T	T				T

**Shyness, Sexual Problems and Social Awkwardness**

My sex life is satisfactory	F				F	F	F	F	F	F	F		F			
Relationships with people turn out the same way with me	T	T			T	T	T	T			T	T			T	T
I often feel nervous when I am around people of the opposite sex	T						T					T		T		
Making friends is not a problem for me	T		T				T	T				T				
I do not know how to meet or talk with members of the opposite sex							T	T	T			T				
I feel shy about meeting or talking to people of the opposite sex	T						T	T				T		T		T

**Appeasement and Dependency**

If someone dislikes me, I always try harder to be nice to that person	T			T				T		T	T	T	T	T	
I tend to be what others expect me to be	T	T				T	T					T	T		T
No matter how bad a relationship may get, I will hold onto it	T		T				T				T	T		T	T
I yearn to be completely "at one" with someone		T			T	T	T	T	T	T	T		T		
I generally rely on others to make decisions for me	T		T				T				T				T
I feel I need to please everyone or else they may reject me	T	T					T	T		T	T	T	T	T	T

**Alienation, Social Withdrawal, and Isolation**

I have at least one stable and satisfying relationship	F	F				T	T				F				
I would like to be a hermit forever											T	T			
I may withdraw and not speak to anyone for weeks at a time	T	T	T			T	T				T				
I am a very good judge of other people								F							
I shut myself up and don't see anyone for months at a time	T					T	T				T				T

**Manipulation and Demandingness**



No matter how hard I try to avoid them, the same difficulties crop up in my most important relationships	T	T		T	T	T	T			T	T	T		T	T
I often worry that I will be left out of things	T		T			T	T	T		T	T	T		T	
I am sensitive to possible rejection by important people in my life	T	T	T	T	T		T	T		T	T	T	T	T	
<b>Lack of Mutuality and Intimacy</b>															
If someone I have known well goes away, I may miss that person					T	T									
It is hard for me to get close to anyone	T					T	T	T		T	T				
I have someone with whom I can share my innermost feelings and who shares their feelings with me						F	F	F		F	F	F		F	
It is my fate to lead a lonely life	T					T	T	T							
I put a lot into relationships and I get a lot back	F				F	F	F	F		F		F		F	

The information displayed in Table 3 indicates that the majority of the sample suffers from complex clinical themes, which should be considered when establishing treatment plans. The features represented here highlight specific areas of vulnerability within the participant's pattern of Object Relations. These clinical themes, as well as diagnoses based on the BORRTI results can be used to



establish primary disorders and secondary co-morbid disorders that are present within each individual's personality profile.

From an object relational perspective, all humans are affected differently by their psychological strengths, vulnerabilities, past experiences, and social and cultural influences; each person's body reacts differently to the experiences that it takes in. This is clearly supported by the findings of this study which indicate the different pathological internal structures in the BORRTI results.

Nineteen of the 29 participants scored high scores in the Alienation subcategory of the BORRTI. This according to Bell (2005) indicates a difficulty with forming deep, meaningful and trusting relationships; they also struggle to experience empathy and tend to guard and isolate themselves. High scores are also an indication of co-morbid borderline, narcissistic, histrionic and/ or schizoid personality disorders. Research conducted by Santina (1999, cited in Li & Bell, 2008), supports these findings. Santina suggests that individuals who abuse substances display difficulties in being able to recognise and differentiate emotions; they are also stated to struggle with forming secure relationships and suffer from chronic feelings of alienation and egocentricity.

In the Egocentricity subcategory, 19 of the 29 participants scored high scores. This according to Bell (2005) suggests that these individuals mistrust other people and are generally self-centred and not overtly concerned with other people's feelings. In essence, these participants only perceive others in relation to themselves and they tend to be demanding, controlling and manipulative (Bell, 2005). Elevated scores in this category are often found in antisocial, narcissistic and histrionic personality disorders, psychotic disorders with paranoid projections, and hostility or negative syndrome schizophrenia (Bell, 2005). Santina's (cited in Li & Bell, 2008) research concurs with these results, suggesting that substance abuse is linked to an increase in egocentricity as is present in the Narcissistic Personality Disorder, as broadly studied by Kohut. Levin (1987, p. 62) theorises about "ego weakness" in alcoholics including displaying impulsivity, the inability to delay gratification, low

affect tolerance, a propensity towards panic-level anxiety and prolonged depression, and an unclear, confused sense of identity. These are indicated to result from a failure of internalisation of good objects and fixation at or regression to the stage of the grandiose self. Impulsivity, inability to delay gratification and low affect tolerance can be linked to numerous categories, namely, Hallucinations and Delusions, Reality Distortion, Social Incompetence and Egocentricity and Alienation. Confused sense of identity can also be linked to Hallucinations and Delusions Reality Distortion and Alienation. Levin (1987) refers to the “grandiose self”, which is referred to as Egocentricity in the BORRTI tool.

Seventeen of the 29 participants had elevated scores in the Insecure Attachment subcategory, which is often found in individuals who are extremely sensitive to rejection and hurt; they also do not tolerate loneliness, separations and/ or loss either, and they have a deep need to be accepted by others. These individuals are prone to jealousy, anxiety and sadomasochistic binds (Bell, 2005). Bell (2005) states that high scores are often an indication of an avoidant, compulsive, dependent or passive-aggressive personality disorder (Bell, 2005). This finding supports the views of Krystal (cited in Bean et al., 1981), who focused more on internal family representations and the dynamics of how these representations influence an individual. This can also be linked to the research of John Bowlby and Mary Ainsworth who found that insecure attachment styles form as a result of inconsistent, dysfunctional and/ or abusive parenting styles (Yalisove, 1997).

Fourteen of the 29 participants scored highly in the Social Incompetence category, which is suggested to be an indication of uncertainty, shyness and nervousness and lack of close relationships, due to avoidance playing a pivotal role in their relationships (Bell, 2005). Elevated scores are often found in individuals with chronic psychotic disorders (Bell, 2005).

Thirteen participants scored high in the Reality Distortion subcategory, which is related to severe distortion in reality – internal and external, delusions of influence, thought withdrawal, thought broadcasting and paranoid, grandiose or depressive beliefs (Bell, 2005). Elevated scores are often

found in schizophrenia, psychotic disorders, personality disorders such as borderline, schizotypal and paranoid personality disorders, and in the substance abuse populations (Bell, 2005). That so many participants obtained high scores in this area could be related to the fact that many participants were of an inpatient psychiatric population, and were therefore in need of such high levels of intervention. This would potentially be different or less in a population that has been in the recovery stages for longer. Self-psychologists, such as Khantzian and Kohut (cited in Bean et al., 1981, p.150) link alcohol use to reality distortions resulting from structural deficits, which are suggested to result from traumatic incidences with the maternal figure. In this way, Khantzian and Kohut (cited in Bean et al., 1981, p.150) suggest that “alcoholics” suffer from pathological self-formulations, which occur due to pathological internalisations, identification and self-structures. Alcohol is thought to be used as an attempt to correct such deficits.

Eight of the sample of 29 scored on the extreme side of the Uncertainty of Perception subscale; the remainder of the sample also scored reasonably high scores. These results suggest that the majority of the sample possesses distorted perceptions of reality, struggle to understand feeling, are indecisive, and use denial and dissociative defense mechanisms, which are often an indication of a Borderline Personality Disorder and substance abuse (Bell, 2005). These findings support the views of Rado, Raskin and Wurmser (cited in Bean et al., 1981; Levin & Weisser, 1996) cited earlier, who emphasise the role of the adaptive function of alcohol use and the role of ego defenses; more specifically, denial and rationalisation. Kohut (cited in Bean et al., 1981) suggests that individuals who make use of defense mechanisms, such as denial and dissociation actually make use of substances in an attempt to lift defenses in order to feel soothed. Importantly, Krystal and Raskin (1970) also refer to denial and splitting defense mechanisms being present in alcohol-dependent individuals, which according to them are used to suppress unpleasant feelings in relation to the self and other.

Only six of the participants achieved high scores in the Hallucination and Delusion subcategory, which indicates individuals who have suffered severe breaks in reality, commonly found in schizophrenic and schizoaffective disorders as well as in individuals suffering with Borderline Personality Disorder and/ or in individuals with Post-traumatic Stress Disorder (Bell, 2005). Although few of the participants scored high scores in this subcategory – indicating that they do not have psychotic symptoms or that their hallucinations and delusions may have lifted somewhat during hospitalisation, the statistical significance indicates a definite correlation between alcohol use/ misuse and Hallucinations and Delusions.

Eckleberry (2009) refers to individuals with personality disorders as being stuck in long-standing cognitive, affective, interpersonal and impulse-control patterns that lead to repetitive disruptive and self-defeating experiences. Personality disorders and alcohol misuse strongly affect both the individuals who have the disorders and those who work, live and interact with them. Individuals with personality disorders often form relationships that are sustained by mutual pathology or extraordinary accommodation of the disordered behaviour by partners who are willing to sacrifice themselves for their own reasons. Addiction treatment can be compromised by unaddressed relationship or family issues. Developing a more resilient and adaptive personality style or changing addictive behaviours impacts the relationship with partners and family members, often strengthening treatment effectiveness and facilitating recovery (Eckleberry, 2009).

Before Bowlby, Spitz (cited in Flanagan, 2011, p.125) stressed the importance of an infant introjecting a soothing object, which should prevent “psychological harm” and faulty ego-functioning. Theorists, including Bowlby and Winnicott (cited in Flanagan, 2011, p.125), emphasise the importance of this fundamental and primary need for attachment. It is suggested that if such primary attachments are not achieved, harmful results occur in terms of weak ego structures – this is

indicative of the scores of the participants of this study. In this way the fullness and quality of a person's inner world is greatly influenced by the quality of their early ties (Flanagan, 2011).

In relation to Flanagan's (2011) statement regarding Object Relations theory being a process whereby an individual's object relations develop to the point where they can distinguish themselves as separate beings from others, whilst still needing attachment to others, this is an ideal development which occurs in the case of individuals with strong ego functions. The results of this sample of individuals with Alcohol Use Disorder indicate that they have not adequately reached this point.

In line with Flanagan's (2011) view regarding an individual's psychological life being determined by their internalisations, which are internalised through interaction with people, more specifically early attachments, much can be said about the role that each of these participants' internalisations have on their psychological life. All 45 of the participants had been admitted into a psychiatric institution due to the fact that their functioning had become significantly impaired. All of the volunteering participants who were identified by the psychological team at the institution had met the diagnosis for Alcohol Use Disorder as well as a co-morbid mood or personality disorder. Of the 45 individuals referred for this study, only 40 of them self-reported themselves in the problematic range of alcohol use; the other 11 had haphazard scoring, potentially indicating severe dysfunction or a desire not to self-disclose. Haphazard scoring could result due to the individual not being mentally stable enough to concentrate and answer the questions adequately – of the five individuals who indicated minimal or no drinking, they also generally scored low scores on the BORRTI, indicating a lesser degree of pathology (Flanagan, 2011).

The participants of this study all have dysfunctional object relations, but they also have an unmanageable relationship with alcohol, this being the primary reason for their admission into the psychiatric hospital. As such, alcohol becomes a symbol of care and nurturance to some individuals (Flanagan, 2011). However, this only occurs in the case of pathological ego functioning, which

notably was identified in all 45 of the participants of the initial sample in this study. Freudian, traditional psychoanalysis and ego psychology suggest that in cases of such pathological ego structures and/ or functioning, this results due to satisfaction or frustration of particular impulses; whereas from an Object Relations point of view, relationship needs were not met. Either theory is applicable to the findings of this study; however, treatment methodologies vary.

Similarities in the sub-sample of all 29 participant's ego functions were identified in terms of Alienation and Social Incompetence. These two BORRTI categories could be linked to the DSM-5 criteria, in that if an individual struggled with pathological ego functions in these two areas, they may influence a performance resulting in the individuals meeting the criteria presented in the DSM-5 as Alcohol Use Disorder. This finding correlates with literature and the AA ideas regarding individuals with Alcohol Use Disorder being exceptionally isolated, which causes them to cling on to inappropriate transitional objects, such as alcohol, even more tightly. The results of the current study also suggest that the participants who have pathological scores in terms of Alienation and Social Incompetence may end up with Alcohol Use Disorder if they abuse or misuse alcohol (Flanagan, 2011).

Based on the above findings, an addiction is an indication that the individual suffering with an alcohol use disorder has a dysfunctional attachment structure, which according to the psychodynamic theorists is as a result of their caregivers in infancy being unavailable or inconsistent, resulting in pathological introjects that fundamentally influence the individual's object relations structure and ego strength in terms of managing frustrations (Flanagan, 2011).

Among the unconscious motivations, an addiction is linked to oral gratification and passive identification with a parent. The individuals need to replace a lost object seems to drive much of their behaviour. It is the object character of the drug that is stated to act as the central motivating power, as

opposed to its pharmacological character (Yalisove, 1997). As seen in the current study's sample, personality structure deficits underlie the individual's alcohol misuse.

Linked to Freud's theory, these 29 participants appear to make use of alcohol as a way of coping with pain and disillusionment in their lives, and Fenichel (cited in Yalisove, 1997) emphasises the fact that addiction is a means of avoiding a depressive breakdown. The psychic pain can be seen in the participants BORRTI profiles. The majority of these individuals display severe psychopathology, which is indicative of them experiencing pain and interpersonal problems in their everyday lives. In this way, alcohol acts as a defensive function (Glover, cited in Yalisove, 1997). As per Kohut's (cited in Yalisove, 1997) theory, the individual uses alcohol in an attempt to re-establish an omnipotent position wherein their self is grandiose or where the other person/ object is looked upon as all-giving and is required to live up to the highest ideals. As soon as interpersonal limitations are imposed, total devastation occurs. Resulting feelings include hurt, loneliness, rejection and abandonment. The importance of alcohol then lies in their effect of reducing or eliminating these affects (Yalisove, 1997).

As part of an individual's addiction, the craving is then equated to a rapid narcissistic decompensation and the breakthrough of archaic feelings evoked by massive narcissistic frustration. The choice of substance by the individual is theorised to be related to the affects linked to this conflict due to their inner structures failing as defenses. In this way, the substance is, indeed, an attempt to self-medicate and to provide support the individual's ego (Yalisove, 1997).

Superego pathology is another aspect of addiction, which based on the scores of this study will influence the participants in terms of experiencing the lack of meaning-giving, life-determining, or life-guiding values and ideals.

The crucial pathological factors suggested in the individual's family appear to be linked to the lack of limit-setting and trustworthiness versus narcissistic indulgence and rage. Parents who did not provide

a minimum of consistency, of reliability, of trustworthiness, of responsiveness to the child, especially during their developmental crises, are not usable as inner protective beacons; instead they become targets of rebellious rage and disdain by the individual.

The participants of this study's results also indicate that due to their inability to symbolise in their inner life, in terms of emotions and self-references, they are likely to be unable to articulate feelings. Substances are used by the individual to alter their world image into a less unpleasant and more meaningful one (Yalisove, 1997).

Self-destructive and self-punitive behaviour plays a notable role in an individual with Alcohol Use Disorder. Very primitive and global fears of humiliation and revenge play a dominant role in the social interaction of these individuals and these are suggested to not be consequences of society's reaction, but part of the individual's make-up to begin with (Yalisove, 1997). As seen in the current study's sample, personality structure deficits underlie the individual's alcohol misuse.

From all the forms of regressive gratification attained with the help of the drug, it appears that the increase in self-esteem, which also occurs in the re-creation of a regressive narcissistic state of self-satisfaction, is the most consistent one. This is particularly relevant when we see this aim of drug use as an integral part of the narcissistic crisis which typically marks the onset of compulsive drug use. The specific reason for the onset of compulsive drug use lies in an acute crisis in which the underlying narcissistic conflicts are mobilised and the affects connected with these conflicts break in with overwhelming force and cannot be coped with without the help of an artificial affect defense (Yalisove, 1997).

The narcissistic crisis is thus the point at which the conflicts and defects converge with a particular external situation and with the availability of the seeming means of solution: the drug. By definition, a "narcissistic crisis" would have to entail a particularly intense disappointment in others, in oneself, or



in both – so intense because of the exaggerated hopes, and so malignant because of its history in reaching back to very early times in the individual’s life.

In the current study’s results, there appears to be a link between defects in affect management, the desperate search for an object substitute, self-destructive qualities, and the search for regressive gratification – together with the intensity of the underlying narcissistic conflicts that form a predisposition for compulsive drug use.

Although as previously highlighted in the literature review, Freud did not specifically focus on alcohol abuse, some of his theories provide a necessary link between psychoanalysis and Object Relations. From Freud’s viewpoint (cited in Smith-Pickard, 2004, p. 59) individuals abuse alcohol in order to regulate their unpleasant feelings. Levin (1986) furthers the link by arguing that Freud indicated that rejection and/ or disappointment of the “object love” can lead to withdrawal and redirection of interest (libido) from the world and into the self. The theoretical idea, that alcohol-dependent individuals withdraw and become self-focused, is supported by the BORRTI findings of the current study, which indicate that the majority of the sample scored pathological scores on the Alienation and Egocentricity scales.

According to Khantzian (cited in Bean et al., 1981), individuals abuse alcohol in an attempt to self-medicate negative feelings. In line with this hypothesis and related to the large amount of pathological ego structures as indicated by the BORRTI scores, it would then be possible that these pathological structures contribute to an individual becoming alcohol dependent as is indicated by the high AUDIT scores. However, more research should be conducted to identify why certain people with problematic ego structures develop alcohol use disorders and other do not. Furthermore, Kernberg links alcohol dependence to primitive defense mechanisms such as splitting, denial and projection in order to split off a part of the self, and alcohol is used to reactivate the grandiose all-good self and object image. In this way, the all-bad internalised object is denied. Grandiosity can be linked to Egocentricity, and

many primitive defense mechanisms such as the above are suggested in the findings of the BORRTI results within this sample. This applies to the following 18 participants (2, 5, 10, 11, 12, 14, 16, 17, 18, 22, 25, 26, 32, 33, 38, 40, 41 and 45).

Jacobson (cited in Levin, 1987) stated that blurring of the self and object occurs in the case of severe psychopathology. This is stated to be particularly noticeable in the early stages of sobriety. All of the participants of the current study were in early treatment stages, generally between the three-week and three-month period.

Taking the self-regulating hypothesis a step further is Levin (1987), who describes Kernberg's stages of development related to psychic structure, namely the id, ego and superego, as well as developmental phases of object relations development. According to him, all individuals who suffer from Alcohol Use Disorder are at the third stage of object relations development, in which the negative and positive self as well as the positive and negative object representations are all fragmented and have not yet integrated into a state of object constancy. Furthermore, the superego is suggested to comprise of the internal parent who is involved in self-regulation and maintenance of the self-esteem.

Kernberg (cited in Levin, 1987) argues that the concept of pseudodependency present in the narcissistic personality illuminates alcoholic pathology. His theory is supported by the high scores of these findings in the Egocentric subscale as well as all the other categories which suggest narcissism could be present in terms of the participants of the current study.

Kohut's (cited in Bean et al., 1981, p.150) theory supports Kernberg's ideas, in that Kohut also emphasises the formation of the self, which occurs due to pathological internalisations, identifications and self-structures. Similarly to Kernberg, these authors state that individuals use substances to lift their defenses in order to give them a feeling of being soothed as well as safety; the reason being that

these defenses suppress feelings in relation to the self and other. The defenses of narcissism are evident in this study.

According to Kohut, addictive behaviour is an attempt by the individual to try and deal with narcissistic disturbances and, in this way, the alcoholic becomes self-absorbed, which is a finding supported by this study. Four areas of self-pathology are noted by Levin (1987). He argues that the individual with alcohol misuse is, firstly, self-destructive; secondly, lacks certain components of the self that mediate self-care and maintain self-esteem; thirdly, overly self-involved, and fourthly, possesses a fragile sense of self and self-representations.

The first and second points are portrayed by the participants of this sample. All of them were admitted as a result of their self-destructive behaviour, which is evident in their lack of self-worth and self-care, as well as their engagement in risk taking behaviour. As mentioned, most of the sample scored pathological scores in the Egocentricity category of the BORRTI. A fragile sense of self is indicated by pathological scores in the different categories of the BORRTI.

As can be noted, each psychoanalytic theorist discussed here has a different focus. Freud focused on an individual's drives, whereas Klein stresses the importance of the internal world of the infant. Winnicott stressed the mother and infant unit. More recently, Kernberg looks at the development of personality structures, namely, the levels of personality organisation, and Kohut specifically focused upon narcissism and the sense of self-development (Watts et al., 2009, p. 185). Although their theories differ slightly, psychoanalysts believe that alcohol has become the alcohol abuser's sole love object and is experienced as part of the self.

### 4.3.2. PEARSON'S CORRELATION COEFFICIENT FINDINGS

The correlations between the BORRTI categories and the AUDIT scores for the sample of 29 participants were worked out at the standard 95% level, and in order for a correlation to be considered to be statistically significant for this sample, a correlation of 31.1% must be attained. The correlation of the entire sample of all the males and females are indicated in the table below.

**Table 4: Pearson's Correlation Coefficient: 29 Participants**

<b>BORRTI Subscale</b>	<b>Pearson's Correlation Coefficient</b>	<b>Significant Correlation 31.1%</b>
Hallucination & Delusion	32.4%	Statistically significant correlation
Reality Distortion	22.3%	Positive correlation
Uncertainty of Perception	17.2%	Positive correlation
Alienation	13%	Slight positive correlation
Social Incompetence	5.7%	Barely any correlation
Egocentricity	1.9%	Barely any correlation
Insecure Attachment	-7.7%	Barely any correlation

The two scales of the BORRTI that test Reality Testing are the Hallucinations and Delusions and the Reality Distortion categories. The highest correlations to alcohol use were found in these categories. The correlation between alcohol use and the Hallucination and Delusion category was the only statistically significant correlation identified, which is supported by the fact that the individuals who were interviewed were in a tertiary-level psychiatric setting and found to have alcohol abuse problems by the psychiatric team. The next highest correlation is between reality distortion and alcohol use; this is not statistically significant, but a high correlation exists. This could be related to the fact that a psychiatric population was interviewed that was in the early stages of recovery.

None of the categories which assessed the Object Relations categories of the full sample were found to be statistically significantly correlated with alcohol use, however high correlation were indicated between alcohol use and Alienation and Uncertainty of Perception. There is a slightly lower correlation between alcohol use and Social Incompetence and Egocentricity – the low correlation in the Egocentricity scale and alcohol use could be related to the participants “faking good”. A negative and extremely low correlation exists between alcohol use and the Insecure Attachment Ego Function, within the current study.

Another finding is that although the scores of this sample show clear Object Relations deficits, often the level of alcohol abuse indicated in their self-reports does not display a statistically significant value, which could be attributed to the fact that the measure used to assess their alcohol use was a self-report measure in which the participants could have minimised their alcohol use. This could also be linked to the fact that males and females may need to be screened using different screening methods – this is discussed in more detail under the next headings.

All of the 45 participants who took part in this study met the DSM-5 criteria for Alcohol Use Disorder and on this basis they were referred by a psychological team for this study as potential participants. The assumption was based on the opinion of the clinical staff at the psychiatric hospital. Based on the results of this finding, no detail was attained regarding the individual’s life events before admission; however, some similarities and isolated criteria were identified in the 29 participants who were included in the analysis. The majority of the participants’ BORRTI profiles indicated pathology in their Reality Testing functions as well as their Object Relations scores; more specifically related to the Alienation and Social Incompetence categories.

A statistically significant correlation was identified between alcohol use and hallucinations and delusions and an extremely high correlation was found between alcohol use and reality distortion. This could be expected as this sample comprised of individuals from a psychiatric population. These

findings do not provide any information regarding criteria or definition of an alcoholic, but instead provide support for the definition of a psychiatric sample. These findings can be linked to the criteria in the DSM-5 (2013), which refers to recurrent physical or psychological problems occurring as a result of alcohol; as well as the fact that the majority of the sample had been admitted to a state general hospital for three weeks prior to being admitted to this psychiatric hospital in order to have their withdrawal monitored, therefore they also meet the specifier for physiological withdrawal.

### **PEARSON’S CORRELATION COEFFICIENT IN TERMS OF GENDER**

Due to the sample comprising of men and women, and there clearly being a difference in the amount of men referred for this study, the Pearson’s correlation coefficient was worked out for each of the BORRTI categories and their correlation with alcohol use, but for two separate samples: firstly, the females and then the males.

### **FEMALE PARTICIPANTS’ PEARSON’S CORRELATION COEFFICIENT**

Of the sample of 29 individuals, 10 were female and at the 95% level, a percentage of 54.9 and above indicates statistical significance.

**Table 5: Pearson’s Correlation Coefficient: Female Participants**

<b>BORRTI Subscale</b>	<b>Pearson’s Correlation Coefficient</b>	<b>Significant Correlation 54.9%</b>
Egocentricity	-57.0%	Statistically significant & negative
Uncertainty of Perception	-50.6%	Statistically significant & negative
Insecure Attachment	-44.7%	High negative correlation
Alienation	-27.7%	Slight negative correlation
Social Incompetence	-22.8%	Slight negative correlation
Reality Distortion	-2.4%	Barely any correlation & negative
Hallucinations & Delusions	3.0%	Barely any correlation & positive

Two of the seven categories, namely, Egocentricity and Uncertainty of Perception indicate statistically significant correlations between alcohol use and each ego function. These are higher correlations that were found in the overall sample correlations. Another finding is that all of the categories registered negative correlations, which indicated that the more the females' alcohol consumption increased, the more their scores in terms of ego-functioning decreased.

**MALE PARTICIPANTS' PEARSON'S CORRELATION COEFFICIENT**

The sample comprised of 19 male participants. In order for the Pearson's Correlation Coefficient to be considered statistically significant at the 95% level, a correlation of 38.9% must be achieved.

**Table 6: Pearson's Correlation Coefficient: Male Participants**

<b>BORRTI Subscale</b>	<b>Pearson's Correlation Coefficient</b>	<b>Significant Correlation 38.9%</b>
Uncertainty of Perception	51.6%	Statistically significant
Hallucination & Delusion	46.0%	Statistically significant
Alienation	32.4%	High correlation
Reality Distortion	30%	Slight positive correlation
Social Incompetence	25.7%	Slight positive correlation
Egocentricity	23.9%	Slight positive correlation
Insecure Attachment	5.9%	Barely any correlation

Two of the categories' correlations are statistically significant, namely Uncertainty of Perception, and Hallucination and Delusions, with the AUDIT scores. The Alienation category has an extremely high correlation with the AUDIT scores. Reality Distortions, Social Incompetence and Egocentricity have slight positive correlations with alcohol use. Barely any correlation can be noted between the Insecure Attachment and AUDIT scores.

There are distinct differences in the scores and results of the males and females in this sample. The scores of the females indicate that the higher their dysfunction is in terms of Object Relations, the less this deficit can be linked to alcohol abuse. This could be due to females being more aware of their social status, or that their denial is worse, or the AUDIT is not an accurate measure for both females and males (as provisionally suggested by Peltzer and colleagues' studies in 2009 and 2011 in South Africa). All of the female scores correlated negatively, excluding the correlation for the Reality Distortion scale. However, all of the male scores correlate positively; this could suggest more underlying disorders in females. The male scores correlated positively, meaning that as the level of dysfunction increases so does their alcohol abuse. The findings show that the Pearson's Correlation Coefficient indicates that the highest correlations between the most categories exist when the male and females in the sample are separated and compared to each other only. When their scores are not separated, the correlations are less and lower.

The female participants had the highest negative correlation between alcohol use and Egocentricity, suggesting that the higher they scored on Egocentricity, the less alcohol they consumed and vice versa. This could be related to narcissistic defense mechanism supporting these individuals' ego structures to such a point that they do not form pathological attachments to alcohol. A similar finding regarding Uncertainty of Perception, whereby the more certain of their perception the female was, the less alcohol they consumed, which could suggest that these females felt too uncertain to consume alcohol, as in the case of Cluster A personality disorders mentioned by Eckleberry (2009). The same can be said for Insecure Attachment and Reality Distortion. The lowest correlation existed in the females of this study in terms of alcohol use and Reality Distortion and Hallucinations and Delusions; this could be due to the fact that the female participants suffered from less reality distortions and delusions than the males of this sample.

A key finding of the current study is that the males of the sample had the highest correlation in terms of Uncertainty of their Perceptions. As such it could be deduced that the more uncertain the individual



is of their perceptions, the more alcohol they consume. This could be due to their attempt to self-regulate by using alcohol to control their emotions. The next significant similarity can be seen in the Hallucinations and Delusions category, which suggests the more that this sample of men hallucinate and have delusions, the more alcohol they consume or vice versa. The male participants' next most similarly affected ego function related to the alcohol use is Alienation. From this sample it could then be deduced that males who consume pathological amounts of alcohol and have pathological levels of uncertainty about their perceptions and who alienate to a large degree, could possibly suffer from delusions and hallucinations. This deduction can be made due to the high levels of correlation between these categories; they are all statistically significant similarities within this sample. The next similarity is related to males' Reality Distortions, Social Incompetence and alcohol use, followed by Egocentricity and Insecure Attachments. With the higher levels of Uncertainty of Perception, it could be suggested that fewer of these individuals have narcissistic defenses and therefore they use alcohol to a greater degree than females to contain their feelings. The high levels of Hallucinations and Delusions as well as Uncertainty of Perception could also be linked to the lower levels of Egocentricity in the males, as well as the lower levels of Insecure Attachments. These scores could be as a result of fragmented ego and these individuals being stuck in flights of fantasy as opposed to attaching to anything in particular, which could have been influenced by them having recently detoxed in hospital.

In the three different analyses presented here, firstly the entire sample, followed by females only and then males, the correlation between alcohol use and Insecure Attachments scored reasonably low in comparison to the rest of the categories. This could highlight the importance of an initial eclectic treatment approach, which suggests that medical treatment would be the most important for males to assist them in dealing with their Uncertainty of Perceptions from a CBT point of view, which may be caused by the paranoia associated with alcohol and drug dependence. The CBT approach could possibly assist them to alienate less and a chemically focused treatment could be applied to stop the

hallucinations and reality distortions. The second treatment priority for males would be social skills training.

The findings of this study correlates with the findings of Stein et al. (2008), who found that substance misuse is much more prevalent in males than in females, with trends indicating an 80:20 percent split across the country. Stein et al. (2008) also suggest that females are more associated with mood and anxiety disorders and males with substance use disorders and these statistics are not influenced by income. All disorders were not covered in this study, however the differences in the male and female sample with regard to the correlation coefficient and the different disorders is clear.

According to Levin (1987), alcoholic women are more likely to suffer from depression than alcoholic men and the females are also more likely to drink to alleviate intolerable feelings of worthlessness and low levels of self-esteem. Blane (cited in Levin, 1987) argues that women drink to deal with feelings of inferiority whereas men drink to deal with repressed dependency needs. This could be linked to the finding of this study in relation to the Pearson's Correlation Coefficient in the female sample – a statistically significant correlation was identified between Egocentricity and AUDIT scores.

Edwards et al. (2003) found women are less likely to drink than men in most cultures; this is stated to be due to the fact that social and cultural factors play a powerful role in altering females vulnerability to developing a problem with alcohol, as there is still less social pressure on women to begin drinking and more pressure for them to stop. In 2002, Bladt (cited in Li & Bell, 2008) also found that drinking behaviour for men differed in comparison to women. Nemes, Weil, Zeiler, Munly, Holtz and Hoffman (2007) found differences between men and women on responses to questions regarding drug and alcohol use and therefore emphasise the need for a specific screening criteria for each gender.

In a study by Buschsbaum et al. (cited in Nemes et al., 2007), it was found that women's alcohol-related problems (24%) are less likely to be recognised by health care providers than men's misuse (67%). Notably, these studies suggest that physicians feel unprepared to diagnose alcohol abuse,

especially among their female patients, and in this way many women who abuse alcohol are often unidentified.

Research evaluating the utility of current instruments suggests that many screening tools used are not sensitive to gender differences (cited in Nemes et al., 2007). Research has also identified differences between men and women alcoholics in relation to symptoms, consequences and help-seeking behaviours (Kordinak, Davis, and Morse, 1998). These differences are due to a variety of biological, psychological and social factors. Biological differences between sexes in relation to alcohol usage relate to the fact that men are capable of consuming larger quantities of alcohol at one time with fewer physical effects than their female counterpart. Women maintain higher blood concentrations of alcohol after consuming equivalent amounts of drinks as men. The medical community suggests that rates of absorption are due to the amount of body water concentrated in an individual's muscle mass. Women on average tend to retain less body water than men; as such, women absorb higher levels of alcohol per kilogram in body mass. Physiological studies also reveal that the genders metabolise alcohol differently, with women having less capacity to do so.

Psychological differences in genders also exist (Banishek et al., 1992, cited in Nemes et al., 2007). Significant differences were found in the relationship between global psychopathology, depression, anxiety and alcohol treatment among substance abuse patients. This finding supports both previous and current studies and the exploratory findings of the current study that have found significant co-morbidity of internalising disorders and alcohol abuse to be more prominent in women than men.

Social factor differences also exist in terms of significantly higher rates of binge drinking, family problems and financial problems appearing in men. Men are more likely to engage in occupationally and socially disruptive behaviours as a result of their alcoholism. In contrast, women are more likely to admit loss of control, experience emotional consequences and report alcohol problems in their families. Ely and colleagues suggest that women are more likely to experience more psychological problems with their drinking than men because of the social stigma. Women are unlikely to receive

treatment for alcohol problems due to a high prevalence of co-occurrence of mental health disorders, inadequate social and financial resources as well as a perceived stigma associated with drug abuse amongst women. This phenomenon is clear in the results of this study. Some women completely denied their use of alcohol and the general correlations worked out indicate a negative correlation between alcohol consumption and ego functions (Nemes et al., 2007).

Bradley et al. (1998) suggest that many screening instruments that assess alcohol and drug use and abuse do not account for the gender differences mentioned above. They further suggest that the traditional cut-off point methods cannot be used in the same format for male and female individuals who abuse alcohol. Importantly, instruments such as the CAGE or AUDIT miss 41% to 62% of Caucasian women. Given that a primary question in these instruments relate to the number of drinks consumed and, as previously cited, alcohol consumption may differ between gender, traditional cut-off points may need to be lowered in order to identify females with alcohol problems (Bradley et al., 1998).

To address the issues related to screening alcohol use, the DAPA-PC is suggested to be a comprehensive screening system to identify and address substance abuse and related problems in both men and women. Questions that are sensitive to the needs of women and minorities were incorporated to make sure the instrument evaluates alcohol use in both genders.

This is interesting in terms of the exclusion criteria applied as a result of the BORRTI scores; of the five participants who were excluded due to low scores, four were women. These studies suggest reasons for the different findings presented above. Although non-purposive sampling techniques were applied, only 18 females and 27 males participated in the study in total and 10 females and 19 males were included in the overall analysis.

As is indicated by the Pearson's Correlation Coefficient for the select sample of 29 participants, only one statistically significant correlation was identified between the BORRTI Hallucinations and

Delusions subcategories and the AUDIT scores. Slight positive correlations were also identified in the Reality Distortion and Uncertainty of Perception categories. In relation to the female-only sample, the only statistically significant correlation was identified between Egocentricity and the AUDIT scores of these participants. However, this was a negative correlation. In the male-only sample all positive correlations were positive, however only two statistically significant correlations were identified between the Uncertainty of Perception and the Hallucinations and Delusions categories and the AUDIT scores.

The differences in the male and female scores affect the strengths of the correlations of the selected sample of 29 participants. Egocentricity has the highest correlation with the AUDIT scores for the female sample, but has the lowest ranking correlation in the male sample. Uncertainty of Perception has a negative correlation and is the second highest correlation in the female sample in relation to the AUDIT scores, whilst the correlation for this category and the AUDIT is the highest and positive for the male sample. Insecure Attachment indicates the third highest correlation in the female sample and is a negative correlation, whilst barely any correlation can be noted in the male sample. The correlation between the Alienation category and the AUDIT is in a similar ranking order for both the female and male sample, but for the females again a negative correlation is indicated, whilst in the male sample a positive correlation is indicated. Social Incompetence also ranks in the same place for both the female and male samples, yet the females' correlation is again negative and the males' correlation is positive. The Hallucinations and Delusions correlation with the AUDIT scores is the second lowest ranked category for the female selected sample, but is ranked in second place for the male selected sample, and presents with a statistically significant rank for the males. The lowest correlation in the female sample is between Reality Distortion and the AUDIT scores, whilst it is the fourth highest correlation in the male sample.

Of the three samples analysed, only four categories in totality were found to have statistically significant correlations with the AUDIT scores. Notably, for the sample of 29 participants, alcohol consumption was found to be statistically correlated with the Hallucinations and Delusions category. This is indicative that the more these individuals' level of alcohol consumption increases, the more they struggle with Hallucinations and Delusions. In the female-only selected sample, the only statistically significant correlation was identified between alcohol consumption and egocentricity, however a negative correlation is indicated. The current study found that in the male-only analysis, positive and statistically significant correlations were identified between the Uncertainty of Perception and Hallucinations and Delusions category and alcohol consumption. Importantly, mental health professionals need to be trained to work with inpatients who present with Alcohol Use Disorder, more specifically males with psychotic features, within the South African context.

### **4.3.3. TRENDS IDENTIFIED**

Three different trends were identified in the findings of this research. The first is related to White female Afrikaans-speaking participants; the next is White Male Afrikaans-speaking participants and the last refers to participants who scored high AUDIT scores, with no pathology in terms of their BORRTI scores.

Based on the categories and the trends from the BORRTI reports (See Appendix J), co-morbidities are suggested within the sample of 29 participants. All of the participant had been initially diagnosed with Alcohol Use Disorder and, with the current study, their scores on the different BORRTI scales are indicative of high levels of co-morbid psychiatric disorders.

According to the BORRTI assessment (Bell, 2005) participants 28, 37 and 41 could have co-morbid narcissistic, histrionic, dependent or passive-aggressive personality disorders. Participants 28, 32, 33

and 38 could be suffering from Alcohol Use Disorder, with co-morbid psychotic disorders, borderline and/ or schizoid personality disorders (Bell, 2005). Participants 2, 3, 5, 8, 10, 11, 12, 14, 16, 18, 22, 24, 25, 26 and 30's profiles suggest that in the absence of a psychotic disorder, this could imply narcissistic, borderline disorder (Bell, 2005). Participant 2, 10, 12, 16, 17, 25, 26, 28, 30 and 33 report lapses in Reality Testing that are suggestive of psychosis. This profile pattern is not necessarily linked to psychotic disorders, as it sometimes occurs in people with a history of schizophrenia and in residual phase, commonly found in borderline, schizotypal and paranoid personality disorders and substance abuse populations (Bell, 2005). Participants 1, 2, 10, 16, 17, 25, 26, 28, 30, 33 and 39 may have a genetic predisposition to psychotic symptoms; phenotypic experience is schizotypal rather than schizophrenic (Bell, 2005). Participants 2, 5, 10, 12, 16, 18, 25, 26, 28, 30, 33, and 39 may have co-morbid borderline personality disorder (Bell, 2005). Participant 22 and 32 have profiles that are most common in people with schizophrenia and other psychotic disorders, though less common in borderline or PTSD patients (Bell, 2005). Participant 14's profile is commonly found in patients with schizophrenia or other psychotic disorders (Bell, 2005). Participant 38's pattern of Reality Testing scores could be suggestive of an anxiety disorder. Participant 39's scores may indicate attitudes and personality traits most commonly associated with dependent, compulsive or passive-aggressive personality disorder and may not be so severe as to cause social dysfunction. Participant 40's scores may be associated with an avoidant personality disorder. Participant 45 scored a single elevation on EGC which is consistent with personality traits most commonly associated with narcissistic, antisocial and histrionic personality disorders. This pattern of Reality Testing scores is most commonly found among patients with schizophrenia or other psychotic disorders (Bell, 2005). Participants 10, 14, 18, 22, 25, 28, 32, 33, 38 and 45 may have substance abuse and/ or borderline disorders. Participants 5, 14, 18, 22, 30, 32 and 40's scores are indicative of individuals with schizophrenia, Borderline Personality Disorder or PTSD.

Hasin, Stinson, Ogburn and Grant (2007) state that co-morbidity of alcohol dependence with depressive, bipolar, anxiety and personality disorders appears attributable to factors shared among these disorders. The factors here in terms of the findings of this study are completely related to ego-functioning, which is pertinent in the ego functioning scales designed by Bell (2005). Pathological scores on most of the scales are suggested to indicate a number of possible disorders, hence pathology in certain ego functions is linked to the presence of mental disorders as presented in cluster A, B and C of the DSM criteria for Personality Disorders.

The results of the current study concur with Evans and Sullivan's (1990) findings, whose studies conducted in the USA suggest that individuals with a psychiatric disorder are at an increased risk for having a substance abuse disorder. They also suggest that chemical abuse rates amongst chronically mentally ill patients exceed 50%. These figures are thought to be conservative due to the fact that psychiatric inpatients underreport substance use – this could account for many people in the sample having scored very low scores on the AUDIT, such as those seen in the scores of Participants 4, 13, 27, 31 and 42.

Weich and Pienaar (2009) suggest that co-morbid SUD and psychiatric illnesses are linked to medication non-compliance, relapse and re-hospitalisation, career distress and homelessness, all of which could be seen in the current study's sample of participants, as a number of them were homeless and the majority of them did not have employment.

The BORRTI scores of the current study provide support for further investigation into whether individuals with Alcohol Use Disorder possibly have a co-morbid psychotic disorder or a Cluster A personality disorder, these being Schizoid, Schizotypal or Paranoid Personality Disorders – as is indicated in the case of all the participants who scored pathological scores on one or more of the following scales: Alienation, Reality Distortion, Uncertainty of Perception and Hallucination and Delusions.



According to Gregory (2006, cited in Eckleberry, 2009, p. 85), 50–70% of individuals with BPD have a substance use disorder and often use alcohol and other drugs in a chaotic and unpredictable pattern. As mentioned earlier, Otto Kernberg (cited in Bean et al., 1981, p. 171) explains that alcohol-dependent individuals make use of primitive defense mechanism, such as splitting, denial and projection in order to split off a part of the self, and alcohol is used to reactivate the grandiose all-good self and object image. In this way, the all-bad internalised object is denied. The pathological self-structure referred to by Kernberg is very apparent in the scores of the participants, as all of the participants indicated in the above table have scores which according to Bell (2005) are considered to be pathological.

Narcissism and NPD is associated with a heightened level of superiority, as can be seen in the case of individuals who score high on the egocentric category of the BORRTI, in which 17 participants recorded high scores (2, 5, 10, 11, 12, 14, 16, 17, 18, 22, 26, 32, 33, 38, 40, 41 and 45).

Rehm et al. (2003) provide support that the presence of psychiatric disorders can be illuminated by the BORRTI. They suggest that mental and behavioural disorders, dependency and psychotic disorders can all be linked to alcohol use. The BORRTI results indicate definite pathology in the sample and also the presence of co-morbid disorders. Each subcategory of the BORRTI tests for different types of disorders. The AUDIT scores suggest the presence of an alcohol use disorder in all of the 29 participants included in this analysis and all of them scored high in certain categories within the BORRTI, which suggests the presence of co-morbid psychiatric disorders in most of the participants.

According to Eckleberry (2009), all human beings have a personality style that is made up of personality traits and individual attitudes, patterns of behaviour and emotions, which are developed early in life in response to challenging life events. According to Eckleberry (2009), individuals with Cluster B personality disorders are more likely than cluster A and C to suffer an alcohol or substance

use disorder. Cluster C's isolated stance results in them isolating themselves and generally not being exposed to the drug culture, however these individuals are suggested to most likely use alcohol as their drug of choice due to the easy accessibility. These ideas are supported by the findings of the BORRTI as is indicated in the below discussion, where the majority of the BORRTI scales identify Cluster B personality disorders.

Literature indicates that there are high levels of co-morbidity between a range of different psychological disorders. According to Edwards, Marshall and Cook (2003, p. 110), alcohol problems and psychiatric disorders are both common and some degree of overlap should be expected in any population. This is clearly seen in the sample. Initially only individuals with alcohol use disorders were going to be used in the sample, however the psychology staff of the hospital suggested that none of the patients admitted there suffered from only Alcohol Use Disorder.

Although a large amount of international literature has focused on the topic of co-morbid alcohol use and personality disorders, there is much less of a focus from South African authors and even less so in relation to co-morbid mood disorders. Many of the participants scored high scores on the BORRTI, indicating notable pathology. This is further supported in that all of the 29 participants scored high scores on the AUDIT scale indicating problem drinking, as well as the Pearson's Correlation Coefficient results, which suggest that definite correlations are present in relation to higher ego functioning deficits and alcohol use. Although the pathological scores on the BORRTI scales do suggest the presence of a number of different disorders, which will be mentioned as findings of the BORRTI scales, for the purpose of this study the main focus falls on co-morbid alcohol use and personality and mood disorders, as the sample was chosen based on the psychological team's diagnosis of participants suffering from Alcohol Use Disorder with co-morbid personality and/ or mood disorders.

Akindipe, Wilson and Stein (2014) found high levels of co-morbidity in individuals with methamphetamine dependence. Co-morbid alcohol use disorder is not presented; this could be due to the fact that these individuals are classified as having substance use disorder, which includes alcohol. The high rate of co-morbidity suggested for individuals with psychiatric disorders and mood disorders (16%) psychotic disorders (13%) and anxiety disorder (7%) stresses the importance of applying an integrated model of care addressing both substance use disorders and psychiatric co-morbidity.

Weich and Pienaar (2009) indicate that a number of studies have explored the prevalence of co-morbid SUD in patients with a mental illness and the findings indicate that prevalence rates range between 12 and 65%. These results were influenced by variables such as population, sample size and diagnostic criteria. According to Weich and Pienaar (2009), these variances emphasise the need for local surveys to be explored as well as the nature of the problems related to dual diagnosis. These authors also state that there is anecdotal evidence of an increase in the prevalence of dual diagnosed patients among psychiatric patients in the Western Cape. Concurrently, there is no service that caters for the unique needs of these patients. Therefore, research is necessary to plan effective future services.

It is additionally indicated that rates of alcohol abuse might have been underestimated, since alcohol is often not viewed as a substance of abuse because it is legal and its use is the norm within a large part of our society. Alternatively, the perception that medication should not be used with alcohol may also have contributed to the relatively low number of patients reporting alcohol misuse (Weich & Pienaar, 2009).

Eckleberry (2009) states that the co-morbidity of substance use disorder, including alcohol and Cluster B personality disorders is much more common than with Cluster A or C personality disorders. Cluster B, the dramatic, erratic or impulsive cluster has the highest rates of alcohol and drug abuse

and dependence. Substance misuse is so common in these individuals that assessment for one in the presence of the other is essential (Eckleberry, 2009, p. 68).

On this basis, the current study acknowledges that a study focusing on excessive alcohol use needs to fundamentally take into consideration co-morbid psychiatric disorders in order to reduce the relapse rate effectively. These factors underscore the importance of this study in order to address this gap within the mental health field.

Although the psychological community has attempted to provide universally appropriate criteria for Alcohol Use Disorder, much controversy still exists in this regard. As was mentioned before, numerous definitions for alcohol use exist and the psychological community differs in their definition based on the different schools of thought, and the way in which Alcohol Use Disorder is defined fundamentally influences the treatment plan. This can be seen in terms of the different rehabilitation facilities alone: some are Christian-based, whilst others emphasise psychoeducation and still others focus on the 12-step programme. Some treatment facilities do not prioritise psychotherapy and facilities that do may provide short-term group therapy, only taking into account the substance misuse or very time-limited individual therapy that does not adequately address the severe co-morbid psychiatric disorders that the individual actually has in addition to their presenting substance related disorder.

The disease concept allows for a broad definition, which is stated to be problematic in terms of adequately diagnosing someone. The disease concept is based on the fact that the alcoholic can be identified by their loss of control around alcohol as well as its negative consequences. This is a reactive approach as no definite symptoms are stipulated in terms of definite warning signs. CBT is also a reactive definition, in that once an individual is given the diagnosis of Alcohol Use Disorder certain behavioural changes can be made to ensure that they do not continue in the same vein. However, there are no distinct criteria in terms of thinking and behaviour which indicate that an

individual with such thoughts and behaviour will develop into an alcoholic. The psychodynamic viewpoint is also more reactive but has a slightly proactive focus. Psychodynamic theories are based on an individual's childhood and their attachments and relationships that are formed at a young age.

Three psychoanalytic views of addiction are presented by Yalisove (1997). The first view is traditional, suggesting that addiction occurs as a result of premorbid psychopathology, which is explained by separation-individuation and self-formation. Treatment from this view is stated to be traditional psychoanalysis. This view, according to Yalisove (1997) is supported by Krystal and Wurmser. The second perspective argues that psychoanalytic techniques should be combined with concepts of specialised addiction approaches. The third group states that a psychoanalytic model is needed, which will assist in the integration of treatment of addiction and psychiatric disorders. This study supports the third view.

The difficulties in treating patients suffering from Alcohol Use Disorder result from the ambivalence in Object Relations in these individuals. Early surfacing of aggressive transference makes treatment difficult and this also relates to the disturbance in affect tolerance. Not only do individuals with Alcohol Use Disorder struggle with negative affect, but they also struggle with pleasurable emotions.

Emotions can only be experienced as pleasurable when accompanied by hope and confidence, which are based on previous good experiences. However, these individuals do not generally have these good experiences to relate back to and because of the nature of their transferences, they expect disappointment and rejection (Krystal, cited by Yalisove, 1997).

Because of the prevalence of magical thinking, combined with the individual's wish for magical powers, and together with a grandiose self-representation, alcoholic and drug-dependent individuals in psychotherapy become terrified of their death wishes directed toward the therapist. Alternately, the individual with the addiction tends to turn their aggression against themselves, and act it out in an accidental injury, suicide attempt or relapse of drug abuse. This behaviour is suggested to continue

until such time that the individual is rescued by a significant caregiver. Much of Melanie Klein’s theorising about the early destructive impulses of the child can be understood in this light. The early mothering is experienced as a permission to live (Yalisove, 1997).

Behaviourists have overlooked this problem because it represents, for the most part, unconscious fantasies demonstrable through the analysis of transferences and characterological patterns.

Implicit in operant conditioning is the concept that an organism will tend to repeat actions that bring it pleasurable consequences (rewards), thus suggesting a broader concept of motivation that goes beyond consciousness or reason.

By means of the BORRTI assessment (Bell, 2005), treatment recommendations for each individual have been outlined (Refer to Appendix K). To understand, broadly, what treatment would be best-suited to the inpatients with Alcohol Use Disorder at a tertiary-level psychiatric hospital assessed in the sample, a model of treatment has been superimposed on the BORRTI results.

The Centre for Substance Abuse Treatment (CSAT) presents four quadrants of care to assess the level of treatment that a client needs, which are based on the non-clarity of the causal relationship.

<b>Mental Disorder Severity</b>	<b>QUADRANT 1:</b> more severe mental disorder less severe substance use disorder	<b>QUADRANT 3:</b> more severe mental disorder more severe substance use disorder
	<b>QUADRANT 2:</b> less severe mental disorder less severe substance use disorder	<b>QUADRANT 4:</b> more severe substance use disorder less severe mental use disorder
<b>Substance Use Severity</b>		

Based on the above presented model, treatment needs to be comprehensive, integrated and continuous. ‘Comprehensive’ suggests that treatment should be able to respond to multiple issues. ‘Integrated’ refers to the fact that substance abuse and mental health treatment should be amalgamated in order to establish an adequate treatment plan. ‘Continuous’ treatment suggests that the client needs to be treated on an ongoing basis for a long period of time.

This model was applied to the profiles of the individuals assessed, based on their self-rating score on the AUDIT and their scores on the BORRTI. In the table below the 29 participants have been ranked in accordance with this model.

<b>Mental Disorder Severity</b>	<b>QUADRANT 1:</b>  Not relevant to any Participants in this study.	<b>QUADRANT 3:</b>  Relevant to Participants: 2, 3, 5, 10, 11, 12, 14, 16, 17, 18, 22, 25, 26, 28, 30, 32, 33, 34, 35, 37, 38, 40, 41 and 45.
	<b>QUADRANT 2:</b>  Relevant to Participant 8	<b>QUADRANT 4:</b>  Relevant to Participants: 21, 24, 29, 36 and 39.
<b>Alcohol Use Severity</b>		

The treatment plan for each of the participants in the different quadrants should vary, however a similar process should be followed for each participant in the same quadrant. The fact that the majority of the sample (24 out of 29 participants) falls into Quadrant 3 indicates complicated disorders, which lessen the prognosis of successful treatment. Importantly, the inpatients, due to their high levels of co-morbidity, have a poor prognosis in recovering from their Alcohol Use Disorder

unless treatment takes cognisance of the presenting complexity and tailor-makes interventions to target the presenting complexity.

Treatment from Jacobs' (cited in Yalisove, 1997) point of view should encourage the application of stress management and coping skill training techniques to alter negative self-concepts, and to increase adaptive and satisfying self-control and problem solving skills. According to Jacobs (cited in Yalisove, 1997), the entire spectrum of approaches must be applied in an integrated manner, if success rates are to increase.

Chafetz (cited in Yalisove, 1997) was a director of the first psychoanalytically-oriented outpatient alcoholism clinic. He went on to become the first director of the National Institute of Alcoholism and Alcohol Abuse. Key aspects of his therapy addressed disturbances of the alcoholic, as well as their sensitivity to disappointments. These individuals have a need for a positive relationship and self-disclosure by the therapist. The alcoholic patient should receive a detailed explanation of the process of therapy, the benefits of the treatment and the usefulness of mutual cooperation. The fixation at the early level of emotional development seems to have resulted from the deprivation in a significant emotional relationship during the early years of life. The symptom-choice of alcoholism seems to be culturally and environmentally determined. Treatment has been found to be most effective when managed so as to establish a warm, giving relationship within the limits of reality.

Although the results of this study indicate some correlations between alcohol use and ego function, specifically in terms of gender; similarities in white, Afrikaans-speaking males and females were identified; namely, high AUDIT scores and no pathological BORRTI scores. This is indicative that not all of these participants' drinking can be suggested to be as a result of poor object relations. The main argument is related to which disorder would be their primary diagnosis and in this case alcohol use is their primary diagnosis; however, based on the rest of the sample's results, it can be deduced that alcohol may present as a symptom, occurring as a result of their poor ego functioning. This



finding underlines the importance of differing between different forms of addiction in terms of severity and drugs of choice.

## **CHAPTER 5: CONCLUSION**

The overall conclusions, limitations and recommendations are discussed in this chapter.

### **5.1. OVERALL CONCLUSIONS**

The objectives of this research study were achieved in that the Object Relations of a group of individuals who used alcohol and had been admitted to a tertiary psychiatric hospital were explored, while the similarities and differences in the sample's object relations were also described.

Studies related to excessive alcohol use have been conducted using the BORRTI internationally. However, the same cannot be said for South African research, as no known studies have been carried out in South Africa using the BORRTI in relation to excessive alcohol use. In addition, the current study acknowledges that excessive alcohol use needs to take into consideration co-morbid psychiatric disorders.

Substance abuse has been proven to be an enormous social problem globally. The DSM-5 (2013) indicates that alcohol is the most commonly used brain depressant in most cultures, which effects society on all levels. Although alcohol abuse has a devastating effect on society in general, relapse rates remain alarmingly high. One reason for this is that no one model exists which adequately defines addiction, aetiology or a treatment plan that has a guaranteed success rate in terms of recovery.

One of the general findings of this study indicates male and female differences in ego functions as well as their pattern of alcohol consumption. The gender differences identified in the results of this study indicate large differences in the correlation of alcohol use and ego functions, so much so that it would seem a different diagnosis could be used for females and males.

The results of this study suggest that the definition, aetiology, prevalence and treatment of an individual with Alcohol Use Disorder should be separated according to gender. The findings indicate that females may not necessarily fit the same criteria as men as their pathology presents differently due to social stigma and genetics. The men's scores generally indicated more aggression and openness around their addiction, whilst the females in the sample were more prone to minimise their addictions. Findings of this study also indicate that the location of the individual would also affect the definition and aetiology of their disorders and treatment plan of the individual.

Fabricus et al. (2007) argue that there is compelling and reliable research which proves that strong gender difference exists with regard to mental illnesses and substance abuse. These findings indicate that female's internalise their problems and as a result suffer more from depression and anxiety. Males, however, were found to externalise more, resulting in them suffering more from delinquency, aggression and substance abuse. Social stigma has also been indicated to play a role in these statistics along with women being less likely than men to seek treatment due to limited finances and domestic responsibilities. Blume (1999) and Green (2006) suggest that this could be due to there being a greater stigma associated with female substance abuse and, furthermore, because women have trouble accessing treatment as they fear retribution from the social welfare system. This system often assumes child rearing to be the female's domain (cited in Fabricus et al., 2007).

Gender differences and alcohol use are supported by the findings in this study. When working out the correlation between alcohol use and the different ego functions and Reality Testing functions measured by the BORRTI, it is clear that gender differences exist in terms of these correlations too. Firstly, all barring one of the females' Pearson's Correlation Coefficients between the BORRTI and AUDIT scores were negatively correlated, meaning that the less alcohol they consumed, the higher their pathological BORRTI scores and vice versa. This could be due to the social stigma associated with alcohol use, so the women in their self-reporting could be 'downplaying' their alcohol

consumption. The females' results indicated statistically significant correlations for the Egocentricity subscale, followed by the Uncertainty of Perception subscale.

The males-only results indicate positive correlations between alcohol use and pathological BORRTI scores, with the statistically significant correlations being found for Uncertainty of Perception, Alienation, Hallucinations and Delusions and Social Incompetence.

This differences in gender scores could also be related to the fact that the AUDIT is not an accurate measure for both females and males. This highlights the importance of a nuanced assessment and treatment approach informed by gender differences.

Many women who abuse alcohol are often unidentified. Research evaluating the utility of current instruments suggests that many screening tools used are not sensitive to gender differences (Cherpietel, 1995, cited in Nemes et al., 2007). Research has identified differences between men and women alcoholics in relation to symptoms, consequences and help-seeking behaviours (Kordinak, Davis, & Morse, 1998).

Psychological differences in genders also exist (Banishek et al., 1992, cited in Nemes et al., 2007 p. 3). In the relationship between global psychopathology, depression, anxiety and alcohol treatment among 507 substance abuse patients, significant differences were found. This finding supports both previous and current studies that have found significant comorbidity of internalising disorders and alcohol abuse to be more prominent in women than men. Although establishing the direction for the relationship between internalising disorders and substance abuse continues, it is clear that negative emotional states is a risk factor for alcohol use.

Social factor differences also exist in terms of significantly higher rates of binge-drinking, family problems and financial problems appearing in men. Men are more likely than women to engage in occupationally and socially disruptive behaviours as a result of their alcoholism. In contrast, women are more likely to admit loss of control, experience emotional consequences and report alcohol

problems in their families. Ely and colleagues suggest that women are more likely to experience more psychological problems with their drinking than men because of the social stigma. Women are unlikely to receive treatment for alcohol problems due to a high prevalence of co-occurrence of mental health disorders, inadequate social and financial resources and a perceived stigma associated with drug abuse amongst women.

Although the entire sample of 29 participants showed some significant similarities in terms of their Hallucinations and Delusions, Reality Distortions, Uncertainty of Perceptions and feelings of alienation, these results could be linked to the fact that the sample comprised of individuals in a psychiatric institution, hence the importance of the therapist identifying all underlying disorders and treating them accordingly.

A holistic treatment model would then begin with an adequate and thorough diagnosis and an individually tailored treatment plan, which would amalgamate all of the main theorists who have had some success in treating addiction. In this light, Zweben, Bell, Khantzian, Kaufman, Levison and Vanicelli (cited in Yalisove, 1997) support the above point. Zweben et al. (cited in Yalisove, 1997, p. 349) coined the term “recovery-oriented psychotherapy”, which is a more specialised form of addiction-focused therapy than psychoanalytic therapy. The recovery-oriented psychotherapy is a combination of some cognitive behavioural approaches in combination with the disease concept and the psychodynamic approach.

The culminated emphasis of AA and psychotherapy of the addicted individual is to evoke, sustain and encourage moments of oneness. The bond is again invoked and strengthened, only this time it is held between humans rather than placed into substances.

In light of severe psychiatric disorders being co-morbid with substance-related disorders, CBT and the AA steps should be considered to treat the ‘surface’, behavioural problems of the individual.

These are less threatening forms of therapy, but vital in terms of stopping the self-destructive behaviour and having the addict re-immense themselves in relationships as opposed to alcohol.

Once a strong enough rapport is formed between the individual and the therapist, the therapist can start to bring in a more in-depth psychoanalytic treatment, focused on the individual's object relations. In accordance with the results of this study, this ordering of treatment approaches will allow for the individuals' Hallucinations and Delusions, Reality Distortions and Uncertainty of Perception to be more contained, either by medication or length of sobriety. Although these categories had the least amount of participants scoring pathological scores, treatment should start by addressing these categories, indicative of psychotic features, for the individuals who scored pathological scores in these subcategories. This can be done by using medication or abstinence from the substance before any real therapeutic work can take place.

The next areas that should take precedence in the treatment approach of individuals with Alcohol Use Disorder are Alienation and Egocentricity, which should be dealt with first as for both categories 19 of the 29 participants recorded pathological scores in these subcategories. This indicates that the first hurdles of object relations therapy are to focus on the therapist forming a deep and meaningful relationship with the patient and working with their egocentricity, mistrust of others, and their perceived controlling, manipulative and demanding behaviour.

Seventeen of the 29 participants had elevated scores in the Insecure Attachment subcategory; as such this should be dealt with early on in the therapeutic relationship in order for a therapeutic alliance to avoid being terminated. The findings of this study indicate that these individuals must be dealt with extreme care as they are highly sensitive to rejection and hurt, as they do not tolerate loneliness and have a deep need to be accepted by others. These individuals are prone to jealousy, anxiety and sadomasochistic binds, which are areas that should be addressed in therapy (Bell, 2005). Another aspect to be addressed in therapy is the high level of uncertainty, shyness and closeness that these

individuals suffer with as indicated by their results in the Social Incompetence subcategory of the BORRTI (Bell, 2005). If the theorist addresses these issues in a consistent and supportive manner, the therapist will become the soothing object which will be introjected and will assist the individual's ego functions to be strengthened. This will assist the individual in not engaging in dysfunctional behaviour, as stressed by numerous theorists including Spitz, Bowlby and Winnicott (cited in Flanagan, 2011). Fowler, Groat and Ulanday (2013), of the Menninger Clinic, in their study of 187 inpatients with substance use disorders with other co-morbid psychiatric disorders found that treatment needs to address the insecure attachment style of the patient over and above the complexity of other psychiatric disorders presenting alongside the substance-related disorder, in order to have better treatment outcomes.

In relation to Flanagan's (2011) statement, therapy should be a process whereby an individual's object relations develop to the point where they can distinguish themselves as separate beings from others, whilst still needing attachment to others – this is an ideal development that occurs in the case of individuals with a strong ego.

All 45 of the participants who took part in this study had been admitted into a specialised tertiary psychiatric institution due to the fact that their psychological life had become pathological in some form, which in this sample have presented in the form of Alcohol Use Disorder and an accompanying comorbid mood or personality disorder. Higher rates of comorbid SUD and psychiatric illnesses have been found to be linked to medication non-compliance, relapse and re-hospitalisation, work-related issues, financial problems, homelessness, HIV infection and an increased prevalence of suicide (Weich & Pienaar, 2009), so it is essential to adequately diagnose and treat these individuals.

Hasin et al. (2007) state that the level of co-morbidity increases with the severity of substance-related disorders, which is supported by the participants' BORRTI scores. All of the participants were

identified as having Alcohol Use Disorder and the fact that they have been admitted into a psychiatric institution together with their scores indicate that their level of pathology is severe.

Whilst treating the individual with Alcohol Use Disorder, a combined treatment approach should include interventions and coping mechanism training that support these individuals' impulsiveness and low frustration tolerance. In alignment with Freud (cited in Yalisove, 1997), individuals with an addiction need to learn to cope with pain and disillusionment, without making use of alcohol as a defensive function (cited in Yalisove, 1997), which according to Fenichel is a way of avoiding a depressive breakdown.

As can be noted, each psychoanalytic theorist discussed in this study has a different focus. Freud focused on an individual's childhood, whereas Klein stresses the importance of the internal world of the infant. Winnicott stressed the mother and infant unit, Kernberg's theory looks at the development of personality structures and Kohut specifically focused upon narcissism and the sense of self-development (Watts et al., 2009). Although their theories differ slightly, psychoanalysts believe that alcohol has become the alcohol abuser's sole love object and is experienced as part of the self, and this is what needs to be rectified in treatment.

According to the results of this study, these individuals appear to have compromised values and ideals, which can be linked to a lack of limit setting and trustworthiness versus narcissistic indulgence and rage. In therapy, boundaries and limit setting must be prioritised to prevent narcissistic indulgence and rage. Global fears of humiliation appear to play a dominant role in the social interaction of these participants, which are generally part of their make-up to begin with (Yalisove, 1997, p. 103).

Adequate therapy will prevent these individuals regressing to create the regressive narcissistic state of self-satisfaction, which appears to increase the self-esteem of the individuals. This is particularly relevant when we see this aim of drug use as an integral part of the narcissistic crisis that typically marks the onset of compulsive drug use. According to Yalisove (1997), the specific reason for the



onset of compulsive drug use lies in an acute crisis in which the underlying narcissistic conflicts are mobilised and the individual's affects connected with these conflicts break in with overwhelming force and cannot be coped with without the help of an artificial affect defense.

Peele (cited in Walant, 1995, p. 184) suggests that there must be a societal shift from the isolation presently found in our culture. Child-rearing practices must facilitate the development of values, including taking responsibility for one's own actions; developing a sense of achievement, self-awareness, and self-respect; and deepening intimacy.

According to Van Heerden, Grimsrud, Seedat, Myer, Williams and Stein (2011), there is limited data on substance use in South Africa and even less so with regard to alcohol use. However, most substance dependent individuals engage in polydrug use patterns that include alcohol. These findings underscore the need for an integrated treatment model to adequately address both substance use disorders and psychiatric co-morbidity.

Although there are clear differences between ethnic groups and their access to health care in South Africa, other aspects between ethnic groups and psychiatric disorders may be more complex, one being the heterogeneity of the construct of ethnicity (Stein et al., 2008). Urban and rural areas also have different prevalence rates when it comes to Alcohol Use Disorder.

A large amount of international literature has focused on the topic of co-morbid alcohol use and personality disorders, yet there is much less of a focus from South African authors and even less so in relation to co-morbid mood disorders. The majority of participants in the current study scored high scores on the BORRTI, indicating notable pathology.

Hasin, Stinson, Ogburn and Grant (2007) state that co-morbidity of alcohol dependence with depressive, bipolar, anxiety and personality disorders appears attributable to factors shared among these disorders. According to the individuals' BORRTI results, the factors were indicated to be

present in many of the participants who took part in this study. Within the current study, only a handful of individuals scored pathological audit scores and “normal” BORRTI scores (Bell, 2005).

Weich and Pienaar (2009) state that comorbid SUD and psychiatric illnesses are linked to increased medication non-compliance, relapse, career distress, hospitalisation and homelessness, all of which could be seen in the sample of participants in this study as a number of participants were homeless and the majority of them did not have employment.

According to Yalisove (1997), chemical dependency is multifactorial and multifaceted in aetiology. These factors are stated to be historical, sociocultural, psychological, sociological and genetic, which are suggested to interact in complex cause and effect relationships. Furthermore, it is suggested that many different types of drug addicts and alcoholics exist. Yalisove (1997) suggests that the traditional approaches mainly look at one aspect of addiction, however, it is suggested that in order to adequately deal with such disorders, an integrated view must be considered.

Flanagan (2011) suggests that all humans are affected by nature and nurture. From an object relational perspective, all humans are affected differently by their psychological strengths, vulnerabilities, past experiences, and social and cultural influences; each person’s body reacts differently to the experiences that it takes in. This is clearly supported by the findings of this study which indicate the different pathological internal structures in the BORRTI results.

Of the entire sample of 45 participants, only five indicated that they did not drink large amounts of alcohol, these being participants 4, 13, 27, 31 and 42. From an Object Relations perspective, it can then be said that the rest of the 40 individuals in this study have pathological attachments to alcohol. Due to 12 of the participants being excluded because of their high scores on the Inconsistency scale, the pathological attachment to alcohol and the corresponding ego functioning for these individuals could not be analysed.

As can be noted, only six of the 29 participants (8, 21, 24, 29, 36 and 39) of the valid sample did not score any pathological scores, which suggests that their ego functioning in these categories is reasonably normal. This suggests that the rest of the sample, being 23 participants, all have pathological ego functions. It could then be theorised that the 23 possibly had a premorbid psychological disorder, which assisted in the development of Alcohol Use Disorder. The six with stable ego functions could possibly have a principal diagnosis of Alcohol Use Disorder.

Jacobson (cited in Yalisove, 1997) stresses the importance in building a theory focused on addictions as a united class of behaviour and the ultimate goal is stated as being descriptive models that will aid in better understanding the addictive process, as well as facilitate early identification and prompt treatment of persons at risk for developing addictive patterns of behaviour.

The findings of this study once again allude to the importance of closing the gaps in the literature, which West and Hardy (2006) emphasise in *The Theory of Addiction*. West and Hardy (2006) refer to the fact that there are many theories on addiction but they are all vastly different, which results in some addressing certain issues, but leaving gaps in most of the theories. As a result of this, West and Hardy (2006) proposed a conceptual framework within which all the differing theories can be placed.

According to West and Hardy (2006), the problem with developing an all-encompassing theory of addiction is the fact that addiction, like social and behavioural science, develops theories that are not complete in terms of analysing the existing literature. This is also due to the fact that theories are not compared with one another directly. This results in theories in these fields not providing a comprehensive account of the topic, but rather particular approaches which are not connected in a framework. In this way one theory could be construed as being less important than another.

In line with this, Meehl (1978, cited in West and Hardy, 2006) states that social and behavioural science theories go out of fashion and rather than being abandoned, the theory becomes part of a multiple theoretical approach, which West and Hardy (2006) state is not conducive to any progress

being made. For theory development to proceed, a much fuller analysis is needed. In relation to addiction, West and Hardy argue for a more comprehensive approach to addiction that takes into consideration all that has been found in addiction studies, including the diversity of addiction, attendant social and economic issues and neuroscience's relationship with addiction.

## **5.2. LIMITATIONS**

In the current study, purposive sampling was used, which resulted in more males being included in the sample than females. The sample was comprised of patients admitted into a government tertiary psychiatric institution and the requirements of this study were specific in terms of diagnoses. The psychiatric team was asked to refer any individuals who firstly had been diagnosed with Alcohol Use Disorder and, secondly, had a co-morbid psychiatric illness (a diagnosis of a mood or personality disorder). The team of professionals reported it as being a challenge to identify such individuals as the majority of their patients struggle with substance abuse problems and have different disorders. This exploratory study focused on Alcohol Use Disorder in a psychiatric hospital, not an alcohol-focused rehabilitation centre. Therefore, the entire sample comprised of individuals diagnosed with co-morbid psychiatric disorders.

Furthermore, the sample comprised of individuals in the early phase of recovery, which did affect their scores. Forty-five inpatients volunteered to be assessed, but only 29 did not meet any of the exclusion criteria, which could have been due to the individual's lack of insight and level of mental health. Many were excluded due to haphazard scoring.

Of the five participants who indicated that they did not suffer from problem alcohol use, four of them were women. The correlation between alcohol use and ego function being negative is also an indication of lack of insight or a problem with the alcohol use screening tool that was used.

All of the participants had been diagnosed with an Alcohol Use Disorder as well as a personality or mood disorder; however, a number of the participants minimised their alcohol use. This can be seen in the results of the AUDIT, where a number of participants scored on the lowest level of alcohol problem, namely between eight and fifteen. Five of the participants scored themselves below 8, suggesting that they do not have a problem with alcohol; 14 of the 43 interviewees scored themselves in the least problematic alcohol use category. Six scored themselves in the next level of problematic alcohol use scoring between 16 and 19. Only 16 of the 43 participants indicated having severe problems with alcohol abuse by scoring above 20. This again indicates a problem with the screening tool or a lack of insight on the part of the participants.

Definite deficits of the ego functioning of the participants of this study were identified by the BORRTI, however, future studies may wish to focus on a detailed analysis of the causes of a subsequent addiction in relation to the Object Relations theory, utilising detailed background information case notes of each patient.

Although Object Relations theory is linked to both the nature and nurture debate, no real attention was given to the social and cultural backgrounds of the individuals in this study. According to the findings of the SASH survey (2009), cultural differences make a difference to drug and alcohol and substance abuse.

The results of this study make general statements regarding gender differences, but differences in alcohol use has been linked to gender as well as to different regions, and it is therefore important to explore these gender and regional differences in more detail as they can influence treatment strategies.

The BORRTI is a useful and rich assessment tool that provides a high-level overview of the individual's object relations. However, this information would ideally be linked to the clinical interviews or sessions conducted by the patients' psychologists in order to enhance treatment.

Gender differences in alcohol use and co-morbid psychiatric disorders were indicated in the results of this study. This study only focuses on individuals with co-morbid alcohol use disorders and personality/ mood disorders, yet there are a range of different disorders that were identified by the BORRTI and literature places much emphasis on the high prevalence rates of anxiety disorders.

Tyrer, Casey and Ferguson; Dowson and Grounds (1995), and Edward, Marshall and Cook (2003) indicate that a high correlation was found between alcohol use and personality disorders. In the same study, depression was the premorbid diagnosis, something this study did not assess either. Tyrer, Casey and Ferguson (1988) indicate that 69% of individuals with alcohol dependence meet the diagnosis of a personality disorder. However, this was not possible to prove in this study due to the sample comprising of personality and mood disorders only.

Different socioeconomic data was not assessed, nor were relapse rates. Many of the individuals assessed had been homeless. This could be linked to lack of a safe object being internalised and the reason they would go back to drinking. Hasin et al. (2007) state that the level of co-morbidity increases with the severity of substance-related disorders. The severity of alcohol use was measured according to a screening instrument, being the AUDIT. No further investigation was conducted.

According to a number of researchers, including Quello et al. (2005), mood disorders are the most common psychiatric co-morbidity of patients with substance use disorders. Some affective disorders were indicated in the BORRTI, which according to Quello et al. (2005) could be accounted for by the fact that alcohol withdrawal can cause temporary depression.

Quello et al. (2005) further state that the high rates of co-morbidity and substance abuse and mood disorders could be accounted for by the fact that the pathological effects of one of the disorders increases the risk for the other disorder. This could also be due to affect control or mood disorders. The current study focused on assessment measures in terms of co-morbidity and hence did not utilise detailed background data nor the treatment plan of the inpatients.

### **5.3. RECOMMENDATIONS**

Purposive sampling was used, which resulted in more males being included in the sample than females. While this could have skewed the overall results, it allowed for findings to appear regarding the differences of males and females which should be explored in more detail in the future. It would possibly be easier to find patients with this specific diagnosis in a rehabilitation centre that is primarily focused on alcohol-dependent individuals. The entire process could be easier and faster if a sample was attained from a rehabilitation centre.

A longitudinal study is recommended in order to see the differences in different individual's Object Relations and their insight as they abstain from alcohol and become healthier. In this way the results of different treatment techniques can be analysed in detail. Different screening methods could be used to test different samples of males and females.

It may be more beneficial to test a sample who has been in recovery for a longer period of time, as the patients may not deny the extent of their alcohol misuse to the same degree. A longitudinal study should be conducted, in which detailed data on all individuals admitted into hospital treatment are analysed. The same study could also be conducted in an alcohol-focused rehabilitation centre, which only focuses on alcohol.

A study having detailed information regarding each participant's background will assist in being able to provide more information regarding aetiology of Alcohol Use Disorder, which will then result in better suited treatment plans for the treatment of affected individuals. For example, Khantzian (cited in Bean et al., 1981, p. 171) argues that alcohol use is based on self-medication, in which case the individual attempts to self-medicated feelings by using alcohol. To establish this in more detail a study should be conducted where in the individual are asked to identify their triggers as well as provide more background information.

Studies should be conducted, which focus on attaining more social and cultural information, which can be linked to a detailed nature vs. nurture debate in relation to addiction. A more detailed analysis of gender and regional differences with regards to Alcohol Use Disorder, appears warranted based on gender differences found in the current exploratory study conducted in Gauteng.

Socioeconomic data should be attained in order to understand the influence of these factors on Object Relations. This will assist in providing a fuller picture.

Detailed description of the different levels of alcohol misuse within each participant should be studied. More detailed data could be collected regarding drinking and co-morbid disorders to see if severity influences the level of co-morbidity as suggested by Hasin et al. (2007). To ensure that an incorrect diagnosis is not given, a detailed background history is needed.

Finally, data regarding previous hospital/ rehabilitation admissions is needed as well as details regarding psychological functioning and disorders. This recommendation is supported by the National Co-morbidity Survey (NCS) (1991) and the ECA (1994) it would be suggested that more research is carried out on substance abuse and co-morbid disorders. Perhaps a study which focuses on polydrug use would be more effective to assess co-morbidity.

Lastly, more detailed research on the co-morbid interplay of DSM-5 disorders needs to be a key priority within the South African context to enhance treatment plans for individuals with co-morbid psychiatric disorders to reduce the high relapse rate of addiction.



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## **APPENDICES**

### **APPENDIX A: DSM-5 DIAGNOSTIC CRITERIA FOR ALCOHOL USE DISORDER**

- A. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:
1. Alcohol is often taken in larger amounts or over a longer period than was intended.
  2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
  3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from the effects.
  4. Craving, or a strong desire or urge to use alcohol.
  5. Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home
  6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
  7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
  8. Recurrent alcohol use in situations in which it is physically hazardous.
  9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
  10. Tolerance, as defined by either of the following:
    - a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect
    - b) markedly diminished effect with continued use of the same amount of alcohol
  11. Withdrawal, as manifested by either of the following:

- a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for alcohol Withdrawal from the specific substances, APA, 2013, p. 499-500)
- b) Alcohol (or a closely related) substance such as a benzodiazepine is taken to relieve or avoid withdrawal symptoms

Severity specifiers:

Moderate: 2-3 symptoms

Severe: 4 or more symptoms

Specify if: With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 4 or 5 is present). Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 4 nor 5 is present)

Adapted from APA (2013, p. 490-491)

**APPENDIX B: LETTER TO GATEKEEPER**

15 March 2014

Dear Mrs Mabena

**RE: RESEARCH STUDY**

My name is Maeve Erasmus. I am currently completing a quantitative study in fulfilment of my master's degree in research psychology at the University of South Africa under the supervision of Christine Laidlaw (clinical psychologist PS0112887). This research aims to describe the Object Relations of Individuals with a psychiatric diagnosis together with alcohol use. The study will contribute to the discipline of psychology to gain an in-depth understanding of the Object Relations of individuals with co-morbidity of a Depressive or Bipolar disorder and/or personality disorder and use of alcohol (i.e. personality dynamics).

My choice of topic is based on the fact that there is a general lack of research in South African literature which focused on psychiatric co-morbidity (with alcohol use) and Object Relations. Current research indicates that although many studies focused on Object Relations and Alcohol Use Disorder have been carried out internationally, far fewer have been carried out in South Africa. Taking this point further, many studies have been conducted internationally which explore different aspects of alcohol use by using the Bells Object Relations and Reality Testing Inventory (BORRTI) and Alcohol Use Disorders Identification Test (AUDIT). However, the same cannot be said for South African Research, as no current studies have been carried out in South Africa using the BORRTI in relation to psychiatric illnesses together with alcohol use. Furthermore, there is limited research internationally which assess the Object Relationships of individuals with alcohol use.



I hereby ask permission to access 50 of your patients who are willing to participate in my study and who meet the diagnosis for a depressive or bipolar disorder and/ or personality disorders and who use alcohol, with or without a personality disorder. All volunteering participants in the study will remain anonymous in that, while their test results will be made known, their identities will remain confidential. Should the participant wish the results of the test, taken under research conditions, to inform their treatment, a report will be provided to their treating clinical psychologist. The administering of the psychometric tests will take place for approximately 60 minutes. Interviewees may refuse to answer any question and may withdraw at any point that they wish. Non-participation or withdrawal in the study will not have any negative consequences for you in any way.

Debriefing and information resources will be provided to the hospital should it be required. The anonymous results will be included in the final work with all identifying remarks and names changed. Feedback regarding the study's outcomes will be made available to all those interested.

**You are in no way required to participate in this study. If you have any queries do not hesitate to ask me. It is necessary for me to obtain your informed consent in order to conduct the study.**

Your support is greatly appreciated.

Yours faithfully

**Researcher: Maeve Erasmus**

Cell no:

Email:

**Supervisor: Christine Laidlaw**

University of South Africa

Tel: +27 12 429 8294

**[laidlc@unisa.ac.za](mailto:laidlc@unisa.ac.za)**

**Head of Departmental Ethical Committee: Prof Kruger**

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## **APPENDIX C: INFORMATION LETTER GIVEN TO POTENTIAL PARTICIPANTS**

15 March 2014

Dear Participant,

I am currently completing a study regarding the Object Relations of individuals who use alcohol and have a co-morbid Depressive or Bipolar disorder and/ or personality disorders, who are in the early recovery stage to inform psychotherapy from an OR perspective. Object Relations refer to a Psychological therapeutic approach, a school of thought which developed from psychodynamic theories. I have obtained the required permission from the relevant faculties for this research to be conducted. I would like to enlist your help in this study.

You are required to note that you are only eligible to participate in this study if you are an individual who uses alcohol and has a co-morbid Depressive or Bipolar disorder and/ or Personality disorders and in the early stage of recovery (have abstained for 4 months).

The information in this study will be gathered in the form of three questionnaires. The first two questionnaires will take ten minutes to complete and the third questionnaire will take approximately half an hour to complete. The first questionnaire gathers biographical information. The AUDIT will be used to assess your level of Alcohol Use Disorder. The BORRTI will be used to assess your Object Relational functioning.

Please be aware that your participation in this study is entirely voluntary. You are not obliged to participate. Should you wish to participate, you will remain completely anonymous at all times. Your identity will not be disclosed under any circumstances. Your responses to the questionnaires will be kept confidential. You are thus kindly requested to answer all questions as honestly as possible. Should you wish to withdraw from the study whilst completing the questionnaires, you are entirely free to do so, in which case you will not be used as a participant.

Should you wish to participate in the study, you will be asked to provide your written consent by signing and dating an informed consent form and placing your initials against each section to indicate that you understand and agree to the conditions of this research study. Please note that a specific number of completed questionnaires will be selected at random to be used in the study. Therefore, your questionnaire may or may not be selected for the study.

Feedback to this study will be provided in the form of a written report which will be available at your request at the UNISA's Main library. Please note that no individual feedback will be able to be given regarding the results. Please send an e-mail (to the below e-mail address) should you like a copy of a report of the study.

Your assistance will be greatly appreciated. Should you require any more information regarding the study, please do not hesitate to contact me at .....

Thanking you in advance.

Yours Sincerely

Ms. Maeve Erasmus

Researcher

Prof. Kruger

Head of Ethical Research Committee of Department of Psychology

Ms. Christine Laidlaw

Supervisor/ Clinical Psychologist

## APPENDIX D: INFORMATION VERBALLY PRESENTED TO PARTICIPANTS

### INTRODUCTION

I am a Masters student doing research on the Object Relations of individuals who use alcohol and have a co-morbid Depressive or Bipolar disorder and/ or Personality disorders. Object Relations are a psychological therapeutic approach, a school of thought which developed from psychodynamic theories.

### GOAL

It is my goal to explore the relationship between alcohol use and Object Relations. I would like to request that you consider participating in my research study. If you do decide to participant, you will be required to complete a consent form as well as three questionnaires, which you will find in the envelope I handed to you in the beginning of this session.

### SAMPLE

This study focused on individual who are dependent on alcohol and as such I would only like to interview people who are alcohol dependent and in the early phase of recovery.

### RIGHT

I will discuss your rights in detail when we go through the consent form, but please be aware that you are free to withdraw from this study at any time and without any penalty.

### REQUEST

If you meet the criteria for this study and you are willing to participate in this study, please stay seated. If you are not interested and/or you do not meet the criteria of this study, please leave the room now.

### BEFORE WE BEGIN

Thank you for choosing to be part of this study, please remember that should you feel uncomfortable at any stage during the testing you are free to withdraw from this study. At this stage I would like to give you some reassurance in the fact that all the identification information that is gathered from this assessment session today will remain confidential. Your identity will also remain anonymous.

### ETHICAL PROCEDURES

I'd like to further reassure you that this research is done according to strict ethical procedures stipulated by the University of South Africa.

### OPEN ENVELOPE

Please can you all remove the contents of your envelopes, you should each have a pencil and an eraser, and three documents, namely the:

1. 2x Consent Forms (one copy for you and one for me)
2. Biographical Questionnaire and AUDIT
3. BORRTI

Please check that the number you initially signed for corresponds with all your documents.

### CONSENT FORM

- Let us work through this consent form together. The title of this research is The Object Relations of individuals who misuse alcohol and have co-morbid Depressive or Bipolar Disorders and/or Personality Disorders receiving treatment in a South African psychiatric hospital, we will discuss this in more detail in a short while.
- Your reference number reflects next.
- My supervisor is Christine Laidlaw and she works at the UNISA.
- My name is Maeve and I will be administering your assessments today.

## SECTION A1: CONFIRMATION OF PARTICIPANT

### AIM OF STUDY

- If you agree with the fact that you were invited to participate in this study by myself, please indicate your confirmation by signing on the line, in the block on the right hand side of the page.
- If you agree with the fact that you were made aware of the aim of this study that the information gained in this study will be used in fulfilment of the requirements for the degree MSc Research Psychology in the Faculty of Human Social Sciences at the University of South Africa, please indicate this by signing on the line, in the block on the right hand side of the page.

## SECTION a2: DECLARATION OF PARTICIPANT

### PROCEDURES, RISKS and RIGHTS

Herewith I, the Participant understand that by initialling in the block provided that I consent to the procedures, risks, and confidentiality limits of this study. I also agree that the Researcher has explained the access to findings as well as the fact that my participation in this study is voluntary.

Participant Number: \_\_\_\_\_ Signature:

\_\_\_\_\_

### RESEARCH PROCEDURE

You will be required to complete:

- Consent form
- Biographical Questionnaire and the Alcohol Use Disorder Test
- Bell Object Relations and Reality Testing Inventory

The results of these tests will be interpreted by a Clinical Psychologist – these results will be used for research purposes.

A report of the findings can be provided to your treating clinical Psychologist, on your written request.

If you understand and are happy with this section, please sign in the right hand block.

### RISKS

There are no potential harmful risks have been identified which are associated with participating in the current study.

If you understand and are happy with this, please sign in the right hand block.

### CONFIDENTIALITY

As already discussed your identity will be kept anonymous, and the results will be kept confidential.

If you understand and are happy with this, please sign in the right hand block.

Anonymous results will be shared as follows:

- A written report of the study will be available at the University of South Africa's Main Library.
- Articles of the study will be published in a relevant scientific journal.

Should the opportunity arise, a presentation of the research will be made at a conference.

### REPORTS

By participating in this study you may learn more about these interesting constructs. If you would like to know the outcome of the research study, there will be a report available at the University of South Africa's main library which will be available for you to read. You can also request a copy of a report, which will be given to your treating Clinical Psychologist on your written request.

If you understand and are happy with this, please sign in the right hand block.



### VOLUNTARY PARTICIPATION:

- My participation is voluntary – please indicate yes or no in blocks provided.
- My decision whether or not to participate will in no way affect my present or future care, employment or lifestyle – please indicate yes or no in blocks provided.

If you understand and are happy with this, please sign in the right hand block.

### LANGUAGE

- The information above was explained to me/the participant by the Researcher (Maeve Erasmus) in English and I am in command of this language.
- I was given the opportunity to ask questions and all these questions were answered satisfactorily.

If you understand and are happy with this, please sign in the right hand block.

### PRESSURE

- No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.

If you understand and are happy with this, please sign in the right hand block.

### COST

- Participation in this study will not result in any additional cost to me.

If you understand and are happy with this, please sign in the right hand block.

### ANY QUESTIONS

- If yes, please sign the section which states: I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED STUDY
- Please add in the date today and sign.

- I will witness all your documents.

SECTION B: STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)

I Maeve Erasmus declare that:

- I have explained the information given in this document to Participant
- Participant was encouraged and given ample time to ask me any questions; this conversation was conducted in English and that and no translator was used.
- I have asked the Participant to detached Section C, and explained to the participant that this section is to be kept by them.

SECTION C EXPLAINED:

Thank you for your participation in this study.

Should, at any time during or after the study experience one of the below scenarios:

- An emergency arises as a result of your participation in the research
- You require any further information with regard to the study, or
- You would like to speak to the Supervisor of this study or the Researcher herself

Kindly contact Maeve Erasmus on 012 361 3475.

Please witness the page and make sure you have removed Section C.

SIGN EACH PAGE

To protect your interests during the research and to comply with the ethical procedures of conducting research at the University of South Africa, you are requested to initial each page of the informed consent form. This will indicate that you understand the nature of the study and what your participation will entail.

## CONSENT FORMS INTO ENVELOPE

Please place your consent form into the envelope

## BIOGRAPHICAL QUESTIONNAIRE & AUDIT

Please complete the biographical questionnaire and then each question of the AUDIT.

In the biographical questionnaire complete:

- Date
- Participant Number
- Gender
- Ethnicity
- Age
- English Language
- Education Level
- Months of sobriety
- Been admitted to treatment before

## AUDIT

Please specify the kind of alcohol you are referring to when you answer the first two questions.

## BIOGRPHICAL QUESTIONNAIRE & AUDIT COMPLETED

When you have completed these, please put the Biographical questionnaire and AUDIT back into your envelope.

## BORRTI

Please take the BORRTI, who will read instructions for us?

“First fill in the background information. Next, read each item carefully, and then circle the letter that shows your answer. Respond according to your most recent experience. If a statement tends to be true for you then circle T in the column labelled True. If a statement tends to be false then circle F in the column labelled False. Circle only one letter for each statement. Please try to respond to all statements. Please press hard when marking your responses”.

**BORRTI COMPLETED**

Place test in envelope once you have completed it and bring it back to me. Once again, I thank you for your valued participation. If you have any questions or concerns about your participation in the study do not hesitate to ask me or to contact me.

**APPENDIX E: INFORMED CONSENT**

UNIVERSITY OF SOUTH AFRICA

<b>INFORMATION AND INFORMED CONSENT FORM</b>	
<b>Title of the research project</b>	A study of the Object Relations of individuals' personality structure who use alcohol and have co-morbid Depressive or Bipolar Disorders and/or Personality Disorders in the early phase of recovery.
<b>Participant Reference number</b>	
<b>SUPERVISOR</b>	Christine Laidlaw
<b>Address</b>	University of South Africa Preller Street Muckleneuk Ridge

	<p>Pretoria</p> <p>0003</p> <p>P.O. Box 392, UNISA, 0003</p>
<b>Researcher</b>	Maeve Erasmus
<b>Contact email</b>	

<p><b>SECTION a1: CONFIRMATION OF PARTICIPANT</b></p> <p><b>AIM OF STUDY</b></p>	
<p>I, the participant, was invited to participate in the above-mentioned research project that is being undertaken by Researcher, Maeve Erasmus.</p> <p>This study is for the Department of Psychology, a faculty of the University of South Africa (UNISA).</p>	<hr/>

**The following aspects have been explained to me, the participant:**

The Aim of this study is to assess the Object Relations of individuals with Alcohol Use Disorder in the early phase of recovery.

The information gained in this study will be used in fulfilment of the requirements for the degree MSc Research Psychology in the Faculty of Human Social Sciences at the University of South Africa.

**SECTION a2: DECLARATION OF PARTICIPANT**

**PROCEDURES, RISKS and RIGHTS**

**Herewith I, the Participant understand that by initialling in the block provided that I consent to the procedures, risks, and confidentiality limits of this study. I also agree that the Researcher has explained the access to findings as well as the fact that my participation in this study is voluntary.**

**Participant Number: \_\_\_\_\_ Signature:**

\_\_\_\_\_

<p><b>Research Procedure:</b></p> <p>I will be required to complete this Consent form, the provided Biographical Questionnaire, the Alcohol Use Disorder Test the Bell Object Relations and Reality Testing Inventory which will be interpreted by a clinical psychologist.</p> <p>The results will be used for research purposes and a report of the findings can be provided to your treating clinical Psychologist, on your written request.</p>	<hr/>
<p><b>Risks:</b></p> <p>There are no potential harmful risks have been identified which are associated with participating in the current study.</p>	<hr/>
<p><b>Confidentiality:</b></p> <p>My identity will not be revealed in any discussion, description or scientific publications by the investigators.</p> <p>Anonymous results will be shared as follows:</p> <ul style="list-style-type: none"><li>• A written report of the study will be available at the University of South Africa's Main Library.</li></ul>	



- Articles of the study will be published in a relevant scientific journal.

Should the opportunity arise, a presentation of the research will be made at a conference.

---

**Voluntary participation:**

My participation is

voluntary

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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My decision whether or not to participate will in no way affect my present or future care, employment or lifestyle

<input type="checkbox"/>	TRUE	<input type="checkbox"/>	FALSE
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**Language:**

The information above was explained to me/the participant by the Researcher (Maeve Erasmus) in English and I am in command of this language.

I was given the opportunity to ask questions and all these

questions were answered satisfactorily.	<hr/>
<b>Pressure:</b>  No pressure was exerted on me to consent to participation and I understand that I may withdraw at any stage without penalisation.	<hr/>
<b>Cost:</b>  Participation in this study will not result in any additional cost to me.	<hr/>
<p><b>I HEREBY VOLUNTARILY CONSENT TO PARTICIPATE IN THE ABOVE-MENTIONED STUDY</b></p> <p><b>Signed/confirmed at Pretoria on this day the _____ March 2014.</b></p>  <p><b>Signature of a Witness, signed at Pretoria on this day the _____ March 2014.</b></p>	

**SECTION b: STATEMENT BY OR ON BEHALF OF INVESTIGATOR(S)**

I, Maeve Erasmus declare that, I have explained the information given in this document to Participant number \_\_\_\_\_.

I, Maeve Erasmus also declare that the Participant was encouraged and given ample time to ask me any questions, that this conversation was conducted in English and that no translator was used.

I have detached Section C and handed it to the participant.

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
--------------------------	-----	--------------------------	----

**Signed/confirmed at Pretoria on this day the \_\_\_\_\_ March 2014.**

**Signature of a Witness, signed at Pretoria on this day the \_\_\_\_\_ March 2014.**

**SECTION c:**

**IMPORTANT MESSAGE TO PARTICIPANT**

Dear Participant

Thank you for your participation in this study.

Should, at any time during or after the study experience one of the below scenarios:

- An emergency arises as a result of your participation in the research
- You require any further information with regard to the study, or
- You would like to speak to the Supervisor, Christine Laidlaw of this study or the Researcher herself – .....

Kindly contact Maeve Erasmus on .....

**APPENDIX F: BRIEF BIOGRAPHICAL QUESTIONNAIRE**

<b>BRIEF BIOGRAPHICAL QUESTIONNAIRE</b>			
<b>DATE</b>			
<b>PARTICIPANT NUMBER</b>			
<b>GENDER</b>			
<b>ETHNICITY</b>			
<b>AGE</b>			
<b>ENGLISH LANGUAGE</b>	1 <sup>ST</sup> Language	2 <sup>nd</sup> Language	3 <sup>rd</sup> Language
<b>EDUCATION LEVEL</b>			
<b>MONTHS OF SOBRIETY</b>			
<b>Have you sought treatment before? If Yes, what year(s) and what kind:</b>			
<hr/>			
<hr/>			
<hr/>			

**APPENDIX G: ALCOHOL USE DISORDER TEST (AUDIT)**

**QUESTION 1**

**How often do you have a drink containing alcohol?**

**Specify kind of alcohol:** \_\_\_\_\_

(0) Never (Skip to Questions 9-10)

(1) Monthly or less

(2) 2 to 4 times a month

(3) 2 to 3 times a week

(4) 4 or more times a week

**QUESTION 2**

**How many drinks containing alcohol do you have on a typical day when you are drinking?**

**Specify kind of alcohol:** \_\_\_\_\_

(0) 1 or 2

(1) 3 or 4

(2) 5 or 6

(3) 7, 8, or 9

(4) 10 or more

**QUESTION 3**

**How often do you have six or more drinks on one occasion?**

(0) Never

(1) Less than monthly

- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

#### **QUESTION 4**

**How often during the last year have you found that you were not able to stop drinking once you had started?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

#### **QUESTION 5**

**How often during the last year have you failed to do what was normally expected from you because of drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

#### **QUESTION 6**

**How often during the last year have you been unable to remember what happened the**

**night before because you had been drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**QUESTION 7**

**How often during the last year have you needed an individual with alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**QUESTION 8**

**How often during the last year have you had a feeling of guilt or remorse after drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily



**QUESTION 9**

**Have you or someone else been injured as a result of your drinking?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

**QUESTION 10**

**Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

**APPENDIX H: THE BELLS OBJECT RELATION AND REALITY TESTING INVENTORY (BORRTI)**

DIRECTIONS

First fill in the background information. Next, read each item carefully, and then circle the letter that shows your answer. Respond according to your most recent experience. If a statement tends to be true for you then circle T in the column labelled True. If a statement tends to be false then circle F in the column labelled False. Circle only one letter for each statement. Please try to respond to all statements. Please press hard when marking your responses.

1. I have at least one stable and satisfying relationship.
2. Sometimes I think I have been possessed by the devil.
3. If someone dislikes me, I will always try harder to be nice to that person.
4. I would like to be a hermit forever.
5. I usually have trouble deciding if something really happened to me or if it was a dream.
6. I may withdraw and not speak to anyone for weeks at a time.
7. Even if my perceptions are inaccurate, I am luckily aware of it and I can correct myself easily.
8. I usually end up hurting those close to me.
9. Drinking alcohol or smoking marijuana can so drastically affect my mind that I cannot be sure of what is real.
10. I believe that people have little or no ability to control their sorrows.
11. My people treat me more like a child than an adult.
12. I experience hallucinations.
13. If someone who I have known well goes away, I will miss that person.
14. I can deal with disagreement at home without disturbing my family relations.
15. I feel out of touch with reality for days at a time.
16. I am extremely sensitive to criticism.

17. Exercising power over other people is a secret pleasure of mine.
18. At times I will do almost anything to get my way.
19. I possess mystical powers.
20. When a person close to me is not giving me his or her full attention I often feel hurt or rejected.
21. I am usually able to size up a new situation quickly.
22. If I become close with a person and he or she proves untrustworthy, I may hate myself for the way the things turned out.
23. I almost never have reason to doubt the accuracy of my own perception of reality.
24. I know my own feelings.
25. It is hard for me to get close to anyone.
26. My sex life is satisfactory.
27. There is an organized plot against me.
28. I tend to be what others expect me to be.
29. No matter how bad a relationship may get I will hold on to it.
30. I feel my thoughts are taken away from me by an external force.
31. I do not usually have strong opinions about things.
32. I have no influence on those around me.
33. I have the feeling that I am a robot, forced to say things or do things without a will of my own.
34. People do not exist when I do not see them.
35. Often, I read things in other people's behaviour that really aren't there.
36. I've been hurt a lot in life.
37. I have someone with whom I can share my innermost feelings and who shares such feelings with me.
38. I believe that I am being plotted against.
39. No matter how hard I try to avoid them, the same difficulties crop up in my relationships.

40. I am being followed.
41. I yearn to be completely “at one” with someone.
42. I am not sure what month or year this is.
43. I am usually able to say the right thing.
44. In relationships, I am not satisfied unless I am with the other person all the time.
45. I experience strange feelings in various parts of my body that I can't explain.
46. Being independent is the only way not to be hurt by others.
47. I am a very good judge of other people.
48. Relationships with people of the opposite sex always turn out the same way with me.
49. Others frequently try to humiliate me.
50. I can hear voices that other people cannot seem to hear.
51. I am rarely out of touch with my own feelings.
52. I can rely on others to make my decisions for me.
53. It is common for me to be convinced that people, places, and things are familiar to me when I really do not know them.
54. I am usually sorry that I trusted someone.
55. When I am angry with someone close to me, I am able to talk it through.
56. My thoughts are being broadcast so that other people know what I am thinking.
57. People are often angry at me, whether they admit it or not.
58. Manipulating others is the best way to get what I want.
59. I often feel nervous when I am around members of the opposite sex.
60. At times I feel like my body is being changed into that of the opposite sex.
61. I often worry that I will be left out of things.
62. I feel that I have to please everyone or else they might reject me.
63. People who hardly know me are reading my thoughts whenever they want.

64. Sometimes I have dreams so vivid that, when I wake up, it seems like they really happened.
65. I shut myself up and do not see anyone for months at a time.
66. I am sensitive to possible rejection by important people in my life.
67. I am often the victim of the cruelty of other people.
68. Making friends is not a problem for me.
69. I believe that I am a condemned person.
70. I do not know how to meet or talk with members of the opposite sex.
71. When I cannot make someone close to me do what I want, I feel hurt or angry.
72. I hear voices that others do not hear, which keep up a running commentary on my behaviour and thoughts.
73. It is my fate to lead a lonely life.
74. I am under the control of some force or power other than myself, which forces me to think things or have impulses that are not my own.
75. My mood affects how I see things.
76. People are never honest with each other.
77. I can always distinguish between reality and fantasy, even during the time I am going to sleep or awakening.
78. I put a lot into relationships and get a lot back.
79. I have the feeling the world is about to come to an end soon.
80. I feel shy about meeting or talking with members of the opposite sex.
81. The most important thing to me in a relationship is to exercise power over the other person.
82. I have a good sense of direction and virtually never lose my way.
83. I try to ignore all unpleasant events.
84. I experience anxious feelings that I cannot explain.
85. When I drink or use drugs, it seems as if those around me have it in for me.

86. I pay so much attention to my own feelings that I may ignore the feelings of others.
87. I frequently do not know where I am, even in my own neighbourhood.
88. I have a hard time accepting the reality of tragic events in my life, like a death in the family.
89. I believe that a good mother should always please her children.
90. Sometimes I see only what I want to see.

## **APPENDIX I: PSYCHOLOGICAL CONSTRUCTS DEFINED**

1. Alienation (ALN) – individual who scores on this subscale finds it difficult to trust and have intimate relationships, which results in their relationships being generally unstable. These individuals are often suspicious, guarded and isolated. They could be angry and hostile and as such their empathy is limited. This subscale measures the broadest dimension of Object Relations. Individuals scoring high on this subscale have a lack of trust and are unable to attain closeness in relationships. They may feel suspicious and therefore isolate and guard themselves. These individuals also lack empathy and the motivations and inner states of others are misjudged or ignored. Borderlines score high on this scale, which correlates positively with depression, a comorbid disorder found with Borderline personality disorder (cited in Bell, Bellington & Becker, 1986).
2. Insecure Attachment (IA) – Insecure attachment refers to individuals who are extremely sensitive to rejection and easily hurt by others. They also have a “desperate longing for closeness” (Bell, 1995, p.12). Loss, loneliness and separation are not well tolerated by these individuals. Worry, guilt and anxiety are key features in these individuals’ relationships. These individuals are also highly sensitive to rejection and have a deep need to be liked and accepted. Their relationships also often result in intense sadomasochistic binds (Bell, Bellington & Becker, 1986).
3. Egocentricity (EGC) – high scorers on this scale are self-centred and have no real concern for others’ feelings (Bell, 1995, p. 12). Three general attitudes are pertinent in these individuals’ relationships, namely: mistrust, manipulation for self-gains, and that others are seen to “exist only in relation to themselves” (cited in Bell, Bellington & Becker, 1986). High scorers are stated to be

most common in hospitalised and borderline samples and this subscale showed “significant correlation with pathological Object Relations in the early memories of a psychiatric sample” (cited in Bell, Bellington & Becker, 1986).

4. Social Incompetence (SI) – this subscale indicates “shyness, nervousness” and social insecurity. “Absence of close relationships and unsatisfactory sexual adjustment”. High scoring individuals often indicate pathological groups and these individuals are often inversely correlated with Somatic Concern, Hostility, Suspiciousness and Excitement – they are emotionally blunted (cited in Bell, Bellington & Becker, 1986).
5. Reality Distortion (RD) – this subscale “suggest severe distortions of external and internal reality”. These individuals may have delusions of influence, thought withdrawal or thought broadcasting. These patients often have paranoid beliefs. They may also harbour grandiose or depressive beliefs. They may become disoriented and have hallucinatory experiences. They are likely to distort meaning of internal experiences. It is common for these patients to exhibit paranoid projection of impulses, wishes and fears (Bells, 1995).
6. Uncertainty of Perception (UP) – these individuals have a keen sense of doubt about their own perception of internal and external reality. They are confused by their feelings and by the behaviour and feelings of others. Their social judgment may be poor as they stumble through interpersonal events, unsure of how to interpret these happenings. Individuals with UP elevations often experience extreme ambivalence and are unable to be decisive in even small matters. They tend to use denial as a principal defense against the intense anxiety they experience when confronted with conflict (Bell, 2005).



7. Hallucinations and Delusions (HD) – elevations on this subscale suggest the presence of hallucinatory experiences and paranoid delusions of various types. This subscale identifies a dimension of ego functioning involving severe breaks with reality.

## **APPENDIX J: TREND ANALYSIS OF SUB-SAMPLE**

### **FIRST TREND: WHITE FEMALE AFRIKAANS-SPEAKING PARTICIPANTS**

Participants 8, 12, 17, 21, 36, 38, 40 and 45 all fall into the female Afrikaans-speaking white female category. The trends will again be discussed in four categories, namely, Object Relations Profile, Reality Testing Profile, Diagnostic Profile and Treatment Recommendation Profile. In each of these categories, similarities and isolated trends will be presented.

### **SIMILAR OBJECT RELATIONS TRENDS: FEMALE PARTICIPANTS**

Participants 21, 40 and 45's scores indicate that there are no specific additional interpretations for this particular combination of Object Relations scores (Bell, 2005).

Participants 8, 17 and 38 scored elevated scores on the ALN and EGC scale, which indicate that they struggle with the give-and-take of relationships (Bell, 2005).

Participant 17 and 38's profile indicates that despite their difficulties with intimacy they continue to seek out relationships that, inevitably, prove to be unstable and painful. These individuals struggle with disturbing feelings of inner emptiness, fear of abandonment and loss, which may lead to desperate attempts to establish relationships with anyone who they believe can soothe these fears and gratify their search for emotional security. These individuals may also experience intense emotional anguish when disappointed by other people, and they may retreat into social withdrawal or engage in self-defeating behaviour. These individuals may feel awkward around members of the opposite sex and socially inadequate in general. Shyness and difficulty making friend's increases these individuals' need to hold onto whatever relationships they have developed. These individuals appear to be mistrustful and guarded and tend to turn on those close to them, they may have little genuine regard for the feelings of other people, but they may feel very vulnerable to humiliation and rejection. Their high degree of interpersonal sensitivity combined with a low degree of empathy could result in the

individual becoming easily injured without considering what they have done to the other person. From these individual's point of view, they may feel they have been wronged and therefore they believe that they are entitled to be demanding, controlling or hostile (Bell, 2005).

#### **ISOLATED OBJECT RELATIONS TRENDS: FEMALE PARTICIPANTS**

Participant 38's profile results indicate that this individual is likely to be mistrustful and suspicious of others.

Participant 17 may come across currently as coldly exploitative and believe that people are generally out to control others for self-centred aims and may have no real awareness or concern for others. These individuals have entitled views and as such justify their hostile, manipulative and demanding behaviour (Bell, 2005).

Participants 17 and 38 may experience intense emotional anguish when disappointed by the others. These dynamics could lead to sadomasochistic or hostile-dependent relationships. These individuals are likely to be particularly vigilant to loss and abandonment and therefore are likely to engage in manipulative, controlling and hostile behaviour (Bell, 2005).

Participant 8 appears to have self-centred aims and profound feelings of alienation and is likely to regard themselves as socially competent and capable of interacting superficially with others. The participant may have the ability to be intensive and abrasive. The participant may come across as street smart and get along anywhere. It appears that concern for others is currently based on what they can get or receive from them (Bell, 2005).

#### **SIMILAR REALITY TESTING PROFILE TRENDS: WHITE AFRIKAANS-SPEAKING FEMALES**

Participants 12, 21 and 40's scores indicate that at the time of testing, they did not experience reality testing problems so severe as to indicate deficits in this area of ego functioning. However, under the pressure of serious internal or external stressors, ego functioning may deteriorate (Bell, 2005).

### **ISOLATED REALITY TESTING TRENDS: WHITE AFRIKAANS-SPEAKING FEMALES**

Participant 38 does not have any specific additional interpretations for this particular combination of Reality Testing scores (Bell, 2005). Participant 8 has no severity sufficient to indicate ego deficits. Under pressure of serious internal or external stressors, ego functioning may deteriorate (Bell, 2005). Participant 24 is suggested to lack insight into their mental condition, with the result that their delusions or hallucinations are believed without question. This occurs because this individual may not have sufficient observing ego to reflect on these lapses in Reality Testing and possibly experiences them as consistent with an idiosyncratic or autistic understanding of themselves and others. Such individuals have an all-encompassing delusional system that explains his unusual experiences, thus reducing internal distress. This kind of break with reality constitutes a preventative defense against further ego disintegration. This participant's profile suggests the lesser forms of reality distortion, such as magical thinking, confusion of dream and wake states, depressive or grandiose beliefs and ideas of reference, in addition to the presence of active delusions or hallucinations (Bell, 2005).

### **SIMILAR DIAGNOSTIC TRENDS: WHITE AFRIKAANS-SPEAKING FEMALES**

Participants 8, 12, 17 and 38's profiles indicate object relations deficits and severe character pathology. Their results also reflect unstable character structure with a high degree of instability resulting in pain and hurt in relationships (Bell, 2005). Participants 8 and 12's scores indicate that in the absence of psychotic disorder these individuals could have narcissistic, borderline or passive aggressive and dependent features (Bell, 2005).

Participants 12 and 17's scores reflect similar unstable character structures; painful self-experiences, unmet longings and retaliatory attitude towards other people. Both these individuals report lapses, suggesting psychosis but not necessary a psychotic disorder. Although these individuals may be reporting lapses in Reality Testing, which are suggestive of psychosis, this profile pattern is not necessarily linked to psychotic disorders. This profile sometimes occurs in people with a history of

schizophrenia and in a residual phase, commonly found in borderline, schizotypal and paranoid personality disorders and the substance abuse population. These individuals may have genetic predisposition to psychotic symptoms; phenotypic experience is schizotypal rather than schizophrenic. Abuse/dependence on substances such as cocaine and alcohol are likely to be a source of experience of reality distortion. These individual's profiles also suggest that they suffer with feelings of alienation and they will retaliate with anger if they perceive hurt (Bell, 2005). Participant 12, 17 and 38's profile are stated to almost never be found in high-functioning normal individuals (Bell, 2005).

#### **ISOLATED DIAGNOSTIC TRENDS: WHITE AFRIKAANS-SPEAKING FEMALES**

Participant 38 is inclined to experience extended periods of social withdrawal; this individual therefore struggles with feelings of alienation and is likely to act out in angry retaliation for perceived hurts. In the absence of psychotic disorder, this profile is most commonly found among individuals with borderline and schizoid personality disorders, and may include narcissistic, dependent and avoidant features (Bell, 2005).

Participant 8 is likely to act out in angry retaliation against others for perceived emotional deprivation. This individual may have antisocial features, demandingness and dependency, as well as grandiose defenses against feelings of helplessness (Bell, 2005). Participant 12 may be experiencing transient breaks in reality, such as those in borderline personality disorder. This individual may also be experiencing dissociative states or re-experiencing flashbacks due to post traumatic stress disorder (Bell, 2005).

Participant 17 may suffer from a type of brain function compromise, such as a seizure disorders, sensory deprivation and traumatic insult (Bell, 2005). Participant 21's profile does not suggest the presence of any specific serious pattern of disturbance in Object Relations or Reality Testing (Bell, 2005). Participant 38's profile is not suggestive of any specific psychological condition, although it is

associated with anxiety disorders and a lower sense of well-being. It is often an indication that the patient wishes to convey to the examiner a sense of desperation or a cry for help (Bell, 2005).

Participant 40 scored a single elevation on the Social Incompetence scale, which according to Bell (1995) does not suggest severe object relations deficits and is often observed in shy or socially insecure individuals. High elevation on this scale may be associated with an avoidant personality disorder and other research has linked this profile to gender identity confusion in young adult males (Bell, 2005).

Participant 45 had an elevated score on the EGC scale, which is consistent with personality traits most commonly associated with narcissistic, antisocial and histrionic personality disorders. This pattern of Reality Testing scores is most commonly found among patients with schizophrenia or other psychotic disorders. Less commonly, borderline patients or patients with re-experiencing phenomena related to PTSD can also have this profile. The profile is seldom found among other diagnostic groups and virtually never occurs among normal people (Bell, 2005).

#### **SIMILAR TREATMENT RECOMMENDATION TRENDS: WHITE AFRIKAANS-SPEAKING**

##### **FEMALES**

Participants 8, 12, 17 and 38 may perceive the therapist principally as a need-gratifying object. These individuals do not easily tolerate frustration that accompanies traditional psychotherapy. Specialised milieu as in drug rehabilitation centres, halfway house and other therapeutic community are suggested to be especially effective with these individuals as they will assist them to maintain behavioural control and an opportunity of relatedness and belonging outside the complexity of a dyadic relationship (Bell, 2005).

Participants 12, 17 and 38's profiles indicate that they are likely to perform better in highly structured groups, such as psycho-educational skills training or the 12-step programme, as no intimate

transaction is required. For this reason directive and supportive counselling with clear boundaries is more effective than individual and group therapy. The individuals tend to have difficulty with the give-and-take of traditional group therapy and have problems tolerating demands for self-disclosure and intimacy. In a therapeutic relationship, these individuals will experience a lack of trust and have excessive expectations, neediness, rejection and sensitivity, which will threaten the therapeutic alliance. As the vicissitudes of the therapeutic relationship unfold, the therapist may be idealised and then devalued. These individuals sometimes have the need to repeatedly disappoint those who trust them and get significant others to turn against them (Bell, 2005).

Participants 12 and 17's profiles do not suggest the need for psychotropic medication. With elevated reality distortion scores, it is important that these individuals be advised to stop using mind-altering drugs and seek treatment; to achieve this group therapy may be helpful in this regard. The therapist should avoid being passive or ambiguous as it may confuse or make the patient anxious and disrupt the therapeutic alliance (Bell, 2005).

Participants 17 and 38 may suffer from denial and other rigid defenses, which could quickly reconstitute and make difficult any form of treatment that utilizes self-reflection and uncovering (Bell, 2005).

Participants 28 and 40's profiles, indicate that interpretations of defense and transference interpretations may be tolerated, and the client might be able to relate experiences within the therapy to other relationship issues in their life (Bell, 2005).

Participants 40 and 45 may benefit from social skills groups that focus on learning specific social skills, behavioural rehearsal, role playing and problem-solving social interactions, particularly in overcoming shyness, learning to initiate and sustain conversation, and learning to read complex social situations better (Bell, 2005).

## **ISOLATED TREATMENT RECOMMENDATIONS TRENDS: WHITE AFRIKAANS-SPEAKING**

### **FEMALES**

Participant 40 may be reluctant to engage emotionally with the therapist and might have difficulty experiencing the therapist's interest as genuine. This individual may act remote and distant, but should eventually become invested in the relationship. This person may also benefit from the sense of belonging and intimacy found in traditional group therapy. They may become a "good" group member who supports the group norms, invests emotionally in the group and encourages cohesiveness. Their profile indicates that they should benefit from interpretations of transactions in the group that reveal underlying feelings of jealousy, competition, sexuality, loss and so forth as well as the accompanying group defenses of fight-flight, dependency and paring (Bell, 2005).

Participant 36's results do not indicate particular patterns of serious object relations or reality testing deficits that would present as obstacles to treatment (Bell, 2005).

Participant 8's profile suggests that this individual will engage with the therapist on a superficial level, which may result in them dropping out of traditional psychotherapy early. If treatment does continue, breaches in rapport and tests of trust can be expected. Insight-oriented psychotherapy should be replaced by behavioural correcting, good boundaries and limit setting, directive counselling or milieu treatment. These individuals have difficulty with the give-and-take of traditional group therapy and have problems tolerating the groups' demands for self-disclosure and intimacy; as such they may do better with highly structured groups such as psycho-education or 12-step groups, where participation does not require intimate transactions with other members. This individual is likely to react to interpretations of narcissistic defenses with hostility and mistrust. Accurate social feedback,



as can sometimes be provided in social skills training or therapeutic communities, may be helpful in correcting this individual's abrasive or off-putting social behaviour (Bell, 2005).

Participant 38's profile indicates that this individual is likely to increase their sense of social competence by participation in psychosocial activities group programmes, social skills training or activity-oriented milieu or day treatments. The elevation on Uncertainty of Perception scale indicates that this person believes that there is something wrong with their mental functioning, which may motivate them to seek treatment. However, an elevation on UP does not necessarily indicate a willingness to proceed with treatment beyond being a cry for help (Bell, 2005).

Participant 12's profile recommends that further assessment of the reality distortion and uncertainty of perception in this individual are needed as they can cause a variety of psychological conditions (Bell, 2005).

Participant 17's profile results indicate that if substance abuse or possible organic pathology is suspected, a neuropsychological evaluation should be considered. Elevation on the Uncertainty of Perception scale suggests this individual may believe something is wrong with their mental functioning and therefore might be motivated to seek treatment, however this does not necessarily indicate a willingness to proceed with treatment beyond being a cry for help. Reality-orientated psychotherapy may be particularly helpful for this individual, with an emphasis placed on excusing distortions as they occur in the therapeutic relationship. The confusion and uncertainty represented by evaluated uncertainty of perception suggests problems with medication compliance, missed appointments and attitudes of helplessness, which could further complicate treatment (Bell, 2005).

Participant 38's profile indicates that this individual is likely to struggle with treatment compliance and attitudes of helplessness may further complicate treatment. Additional evaluation is needed in order to determine whether the respondent's doubts about their ability to perceive internal and external reality may include disorientation and other indicators of organic pathology.

Neuropsychological testing is recommended in the context of any history that suggests compromise of brain function (Bell, 2005).

Participant 45's profile indicates that self-help groups and psycho-educational programmes may be helpful for this individual. Further evaluation for the presence of a psychotic disorder is warranted and psychotropic medications should be considered for relief of target symptoms suggested by the items. Reality-oriented treatment with emphasis on practical problem solving may be helpful. Psychosocial interventions, including group membership and supported work programmes, may be useful in bolstering fragile ego functions and reducing the isolation that significant others to help sort out the reality of current circumstances. Referral to self-help groups and psycho-educational programmes has also been helpful for individuals with this profile. Skills training groups that emphasise reality checking could also be helpful (Bell, 2005).

Participant 21's results do not indicate a particular pattern of serious Object Relations or Reality Testing deficits that would present obstacles in treatment (Bell, 2005).

## **SECOND TREND: WHITE MALE AFRIKAANS SPEAKING PARTICIPANTS**

The sample of white male Afrikaans-speaking participants comprises of participant 2, 10, 11, 16, 22, 24, 29, 30, 32, 33, 35 and 39.

## **SIMILAR OBJECT RELATION TRENDS: WHITE MALE AFRIKAANS-SPEAKING PARTICIPANTS**

Participants 29, 35 and 39 have no specific additional interpretations for this particular combination of Object Relations scores (Bell, 2005).

Participants 2, 10, 11, 33 and 32 have a pattern of Object Relations scores which indicates that despite these individual's difficulties with intimacy they continue to seek out relationships that inevitably prove unstable and painful. Disturbing feelings of inner emptiness and fear of abandonment and loss may lead to desperate attempts to establish relationships with anyone who they believe can soothe

these fears and gratify their search for emotional security. These individuals may experience intense emotional anguish when disappointed by the other person, and they may retreat into social withdrawal or self-defeating behaviour (Bell, 2005).

Participants 2, 11, 24 and 30 consider themselves to be socially competent and they are generally able to manage superficial acquaintances, but may be abrasive and insensitive to social nuances (Bell, 2005). Participants 10, 32 and 32 feel awkward around members of the opposite sex and socially inadequate in general (Bell, 2005).

Participants 2, 10, 11, 16, 30, 32 and 33 scored elevated scores on the ALN and EGC scale, which indicate that they struggle with the give-and-take of relationships. These individuals are mistrustful and guarded and tend to turn on those close to them (Bell, 2005). Participants 11, 32 and 33 have little genuine regard for the feelings of other people, but they may feel very vulnerable to humiliation and rejection (Bell, 2005).

Participants 2, 32 and 33 have a high degree of interpersonal sensitivity combined with a low degree of empathy which could result in the individuals becoming easily injured without considering what they have done to the other person. These individuals have been wronged and therefore they are entitled to be demanding, controlling or hostile (Bell, 2005).

Participants 2, 10, 11 and 33 have entitled views and as such justify their hostile, manipulative and demanding behaviour (Bell, 2005). Participants 2, 10, 32 and 33 may experience intense emotional anguish when disappointed by the other person. These individuals may be coldly exploitative and believe that people are generally out to control others for self-centred aims and may have no real awareness or concern for others. These dynamics could lead to sadomasochistic or hostile-dependent relationships (Bell, 2005).

Participants 2, 11 and 33 have high levels of mistrust, which accompanied with their high levels of emotional hunger result in intense engagement and then withdrawal when in relationships (Bell,

2005). Participants 2 and 32 are easily disappointed and as such engage in manipulating and controlling behaviour (Bell, 2005).

Participants 10, 11, 32 and 33 are likely to be particularly vigilant to loss and abandonment, therefore these individuals engage in manipulative, controlling and hostile behaviour (Bell, 2005). Participants 11 and 22's profiles indicate that they have self-centred aims (Bell, 2005). Participants 24 and 30 are suggested to be street smart (Bell, 2005).

### **ISOLATED OBJECT RELATIONS TRENDS: WHITE MALE AFRIKAANS-SPEAKING**

#### **PARTICIPANTS**

Participant 30 is focused on what others can give them (Bell, 2005). Participant 33 is shy and has difficulty making friends and this increases this person's need to hold onto whatever relationships they have developed. This individual is likely to turn away from others rather than against them, and therefore a high level of social withdrawal is likely (Bell, 2005).

### **SIMILAR REALITY TESTING PROFILE: WHITE MALE AFRIKAANS-SPEAKING PARTICIPANTS**

Participant 39 has no specific additional interpretations for this particular combination of Reality Testing scores (Bell, 2005). Participants 11, 16, 24, 29 and 39 have a combination of BORRTI Reality Testing scores which indicate that at the time of testing, the clients did not experience Reality Testing problems so severe as to indicate deficits in this area of ego functioning. However, under the pressure of serious internal or external stressors, ego functioning may deteriorate (Bell, 2005).

Participants 2, 10 and 30 recognise inadequacy of perceptions and often feel on edge of becoming psychotic (Bell, 2005).

Participant 22 and 32 have some awareness of the inaccuracy of their scores; these individual may be able to draw upon some observing ego that has not been wholly absorbed by a delusional system. It is

likely that these individuals experiences anxiety about their medical condition and they may feel very confused and frightened by it (Bell, 2005).

### **ISOLATED OBJECT RELATION TRENDS: WHITE MALE AFRIKAANS-SPEAKING**

#### **PARTICIPANTS**

Participant 33 recognises the inaccuracy of their perception and may feel that they are on the edge of becoming psychotic (Bell, 2005).

### **SIMILAR DIAGNOSTIC TRENDS: WHITE MALE AFRIKAANS-SPEAKING PARTICIPANTS**

Participants 2, 10, 11, 16, 22, 24, 30, 33, 32 and 35 have profiles that indicate Object Relations deficits and severe character pathology (Bell, 2005).

Participants 2, 10, 11, 16, 22, 24 and 30 have scores that reflect an unstable character structure, painful self-experience, unmet longings and retaliatory attitude towards other people (Bell, 2005).

The profiles of participant 32 and 33 suggest that these individuals struggle with alienation; they indicate angry protest and retaliation for perceive hurts. In the absence of psychotic disorder, this profile is most commonly found among individuals with borderline and schizoid personality disorders, and may include narcissistic, dependent and avoidant features. These individuals also have an unstable character structure with a high degree of painfulness in relationships, leading to periods of social withdrawal (Bell, 2005).

Participants 2, 11, 16 and 30 retaliate with anger when they perceive emotional deprivation. These individuals also have antisocial features, with demandingness and dependency. They additionally struggle with grandiose defenses against feelings of helplessness. These individuals report lapses in reality, which suggests the presence of psychosis but not necessary a psychotic disorder (Bell, 2005).

Participants 2, 10, 11, 16, 22, 24, 25 and 30's profiles suggest that in the absence of psychotic disorder, narcissistic, borderline or passive aggressive features may be present (Bell, 2005).

Participants 2, 10, 16, 30 and 33 may have reported lapses in Reality Testing, which are suggestive of psychosis and indicate that these individuals may fear becoming psychotic. This profile, however, is not necessarily linked to psychotic disorders. It sometimes occurs in people with a history of schizophrenia and in the residual phase, commonly found in borderline, schizotypal and paranoid personality disorders and substance abuse population (Bell, 2005).

Participants 2, 10, 16, 30, 33 and 39 may have a genetic predisposition to psychotic symptoms; phenotypic experience is schizotypal rather than schizophrenic. They may also be experiencing transient breaks in reality, such as those with borderline personality disorder that may be experienced in dissociative state or re-experience flashbacks due to post traumatic stress disorder. Abuse/dependence on substances such as cocaine and alcohol is likely to be a source of experience of reality distortion. Other types of brain function compromise – seizure disorders, sensory deprivation and traumatic insult cause elevations on this scale (Bell, 2005).

Participants 10, 16 and 22's profiles suggest alienation and angry retaliation for perceived hurts (Bell, 2005). Participants 10, 22, 33 have profiles which are almost never found in high-functioning normal individuals (Bell, 2005). Participant 22 and 32 have profiles that are most commonly found in people with schizophrenia and other psychotic disorders. These patterns of scores are less common in borderline or PTSD patients (Bell, 2005).

#### **ISOLATED DIAGNOSTIC TRENDS: WHITE MALE AFRIKAANS-SPEAKING PARTICIPANTS**

Participant 29's results do not suggest the presence of any specific serious pattern of disturbance in Object Relations or Reality Testing. A single elevation on IA is the most common pathological profile found among high functioning adults and students. It may indicate attitudes and personality traits most commonly associated with dependent, compulsive, or passive-aggressive personality disorder and may not be so severe as to cause social dysfunction. Although this respondent may be reporting lapses in Reality Testing suggestive of psychosis, a single elevation on RD without a corresponding

elevated score on HD has not been closely linked by research to psychotic disorders. It is more commonly found in borderline, schizotypal and paranoid personality disorder and in substance abuse populations. These results do not suggest the presence of any specific serious pattern of disturbance in Object Relations or Reality Testing (Bell, 2005).

Participant 32's pattern of Object Relations are seldom found among other diagnostic groups and virtually never occurs among normal individuals (Bell, 2005).

#### **SIMILAR TREATMENT RECOMMENDATIONS: WHITE MALE AFRIKAANS-SPEAKING PARTICIPANTS**

Participants 29 and 39 are likely to have sufficient interest in relationships and enough available emotional pain to provide motivation for insight-oriented psychotherapy. This psychotherapy may be brief or long term, depending on the goals of treatment. Such individuals tend to quickly engage the therapist in complex transference paradigms and can be highly reactive to the therapist's behaviour and actions. Interpretations of defense and transference interpretations may be tolerated, and the client might be able to relate experiences within the therapy to other relationship issues in their lives. These participants support the group norms, invest emotionally in the group and encourage cohesiveness (Bell, 2005).

Participants 2, 10, 11, 22, 24, 32 and 33 have profiles which suggest that the therapeutic alliance of these individuals will be threatened by a lack of trust, and are likely to display excessive expectations, neediness, rejection and sensitivity to the other. The therapist may also be idealised and then devalued as the vicissitudes of the therapeutic relationship unfold (Bell, 2005).

Participants 2, 10, 11, 16, 22, 30, 32 and 33 may perceive the therapist principally as a need-gratifying object. These individuals do not easily tolerate frustration inherent in traditional psychotherapy. Directive and supportive counselling with clear boundaries is more effective than individual and group therapy (Bell, 2005).

Participants 2, 10, 11, 22 and 33 sometimes have the need to repeatedly disappoint those who trust them and get significant others to turn against them (Bell, 2005). Participants 2, 10, 11, 16, 22, 24, 32 and 33 tend to have difficulty with the give-and-take of traditional group therapy and have problems tolerating demands for self-disclosure and intimacy (Bell, 2005).

Participants 2, 10, 11, 16, 22, 24, 30, 32 and 33 tend to do better in highly structured groups (activity, psycho-educational skills training or the 12-steps programme of AA), where no intimate transaction is required (Bell, 2005).

Participants 2, 10, 11, 16, 22, 30, 32 and 33 will benefit from specialised settings, such as in drug rehabilitation centres, halfway house and other therapeutic community especially effective to maintain behavioural control and opportunity of relatedness and belonging outside complexity of a dyadic relationship (Bell, 2005).

Participants 32 and 33 often increase their sense of social competence by participation in psychosocial activities group programmes, social skills training, or activity-oriented milieu or day treatments (Bell, 2005). Based on their profiles, participants 2, 10, 16, 30 and 33 require a further assessment of their reality distortion and uncertainty of perception, in order to identify the variety of psychological conditions that could be present (Bell, 2005).

Participant 2, 10, 30 and 39's profiles do not in themselves suggest the need for psychotropic medication. With elevated reality distortion scores such as these, it is suggested to be important to take note if the individuals who report using mind-altering substances. In such cases they should be advised to stop and seek treatment (Bell, 2005).

Participants 33 and 39 have elevated scores on the RD scale and as such if they report using mind-altering substances, they should be strongly encouraged to stop their drug use and to seek substance abuse treatment if necessary (Bell, 2005). Participants 2, 10 and 33's scores indicate that they may have organic pathology; as such a neuropsychological evaluation should be considered (Bell, 2005).



Participants 14 and 31 should respond well to reality-oriented treatment, which emphasises practical problem solving (Bell, 2005). Participants 40 and 45 should be exposed to social skills groups that focus on learning specific social skills, behavioural rehearsal, role playing and problem-solving social interactions as this may also be helpful, particularly in overcoming shyness, learning to initiate and sustain conversation, and learning to read complex social situations better (Bell, 2005).

Participants 2, 10 and 33 scored elevated scores on the Uncertainty of Perception scale; this suggests that a person may believe something is wrong with their mental functioning and therefore may be motivated to seek treatment. An elevation on the UP does not necessarily indicate a willingness to proceed with treatment beyond being a cry for help (Bell, 2005).

Participants 2, 10, 11, 16, 22, 30 and 33's profiles indicate that they may struggle with denial and other rigid defenses could quickly reconstitute and make difficult any form of treatment that utilises self-reflection and uncovering (Bell, 2005). Participants 2, 10, 11, 16, 22, 33 and 39 are likely to benefit from reality-orientated psychotherapy, with an emphasis on excusing distortions as they occur in the therapeutic relationship (Bell, 2005).

Participants 2, 10, 11, 12, 16, 17, 25, 26, 30, 33, 28 and 39 are likely to benefit from group therapy (Bell, 2005). Participants 2, 10, 16, 30, 33 and 39 may become anxious and disrupt the therapeutic alliance if the therapist does not avoid being passive or ambiguous as it may confuse the individual (Bell, 2005).

Participants 2, 10 and 33's profiles indicate that the confusion and uncertainty represented by elevated scores on the Uncertainty of Perception scale suggests that these individuals may experience problems with medication compliance, missed appointments and attitudes of helplessness, which could further complicate treatment (Bell, 2005). Participants 16, 24 and 30's profile indicate a strong likelihood that these individuals may drop out early from traditional therapy (Bell, 2005).

Participants 16, 24, 29, 30 and 35 should benefit from behavioural correcting as opposed to insight-oriented psychotherapy. These individuals should be taught good boundaries and limit setting in the form of directive counselling or treatment (Bell, 2005). Participants 16 and 30's profile indicates that if they continue with therapy as opposed to dropping out early, breaches in rapport are likely and the individuals are likely to engage in tests of trust. In terms of narcissistic defenses the therapeutic alliance will probably be met with mistrust (Bell, 2005).

### **ISOLATED TREATMENT RECOMMENDATION TRENDS: WHITE MALE AFRIKAANS-SPEAKING PARTICIPANTS**

Participant 39 may benefit from the sense of belonging and intimacy found in traditional group therapy and may become a "good" group member who supports the group norms, invests emotionally in the group and encourages cohesiveness. Further assessment of reality distortion phenomena may be needed because it can be caused by a wide variety of psychological conditions (Bell, 2005).

Participant 2 may benefit from transactional interpretations, which can assist them in understanding the way in which they disregard the emotional needs of others, sabotage relationships with mistrust or turn others against them (Bell, 2005).

Participant 35 may be guarded in individual therapy and might have difficulty in forming a therapeutic alliance. There is a strong likelihood that this individual may drop out early from traditional therapy, however, if treatment continues, breaches in rapport and tests of trust can be expected (Bell, 2005). Participant 33's profile suggests the need for psychotropic medications (Bell, 2005).

Participant 30 may respond well to psychosocial interviews, which include activities with group members that may be useful in bolstering a fragile ego and reducing isolation (Bell, 2005).

Participant 22 may benefit from skills training groups, self-help group and psycho-educational programmes (Bell, 2005).

Participant 29's profile indicates that this individual is likely to be sufficiently interested in relationships and has experienced enough available emotional pain to provide motivation for insight-oriented psychotherapy. Such individuals engage therapist in complex paradigms and are highly reactive to therapist behaviour. Defense and transference in therapy may be tolerated. This individual may also benefit from the sense of belonging and intimacy found in traditional group therapy. They may be a good group member, in that they may invest emotionally and encourage other members (Bell, 2005).

Participant 32's profile indicates that a further evaluation should be conducted to identify the presence of a psychotic disorder. Psychotropic medications should be considered for relief of target symptoms which are suggested by the items. Psychosocial interventions, including activities, group membership and supported work programmes may be useful in bolstering fragile ego functions and reducing the isolation from significant others and to help sort out the reality of current circumstances should be considered. Referral to self-help groups and psycho-educational programmes has also been helpful for patients who continue to experience psychotropic phenomena over a long period of time. Skills training groups that emphasise reality checking could also be helpful (Bell, 2005).

### **THIRD TREND: HIGH AUDIT SCORES AND NO PATHOLOGICAL BORRTI SCORES**

These trends are applicable to participants 8, 21, 24, 29, 36 and 39.

### **Similar Object Relations Trends: High Audit No BORRTI Pathology**

Participant 21, 29 and 29's scores indicate that there are no specific additional interpretations for this particular combination of Object Relations scores (Bell, 2005). Participant 24 and 8's scores indicate that these individuals have the ability to be intense, abrasive and street smart (Bell, 2005).

### **ISOLATED OBJECT RELATIONS TRENDS: High Audit No BORRTI Pathology**

Participant 8's score indicates that this individual has entitled views and therefore justifies their hostile, manipulative and demanding behaviour. This individual has self-centred aims and struggles with profound feelings of alienation, although this individual is likely to regard themselves as socially competent and capable of interacting superficially with others. Concern for others is based on what they can get out of the interaction (Bell, 2005).

Participant 24's results indicate that this individual experiences alienation and self-experience in terms of social competence in such a way that this profile is an indication of a homeless individual (Bell, 2005).

### **SIMILAR REALITY TESTING TREND: LOW AUDIT AND NO BORRTI PATHOLOGY**

Participant 21, 24, 29 and 39' scored a combination of Reality Testing scores which indicate that at the time of testing, the clients did not experience Reality Testing problems that were severe enough to indicate deficits in this area of ego functioning. However, under the pressure of serious internal or external stressors, their ego functioning may deteriorate (Bell, 2005).

### **ISOLATED REALITY TESTING TRENDS: Low Audit and No BORRTI Pathology**

Participant 8's results indicate no severity sufficient to indicate ego deficits. However, under pressure of serious internal or external stressors, ego functioning may deteriorate (Bell, 2005).

Participant 39's scores indicate that there are no specific additional interpretations for this particular combination of Reality Testing scores (Bell, 2005).

### **SIMILAR DIAGNOSTIC TRENDS: LOW AUDIT AND NO BORRTI PATHOLOGY**

Participant 8 and 24's profiles indicate Object Relations deficits and severe character pathology. In the absence of psychotic disorder this could suggest narcissistic, borderline or passive aggressive and dependent features (Bell, 2005). Participants 21 and 29's results do not suggest the presence of any specific serious pattern of disturbance in Object Relations or Reality Testing (Bell, 2005).

### **ISOLATED DIAGNOSTIC TRENDS: LOW AUDIT AND NO BORRTI PATHOLOGY**

Participant 24's results reflect an unstable character structure, painful self-experience, unmet longings and retaliatory attitude towards other people (Bell, 2005). Participant 29's results do not suggest the presence of any specific serious pattern of disturbance in Object Relations or Reality Testing (Bell, 2005). Participant 8's results suggest that this individual will retaliate angrily against others for perceived emotional deprivation. Some individuals with this profile have antisocial features, demandingness, dependency and grandiose defenses against feelings of helplessness (Bell, 2005).

Participant 39 scored a single elevated score on the IA scale, which is the most common pathological profile found among high functioning adults and students. It may indicate attitudes and personality traits most commonly associated with dependent, compulsive or passive-aggressive personality disorder and may not be so severe as to cause social dysfunction. Although this respondent might be reporting lapses in Reality Testing suggestive of psychosis, a single elevation on RD without a corresponding elevated score on HD has not been closely linked by research to psychotic disorders. It is more commonly found in borderline, schizotypal and Paranoid Personality Disorder and in substance abuse populations. This individual may have a genetic predisposition to psychotic symptoms; phenotypic experience is schizotypal rather than schizophrenic. The person may be experiencing transient breaks in reality, such as those in Borderline Personality Disorder which might be experienced in dissociative state or re-experience flashbacks due to Post Traumatic Stress Disorder. Substance abuse, such as cocaine and alcohol, is likely to be a source of experience of

reality distortion. Other types of brain functions comprise of seizure disorders, sensory deprivation and traumatic insult, which cause elevations on this scale (Bell, 2005).

#### **SIMILAR Treatment RECOMMENDATIONS: LOW AUDIT AND NO BORRTI PATHOLOGY**

Participants 29 and 39's results indicate that these individuals are likely to have sufficient interest in relationships and enough available emotional pain to provide motivation for insight-oriented psychotherapy. Such individuals are suggested to quickly engage the therapist in complex transference paradigms and can be highly reactive to the therapist's behaviour and actions. Interpretations of defense and transference interpretations may be tolerated, and the client might be able to relate experiences within the therapy to other relationship issues in his life. These individuals tend to support the group norms, invest emotionally in the group and encourage cohesiveness (Bell, 2005).

Participants 26 and 39's scores suggest that there is no need for psychotropic medication for these individuals (Bell, 2005).

Participants 8, 24 and 29's profile results indicate that insight-oriented psychotherapy should be replaced by behavioural correcting, good boundaries and limit setting, directive counselling or milieu treatment (Bell, 2005).

#### **ISOLATED TREATMENT RECOMMENDATION TRENDS: LOW AUDIT AND NO BORRTI PATHOLOGY**

Participant 36's results do not indicate particular patterns of serious Object Relations or Reality Testing deficits that would present obstacles to treatment (Bell, 2005).

Participant 39's results indicate that this individual may benefit from the sense of belonging and intimacy found in traditional group therapy. They may become a "good" group member who supports the group norms, invests emotionally in the group and encourages cohesiveness (Bell, 2005).

Participant 21's results do not indicate particular patterns of serious object relations or reality testing deficits that would present obstacles to treatment (Bell, 2005).

Participant 24's scores indicate that this individual tends to have difficulty with the give-and-take or traditional group therapy and have problems tolerating demands for self-disclosure and intimacy, therefore this person is likely to do better in highly structured groups where no intimate transaction is required. This person's profile suggests that the therapeutic alliance will be threatened by a lack trust and excessive expectations, neediness, rejection and sensitivity on to the other, and there is a strong likelihood that this individual may drop out early from traditional therapy (Bell, 2005).

Participant 39's scores indicate that a further assessment of reality distortion phenomena may be needed because it can be caused by a wide variety of psychological conditions. It is also recommended that individuals with this profile, who have elevations on RD and who report the use of mind-altering substances, should be strongly encouraged to stop their drug use and to seek substance abuse treatment if necessary. Reality-orientated psychotherapy may be particularly helpful for this individual, with an emphasis on excusing distortions as they occur and in the therapeutic relationship. Group therapy may be helpful in this regard. Furthermore, therapists should avoid being passive or ambiguous as it may confuse or make the patient anxious and disrupt the therapeutic alliance (Bell, 2005).

Participant 29's scores indicate that this individual is likely to have sufficient interest in relations and enough available emotional pain to provide motivation for insight-oriented psychotherapy. Such individuals engage therapist in complex paradigms and are highly reactive to therapist behaviour. Reflection of defenses and transferences in therapy may be tolerated by this individual. This person may also benefit from a sense of belonging and intimacy found in traditional group therapy, as they may be a good group member who invests emotionally and encourages others (Bell, 2005).

Participant 8's profile suggests that interpretations of narcissistic defenses will probably be met with hostility and mistrust. This individual may do better with highly structured groups where participation does not require intimate transactions with other members. This individual has difficulty with the give-and-take of traditional group therapy and has problems tolerating the group's demands for self-disclosure and intimacy. Accurate social feedback, as can sometimes be provided in social skills training or therapeutic communities, may be helpful in correcting this individual's abrasive or off-putting social behaviour. This profile suggests superficiality in the client's initial engagement with therapist, so they may drop out of traditional psychotherapy early. If treatment continues, breaches in rapport and tests of trust can be expected. These individuals often do not easily tolerate frustration inherent in traditional psychotherapy. Specialised treatment methodologies such as those found in drug rehabilitation centres, halfway house and other therapeutic communities are especially effective to maintain behavioural control and opportunity of relatedness and belonging outside complexity of a dyadic relationship (Bell, 2005).



## **APPENDIX K: INDIVIDUAL TREATMENT RECOMMENDATIONS**

Based on their BORRTI reports, the following treatment recommendations were made by the BORRTI assessment (Bell, 2005). Participants 29, 28, 37, 39 and 41 are likely to have sufficient interest in relationships and enough available emotional pain to provide motivation for insight-oriented psychotherapy. Such individuals tend to quickly engage the therapist in complex transference paradigms and can be highly reactive to the therapist's behaviour and actions (Bell, 2005).

Participants 29, 28, 39 and 40 may be able to tolerate interpretations of defense and transference, and the clients might be able to relate experiences within the therapy to other relationship issues in their life (Bell, 2005). Participant 29, 28 and 39 invest emotionally in the group and encourage cohesiveness. Participants 28, 37 and 41 could be so anxious about growing dependency that they might flee the intensity of the treatment relationships. Therapist's vacations, cancelled sessions or absences may be poorly tolerated and experienced by the client as abandonment. The client may become mistrustful and rageful when interpretations of narcissistic defenses are made, and they will be very sensitive to feelings of shame and humiliation. Respect for the patients' defenses, along with slow and careful clarifications of therapeutic reactions, may be necessary to prevent a disruption in treatment. However, they may lack empathy for other group members and have difficulty with the give-and-take of a group (Bell, 2005).

Participants 28, 37, 39, 40 and 41 may benefit from the sense of belonging and intimacy found in traditional group therapy (Bell, 2005). Participants 2, 37 and 41 may respond well to transactional interpretations that can assist in understanding the way in which they disregard the emotional needs of others, sabotage relationships with mistrust or turn others against them (Bell, 2005). Participants 8, 14 and 35 may stop treatment early, but if they continue, it is likely that breaches in rapport and tests of trust will occur (Bell, 2005).

Participants 2, 3, 5, 10, 11, 12, 17, 18, 22, 25, 26, 32, 33 and 38 have profiles which suggest that the therapeutic alliance will be threatened by a lack trust, and excessive expectations, neediness, rejection and sensitivity of the individual towards the therapist. The therapist may be idealised and then devalued as the vicissitudes of the therapeutic relationship unfold –individuals with this profile may perceive the therapist principally as a need-gratifying object (Bell, 2005).

Participants 2, 3, 5, 8, 10, 11, 12, 14, 16, 17, 18, 22, 25, 26, 30, 32, 33 and 38 do not easily tolerate frustration inherent in traditional psychotherapy and these individuals often have the need to repeatedly disappoint those who trust them and get significant others to turn against them (Bell, 2005).

Participants 2, 3, 5, 10, 11, 12, 17, 18, 22, 32, 33 and 38 are likely to handle directive and supportive counselling with clear boundaries more effectively than individual and group therapy (Bell, 2005).

Participant 2, 3, 5, 10, 11, 12, 16, 17, 18, 22, 24, 25, 26, 30, 32, 33 and 38 tend to have difficulty with the give-and-take or traditional group therapy and have problems tolerating demands for self-disclosure and intimacy. They tend to do better in highly structured groups (activity, psycho-educational skills training or the 12-steps programme of Alcoholics Anonymous) and no intimate transaction is required (Bell, 2005).

Participants 2, 3, 5, 8, 10, 11, 12, 14, 16, 17, 18, 22, 25, 26, 30, 32, 33 and 38 are likely to benefit from specialised milieu as in drug rehabilitation centres, halfway house and other therapeutic communities especially effective to maintain behavioural control and opportunity of relatedness and belonging outside complexity of a dyadic relationship (Bell, 2005).

Participants 32, 33 and 38's profiles indicate that these individuals can increase their sense of social competence by participation in psychosocial activities, group programmes, social skills training, or activity-oriented milieu or day treatments (Bell, 2005).

Participants 2, 10, 12, 16, 25, 26, 28, 30 and 33's profiles indicate that a further assessment of the reality distortion and uncertainty of perception is needed as they can cause a variety of psychological conditions (Bell, 2005). Participants 2, 10, 12, 17, 25, 26, 28, 30 and 39's scores do not suggest the need for psychotropic medication (Bell, 2005).

Participants 2, 10, 12, 17, 25, 26, 28, 30, 33 and 39's profile results indicate elevated scores on the RD scale. Bell (1995) states that if these individuals report making use of mind-altering substances they should be strongly encouraged to stop their drug use and to seek substance abuse treatment.

Participants 2, 10, 17, 25, 26, 28 and 33's profiles suggest that a neuropsychological evaluation should be considered due to the possibility of substance abuse or organic pathology in these individuals. Their elevated scores on the Uncertainty of Perception scale suggest that these individuals may believe something is wrong with their mental functioning and therefore might be motivated to seek treatment; however, an elevation on the UP does not necessarily indicate a willingness to proceed with treatment beyond being a cry for help (Bell, 2005).

Participants 2, 10, 11, 16, 17, 18, 22, 25, 26, 28, 30, 33 and 38 make use of denial and other rigid defenses, which make any form of treatment that utilizes self-reflection and uncovering difficult (Bell, 2005). Participants 2, 10, 11, 16, 17, 18, 22, 25, 26, 28, 30, 33 and 39 may benefit particularly from reality-orientated psychotherapy, with an emphasis on excusing distortions as they occur in the therapeutic relationship (Bell, 2005).

Participants 2, 10, 11, 12, 16, 17, 25, 26, 30, 33, 28 and 39 may benefit from group therapy (Bell, 2005). Participants 2, 10, 12, 16, 17, 25, 26, 28, 30, 33 and 39's profile scores indicate that the therapist should avoid being passive or ambiguous as it may confuse or make the patient anxious and disrupt the therapeutic alliance (Bell, 2005).

Participants 2, 10, 17, 25, 28 and 33's profiles indicate confusion and uncertainty represented by evaluated uncertainty of perception, which suggest problems with medication compliance, missed

appointments and attitudes of helplessness, which could further complicate treatment (Bell, 2005). Participants 16, 24 and 30's profiles indicate a strong likelihood that they may drop out early from traditional therapy (Bell, 2005).

Participants 8, 14, 16, 24, 29, 30 and 35 may benefit more from behavioural correcting as opposed to insight-oriented psychotherapy. The behavioural correcting should address good boundaries and limit setting, in the form of directive counselling or milieu treatment (Bell, 2005). Participants 18, 22 and 45 may find self-help group and psycho-educational programmes helpful (Bell, 2005).

Participants 8, 14 and 35's profiles indicate that these individuals have difficulty with the give-and-take of traditional group therapy and have problems tolerating the group's demands for self-disclosure and intimacy. They may do better with highly structured groups, such as psycho-education or 12-step groups, where participation does not require intimate transactions with other members (Bell, 2005).

Participants 5, 14, 32 and 45's scores suggest that a further evaluation for the presence of a psychotic disorder is warranted. Psychotropic medications should be considered for relief of target symptoms suggested by the items (Bell, 2005). Participant 14, 32 and 45's scores indicate that a reality-oriented treatment with emphasis on practical problem solving may be helpful (Bell, 2005).

Participants 5, 32 and 45 may benefit from self-help groups and psycho-educational programmes; this is due to the fact that their results indicate that they may continue to experience psychotic phenomena over a long period of time. Skills training groups that emphasise reality checking could also be helpful (Bell, 2005).

Participants 40 and 45 may benefit from social skills groups that focus on learning specific social skills, behavioural rehearsal, and role playing and problem-solving. Social interactions may also be helpful, particularly in overcoming shyness, learning to initiate and sustain conversation, and learning to read complex social situations better (Bell, 2005).

Participants 39 and 40 may become “good” group members who supports the group norms, invest emotionally in the group and encourages cohesiveness (Bell, 2005). Participants 18 and 22 may benefit from group skills training in which they identify the reality of the situation (Bell, 2005).

Participants 14 and 35 may be guarded in individual therapy and might have difficulty in forming a therapeutic alliance. There is a strong likelihood that these individuals may drop out early from traditional therapy (Bell, 2005). Participants 5, 14, 18, 30, 32 and 45’s results indicate that psychosocial interventions, including group activities may be useful in bolstering fragile ego and reducing isolation (Bell, 2005).

Participants 16 and 30’s profile suggest that if they do not drop out of treatment early, breaches in rapport are likely and these individuals are likely to engage in tests of trust. Their narcissistic defenses will probably result in them being mistrustful of the therapeutic alliance (Bell, 2005). Participants 21 and 36’s results do not indicate particular patterns of serious Object Relations deficits or Reality Testing deficits that would present obstacles to treatment (Bell, 2005).

Participant 40’s results indicate that this individual may be reluctant to engage emotionally with the therapist and might have difficulty experiencing the therapist’s interest as genuine. This individual may act remote and distant, but should eventually become invested in the relationship. The participant can benefit from interpretations of transactions in a group setting which may encourage cohesiveness, as well as from interpretations of transactions in the group that reveal underlying feelings of jealousy, competition, sexuality, loss and so forth as well as the accompanying group defenses of fight-flight, dependency and paring (Bell, 2005).

Participant 8’s profile suggests that this individual’s initial engagement with the therapist may be superficial, which may cause this individual to drop out of traditional psychotherapy early (Bell, 2005). Participant 39’s profile suggests that a further assessment of reality distortion phenomena may

be needed as it can be caused by a wide variety of psychological conditions (Bell, 2005). Participant 33's profile suggests the need for psychotropic medications (Bell, 2005).

Participant 38's profile indicates an elevated UP scale score, which suggests that the individual believes that there is something wrong with their mental functioning, which may result in them appearing motivated to seek treatment. However, an elevation on UP does not necessarily indicate a willingness to proceed with treatment beyond being a cry for help. Difficulty with treatment compliance and attitudes of helplessness may further complicate treatment (Bell, 2005).

Participant 18's results suggest that an evaluation for the presence of a psychotic disorder is warranted (Bell, 2005). Participant 21's results do not indicate a particular pattern of serious Object Relations deficit or Reality Testing deficits that would present obstacles in treatment (Bell, 2005). Participant 29 is likely to be sufficiently interested in relations and possesses enough available emotional pain to provide motion for insight-oriented therapy. Such individuals are likely to engage the therapist in complex paradigms and be highly reactive to therapist behaviour. Defense and transference in therapy may be tolerated and such individuals may benefit from a sense of belonging and intimacy found in traditional group therapy. They may be good group members in terms of being emotionally encouraging through their own investment in the group (Bell, 2005).

Participant 14's profile indicates that interpretations of narcissistic defenses will probably be met with hostility and mistrust (Bell, 2005). Participant 8 may benefit from accurate social feedback, as can sometimes be provided in social skills training or therapeutic communities that may be helpful in correcting this individual's abrasive or off-putting social behaviour (Bell, 2005).

Participant 38's profile indicates that a further evaluation is needed in order to determine whether the respondent's doubts about the ability to perceive internal and external reality may include disorientation and other indicators of organic pathology. If this individual has a history of brain function problems, neuropsychological testing is recommended (Bell, 2005).

## APPENDIX L: HPCSA ETHICAL PRINCIPLES

### BASIC ETHICAL PRINCIPLES IN HEALTH RESEARCH (Exact Replica of HPCSA, 2013):

4.1 Some core ethical values and standards have the status of *basic ethical principles*.

4.1.1. *The principle of best interest or well-being:* **The principle of non-maleficence:** risks and harms of research to participants must be minimised. **The principle of beneficence:** The benefits of health research must outweigh the risks to the research participants.

4.1.2. *The principle of respect for persons:* **The principle of autonomy:** participants that are capable of deliberation about personal choices should be treated with respect for their capacity of self-determination and be afforded the opportunity to make informed decisions with regard to their participation in research. Therefore there must be special protections for those with diminished or impaired autonomy i.e. dependant and or vulnerable participants need to be afforded safeguards against harm or abuse.

**4.1.3. The principle of confidentiality:** A participant's right to both privacy and confidentiality must be protected. The researcher must ensure that where personal information about 3 research participants or a community is collected, stored, used or destroyed, this is done in ways that respect the privacy or confidentiality of participants or the community and any agreements made with the participants or the community

4.1.4. *The principle of justice:* Justice imposes an ethical obligation to treat each person in accordance with what is right and proper. In research this is primarily distributive justice whereby there should be equitable distribution of both burdens and benefits of research participation. It is an ethical imperative that the study should leave the participant and/ or community better off or no worse off. Researchers have an obligation to justify their choice of research questions and to ensure that

such questions are neither gratuitous nor result in the exploitation of study participants. The selection, recruitment, exclusion and inclusion of research participants must be just and fair, based on sound scientific and ethical principles. No persons may be inappropriately or unjustly excluded on the basis of race, age, sex, sexual orientation, disability, education, religious beliefs, pregnancy, marital status, ethnic or social origin, conscience, belief or language. Where research involves participants from vulnerable communities, added protections will be necessary to safeguard their vulnerabilities. There needs to be justification for doing research in vulnerable communities. Moreover, the research should be responsive to their particular vulnerabilities. Enhanced or added consent procedures would be necessary where appropriate. Vulnerable communities should not be targeted for research just because of administrative and logistical ease of availability.