THE MUTUALITY OF AUTONOMY SCALE:
AN IMPLICIT MEASURE OF OBJECT RELATIONS
FOR THE RORSCHACH INKBLOT METHOD

J. Christopher Fowler

The Erik H. Erikson Institute for Education and Research
The Austen Riggs Center

and

Philip Erdberg

Rorschach Research Council

The mental internalization of critical experiences with important early childhood caregivers forms the foundation of how each individual perceives, reacts to, and organizes his or her life with people. The quality and character of these internal object relationships impact the quality of current functioning, ranging from relative health and happiness to debilitating experiences of suspiciousness, fear of intrusion, and psychosis. Psychoanalysts generally place great importance on the theoretical and clinical significance of object relations and the accurate assessment of these phenomena. The Mutuality of Autonomy scale for the Rorschach (MOA: Urist, 1977) is one implicit measure of object relations that has broad empirical and clinical support. This brief article provides an introduction to the scale's development, scoring, and applications.

Introduction

Personality assessment for clinical purposes has broadened from the focus of testing to determine analyzability to an approach that emphasizes the assessment of problems that interfere with the establishment of a therapeutic alliance. This broadened approach helps identify potential therapeutic levers, as well as predicting potential therapeutic stalemates and transference enactments that may not be readily discernible in the course of a standard diagnostic evaluation. The ability to employ new models for predicting potential transference paradigms has become critical, as more patients are referred to treatment with severe character pathology and vulnerability to psychosis and suicide. Such patients create special challenges for therapists and hospital staff because premature terminations, turbulent interactions, power struggles and negative therapeutic reactions are more
the rule than the exception. Predicting potential transference paradigms is best done through a careful assessment of object relations prior to beginning psychotherapy because the capacity for interpersonal relating to a therapist depends largely on an individual patient's internal array of object representations.

The strength of object relations theory when applied to psychological assessment is that it provides an understanding of the complex interactions among self and object representations, defenses, pathological formations and ego strengths that make up the entire personality. The Mutuality of Autonomy Scale (MOA: Urist, 1977) is an implicit measure of object relations functioning that has gained broad theoretical and clinical support. Jeffrey Urist first introduced the MOA in 1977 in order to assess the quality and dimensions of an individual's repertoire of internalized object relationships as revealed in his or her Rorschach percepts.

While the MOA has extensive research and empirical support through comparison of diagnostic groups, different clinical groups, and some limited psychotherapy research, the principal utility of the measure is its idiographic use in anticipating the quality of interpersonal interactions with therapists and those close to the patient. As such, it is viewed as a clinical object relations scale for specific clinical applications. It is relatively simple to score and has excellent interrater reliability estimates. There is a growing research base on the MOA for child and adult populations and there is a growing body of evidence with comparative results from inpatient samples from various hospitals in the United States. There is also ample empirical research linking to clinical syndromes and clinically relevant behavior.

**Overview**

Since its introduction in 1977, various researchers have suggested modifications (Urist & Shill, 1982; Spear & Sugarman, 1984; Holaday & Sparks, 2001) based on a variety of rationales. Despite these recommendations, empirical studies and case reports rely almost exclusively on the original scoring (Urist, 1977). Given the fact that the empirical foundations for the scale’s validity rest on this extensive body of research utilizing the original scoring, we recommend using the original seven-point Likert-type scale. General considerations for the use of the Mutuality of Autonomy Scale should include a valid administration of Rorschach protocols utilizing Exner’s (1993) administration guidelines. We have found through a variety of investigations that relatively brief protocols can be considered valid for this content scale; however, records of any length with fewer than two movement responses are invalid and should not be used for this purpose.

The Mutuality of Autonomy Scale provides a structure for assessing a range of internal object representations, the prototypic expectations for relationships, and their most and least adaptive functioning. The scale is based on the assumption that the portrayal of relationships on the Rorschach corresponds to past experience and current definition of human relationships. Based on the developmental object relation theories of Kernberg, Kohut, Mahler, and Mayman, the scale was constructed...
to focus primarily on the developmental progression of separation-individuation from engulfing/fused representations to highly differentiated self-other representations. A second focus of the MOA is the assessment of the degree of malevolent control and destructiveness perceived in imbalanced object relations. This points to its value in assessing the degree to which relationships are perceived as mutually enriching, safe, and well-balanced, as opposed to relationships represented as destructive, dangerous, and overwhelming.

The MOA assesses the thematic content of relationships (stated or implied) between animal, inanimate, and human objects in Rorschach percepts. This Likert-type scale ranges from scale points 1-7, with the lower scores more indicative of health and higher scores reflecting increasing malevolence and loss of distinct boundaries and differentiation among objects.

Scale point 1 reflects the capacity to construe self and other representations as structurally differentiated and engaged in mutually interactive and reciprocal activity. An illustrative response for Card III follows: “Two people doing a synchronized dance, like in a ritual ceremony for a wedding”. This response indicates that the two people are well differentiated and are recognizing the other’s autonomy through their ritualized activity.

Objects and experiences that are differentiated but indicate parallel activity with minimal engagement or recognition of the other object receive a score of 2. Responses such as “Two people washing clothes”, or “Animals climbing a tree” convey a sense of autonomy, but without the indication of an explicit recognition of the other’s independence. Both scales scores 1 and 2 are similar to cooperative movement responses found in the Comprehensive System; however, inanimate movement is also scored in the Mutuality of Autonomy scale.

Scale point 3 reflects dependent relationships in which one or both objects are reliant on the other for stability. Responses such as, “A friendly animal helping these bears up the side of a mountain” or “Two baby birds being fed by the mother bird” clearly indicates that objects do not function independently without external support.

Scale point 4 captures the prototypic mirroring object relationship and often reveals an emerging loss of autonomy between figures where one object is seen as a reflection, an imprint or a mimetic of the other. Responses such as, “Siamese twins because they are connected at the waist” or “A butler staring in the mirror and that’s his reflection” imply that relationships between objects exists only insofar as it is seen as a reflection or an extension of the other. Other examples include, “a smeared fingerprint” and “a shadow cast by a figure walking by”.

Scale point 5 reflects an increasing malevolence and sense of one object controlled or forcibly influenced by another. Percepts in which one object is casting a spell on another or coercively influencing another object such as, “A witch casting a spell over this baby, it’s helpless and defenseless against the power of the spell” should be scored as a 5.
Scale point 6 reflects an increasingly severe imbalance of mutuality, cast in decidedly destructive terms such that the autonomy and survival of the weaker object is seriously jeopardized. An example from Card II illustrates this principle: “One bear is ripping the throat out of the other. Blood is splattered all over the fur and the ground”.

Scale point 7 reflects the complete loss of autonomy of one or more figures by an overpowering, diffuse, and enveloping force. Here the loss of autonomy results in the death and annihilation of the object, such as that found in the following response to Card IX: “An evil fog enveloping this frog. The poison is dissolving its skin”.

Calculating and Summarizing MOA Data

Because the MOA is anchored to theoretical stages of development, a number of conceptually relevant summary scores were developed from raw scores. The arithmetic mean has been used frequently in research studies, and Tuber (1989) suggests that the mean may serve to capture the person’s modal object-relational quality. We found this to be less than fruitful in adult inpatient cases, and instead recommend evaluating several alternative indices. First, the single healthiest, most developmentally advanced score will give some indication of the highest level of adaptation possible, while the poorest, most malevolent and pathological score is often a harbinger for the person’s most disturbed relational functioning. We have also found the range between highest and lowest to be a helpful indicator of the patient’s range of interpersonal functioning. It is quite common, for example, to find the complete range of MOA scores in the protocols of patients diagnosed with Borderline Personality Disorder. This range is consistent with the prototypic borderline profile of intact ego functioning contrasting with vulnerability for massive regression.

Another clinically useful summary score for the MOA is the pathological score (PATH: Berg, Packer & Nunno, 1993), which is the sum of all level 5, 6, and 7 scores. When encountering a patient with a PATH score above 2, one can anticipate periods of stormy interactions, marked by the patient’s increased vigilance and fear of being controlled and coerced. When encountering individual protocols with higher than average PATH scores, the therapist may do well to anticipate that such patients will experience the therapist as wishing to control or manipulate them. As with any Rorschach prediction, the potential for such internal predispositions to surface will be in part dependent on environmental factors, and therefore may not be immediately manifest in the treatment.

A high prevalence scale score of 7 should signal to the examiner and therapist the strong possibility that the patient may, under stress, lose the capacity to differentiate self from other. Scale scores of 7 indicate a breakdown in self and other boundaries, which is often indicative of an underlying psychotic process. Scales scores of 7 have been found to be predictive of patients who self mutilate and have
a higher likelihood of Axis I psychotic symptoms (Fowler, Hilsenroth, & Nolan 2000).

Empirical Foundations

The MOA is quick and easy to score, requiring no more than 10 to 15 minutes for an average length protocol. Early empirical studies reported reliability estimates utilizing the exact percent agreement—a reliability estimate that is not appropriate for a dimensional scale because it is unable to discriminate degrees of agreement and disagreement across the dimensional categories.

Recently, researchers (Bombel, Mihura, Meyer & Katko, 2005) conducted a meta-analysis of MOA reliability from the 31 independent data sets of data from 35 studies. The authors reported excellent reliability for both response level reliability (K= .82) and protocol level reliability (ICC= .90). For clinical purposes the response level reliability is most relevant. Traditionally, ICC values are interpreted as follows: values greater than .74 are considered to indicate excellent reliability, .60 to .74 are considered good, .40 to .59 are considered fair, and values below .40 are considered poor (Cicchetti, 1994; Cicchetti & Sparrow, 1981). With proper training, assessors should be able score the MOA with confidence and a high degree of reliability.

Urist’s (1977) original study investigated the construct and predictive validity of the MOA by predicting patient behaviors on inpatient psychiatric wards based on admission Rorschach records. He reported a strong correlation between MOA scores and staff ratings of patient autonomous functioning. A follow-up study (Urist & Shill, 1982) corroborated this finding with an independent sample, indicating that patients’ Rorschachs predicted the quality and nature of interpersonal interactions on the psychiatric ward. Among the many studies conducted by Steven Tuber assessing the MOA and child samples, the most intriguing was his finding that children’s MOA scores, particularly the pathological scores, predicted adult re-hospitalization up to 20 years after the initial Rorschach was administered. Tuber concluded that the quality of their internal object representations left them vulnerable to collapse.

In adult samples, Fowler, Hilsenroth and Nolan (2000), found that self-mutilating borderline patients manifested more malevolent representations than a matched group of borderline patients who were not engaging in self-mutilation during hospitalization. Fowler concluded that borderline patients who self-mutilate appeared to do so in order to contain and control a dissolving sense of self and other that was manifested in their MOA responses. In a study linking the Rorschach to the DSM-IV criteria for borderline personality disorder, Blais, Hilsenroth, Fowler, and Conboy (1999) demonstrated that the MOA highest score, in combination with Rorschach Oral Dependency scores and devaluation predicted BPD total criteria among patients with a Cluster B personality disorder. In a related study Blais, Hilsenroth, Castlebury, Fowler, and Baity (2001) demonstrated that the MOA, in combination with the Rorschach Oral Dependency Scale and devaluation as a defense demonstrated incremental validity above and beyond the MMPI-2 in predicting BPD total
criteria across all cluster B personality disorder groups. This incremental validity was 30% above and beyond the MMPI-2, a quite impressive level.

In the arena of psychoanalysis, it is widely held that changes in internal object relations and diminished excessive aggressive and hostile introjects will lead to diminished symptoms, an increased capacity to love and work, and a decrease in stormy interpersonal relationships. Several research teams have explored this link between changes in object representations and treatment outcome. In one of the most in-depth and extensive studies of intrapsychic change, Blatt and Ford (1994) examined the nature of intrapsychic and behavioral change across a group of 90 seriously disturbed psychiatric inpatients undergoing intensive psychoanalytic psychotherapy in a therapeutic milieu. At one year into treatment, the researchers found that the patients, as a whole, had made significant improvement in externally validated real world behaviors such as social behavior and symptom expression. For patients primarily concerned with maintaining need-gratifying relationships, changes in the MOA mean score were associated with a move from experiencing relationships as malevolent, controlling and fused, to more benign and differentiated. This structural change corresponded to the anaclitic patients’ improved social competence and motivation for treatment.

Fowler (Fowler, Ackerman, Speanberg, Bailey, Blagys, & Conklin, 2004) demonstrated that the mean MOA score correlated with poorer symptom functioning, as well as relationship functioning and occupational functioning at the time of admission. More importantly, the authors found that the 77 patients demonstrated a medium effect size change in the quality of representations after sixteen months of treatment with the greatest improvement occurring in the differentiation of objects with fewer instances of malevolent, engulfing representations. Furthermore, the degree of improvement in MOA scores correlated positively with improvement in relationship and occupational functioning.

A number of case reports demonstrate the ease of applying the MOA to the assessment of individual cases to anticipate cyclical relationship paradigms. For example, in child assessments, Tuber (Tuber, 1989) provided vignettes from 4 treatments that occurred after predictions were made from the MOA scores. The first three cases suggested a high degree of correlation with later treatment experiences. The 4th case example failed to provide clinically important understanding of the treatment process. This clearly indicated that the MOA is not applicable in all cases and emphasized the need to retain clinical judgment with use of the MOA.

Conclusions

While the data on the MOA appear quite promising, there remain a number of questions to be addressed from an empirical point of view in order to validate the scale and further improve its clinical validity. First, a meta-analysis of the criterion validity of the MOA is necessary to evaluate the scale across multiple domains and to determine which summary scores are most valid. Further examination of its in-
cremental validity would also allow a more measured approach to the scale’s utility. Despite the numerous clinical studies examining patient populations and specific behavioral criteria, there is a dearth of normative samples. Currently we are undertaking an examination of Rorschach protocols from the Rorschach Workshops normative sample to include child, adolescent and adult samples. Finally, while the scoring of the MOA is relatively simple, complex responses pose difficulties for examiners; therefore, we intend to set forth a set of discrete scoring rules, providing examples of complex responses in order to increase the reliability of scoring.

References


Copyright © December 2005 / January 2006


Received: 31 January 2006

Address Correspondence to:
J. Christopher Fowler
25 Main St.
Stockbridge, MA 01262
United States of America