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Objectivity in psychoanalytic judgements

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Background There is widespread scepticism concerning the reliability and validity of psychoanalytic judgements of patient–therapist transactions. We predicted that (a) in reviewing the initial part of 14 videotaped assessment interviews with borderline and dysthymic subjects, dynamic psychotherapists would agree in their ratings of psychoanalytically relevant characteristics of subjects' interpersonal relations; (b) inter-correlations among the ratings would conform with those expected from psychoanalytic descriptions of 'paranoid–schizoid' and 'depressive position' states of mind; and (c) these ratings would differentiate between borderline and dysthymic groups.

Method Six trained psychotherapists who were blind to the design of the study, independently rated qualities of interpersonal relatedness during the first 30 minutes of each interview, on a 30-item 'personal relatedness profile'.

Results There was satisfactory interrater reliability in judgements among the raters, and evidence that the items were interrelated. There was also a significant difference between the two subject groups.

Conclusions It is possible to make reliable psychoanalytic judgements about qualities of interpersonal relatedness. Moreover, there is evidence that paranoid–schizoid and depressive positive aspects of psychological functioning do constitute a meaningful constellation of clinically grounded phenomena.

In his attack on psychoanalysis as a pseudo-science, Eysenck (1985) insisted that: "a science cannot be based on subjective interpretations". We have responded to this criticism by testing whether it is possible for independent raters to agree in their psychoanalytic judgements about videotaped patient–therapist transactions. A further aim was to examine the coherence and clinical validity of Klein's characterisation of paranoid–schizoid and depressive position modes of mental functioning.

METHOD

Focus of the study

Henry *et al* (1986) proposed that: "interpersonal transactions in the therapy dyad should become the fundamental unit of psychotherapy process analysis". We adopt this view because it is in keeping with psychoanalytic attitudes and practice. Our research is partly concerned with 'role relationships' and affective states manifest in patient–therapist transactions, and has affinity with previous approaches such as Luborsky's 'Core conflictual relationship theme method' (1977; Luborsky & Crits-Christoph, 1989), the technique of 'Configurational analysis' devised by Horowitz (1987, 1991), and the 'Structural analysis of social behavior' (Benjamin, 1974; Hartley, 1991). In order to capture the qualities of more disturbed *vis-à-vis* more integrated kinds of interpersonal experience, we have found it necessary to draw upon a body of psychoanalytic writing not previously tapped in this methodological tradition. We focused upon features of paranoid–schizoid and depressive functioning highlighted within Kleinian psychoanalytic literature (Klein, 1935, 1946; Segal, 1973). We also drew upon work by Taylor & Feldman (personal communication), who devised a set of 'Object attribute' scales to capture the qualities of a subject's 'internal world' of phantasised people and their interactions.

The paranoid–schizoid position characterises a psychological stance in which an individual deploys omnipotent defences to control a fragmented, nightmarish world in the face of threatened annihilation by persecutors who are experienced as being split from idealised figures. In the depressive position, the individual's basic anxieties are of losing or harming a figure on whom they depend. This figure is separate and has a life of its own, someone who is both loved and hated and in relation to whom the individual may feel pining, concern and guilt. Although an individual may alternate between the two positions, they are essentially antithetical to one another; at any given time people experience others from either the paranoid–schizoid or the depressive position. Therefore, someone who functions primarily in the paranoid–schizoid position will have few experiences of depressive position quality, and *vice versa*. In this sense the respective positions can be considered to represent the poles of a single dimension of social experience.

Hypotheses and predictions

The aim of our study was to highlight how the qualities of a person's interpersonal relations (and 'internal object relations', since we were focusing on the ways individuals experience themselves and others) are available for systematic scientific study. The hypotheses underlying the investigation were as follows: (a) there are patterns of interpersonal relatedness between a subject and therapist that may be characterised according to whether these are paranoid–schizoid or depressive position in quality; (b) such patterns represent constellations of clinical features that may be enumerated separately, and judged reliably by independent psychotherapists; and (c) subjects who satisfy diagnostic criteria for borderline personality disorder are more likely to manifest paranoid–schizoid features and less likely to experience people from the 'depressive position' than those with dysthymia. Although this latter hypothesis has not been tested before, there is evidence (Westen, 1990) that individuals with borderline personality disorder are prone to experience others as malevolent, to experience relationships in need-gratifying ways, and to be especially sensitive to abandonment.

Our predictions were that: (a) independent clinicians would be able to agree in

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their 'subjective' judgements about the same psychoanalytically-relevant events and interpersonal transactions within videotaped interviews; (b) the overall patterns of relatedness so judged would conform with those characterised as paranoid–schizoid and depressive position in quality; and (c) there would be at least suggestive evidence that these patterns of relatedness have clinical validity, as they would differentiate two groups of subjects whose distinct conventional psychiatric diagnoses might correspond with contrasts in styles of object relations.

Procedure

Clinicians who were in psychodynamic training in two institutions judged the role–relationship patterns and states of mind of a series of female subjects, as each subject interacted with a psychotherapist. The materials judged were videotapes of assessment interviews conducted along psychoanalytic lines by R.P.H. within a National Health Service psychoanalytic psychotherapy setting. The interviews had been conducted according to routine clinical practice, mostly a number of years before the present study was conceived, and in accordance with established ethical guidelines for such clinical research.

The videotapes were selected from a collection of such taped interviews on the basis of the case records of the subjects interviewed. M.P.H.P. and R.P.H., trained psychiatrists, independently rated the case notes of all female subjects aged between 25 and 35 years who had had their assessments videotaped. The assessing psychotherapist's report was excluded from the case notes before rating, so that the evidence available comprised a referral letter from a general practitioner or psychiatrist outlining the subject's background and psychiatric history, and a questionnaire inviting the subject to describe his or her background and presenting complaints. DSM–III–R diagnostic criteria (American Psychiatric Association, 1987) were employed when making diagnoses. We included all subjects who met the diagnostic criteria for borderline personality disorder, and the same number of unselected subjects with dysthymia, as agreed by both judges. As far as could be judged from the case notes, none of the subjects had any axis I or axis II comorbidity. It is important to note that the videotapes were not reviewed prior to this screening of the case records.

The nature of the interviews was that the interviewer introduced himself and in the interview, but then provided little by way of structured questions, and allowed the course of the interview to be shaped by the subject's own responses to the situation. The interviewer's aim was to focus on how the subject experienced both the interviewer and the setting, and to an articulate understanding of this as clearly and sensitively as possible. Thus, in contrast to the usual psychiatric interview, the interviewer focused upon the nature of the relations between the subject and himself, rather than pursuing details of the clinical history or current phenomenology (which the interviewer would address separately, when indicated, towards the end of the 90-minute interview).

Subsequently, judges were asked to view the first 30 minutes of 14 videotaped interviews, and to rate the clinical material according to the Personal Relatedness Profile (PRP; see Appendix). The only training the judges received on the PRP was discussion and guidance in relation to two brief excerpts of transcribed interview material from subjects outside the study, and a single practice videotape. The 30 unipolar items of the PRP cover three distinct but closely related areas of interpersonal functioning: the 'relatedness patterns' typical of each subject; the characteristics of the people (objects) whom the subject either describes in his or her own life or appears to find in the person of the therapist; and the predominant affective states to which the subject is prone.

To some extent, the division into the three areas is arbitrary; our aim was to encompass the most important features of paranoid–schizoid and depressive position functioning according to criteria that partly overlap and partly complement each other. Fifteen of the items were intended to capture aspects of paranoid–schizoid functioning, and 15 were to assess depressive position functioning. Theoretically, it might be expected that low scores on the paranoid–schizoid items would be characteristic of depressive position functioning, and *vice versa*. The use of unipolar scales allowed us to examine this.

RESULTS

Reliability of item ratings

A preliminary matter was to deal with the ratings where a subject was judged to be 'unclassifiable' with respect to a particular item. Such judgements were rare, just 1.7% of the 2520 ratings. We decided to adopt a conservative approach and to assign to these instances mean values calculated from the remaining subjects' scores on that variable. The use of this centralising estimate is neutral with respect to the measured agreement among judges.

In order to measure and test agreement among the judges on the relative ordering of the 14 subjects on each item, we employed Kendall's W (which takes values from 0 for no agreement, to 1 for perfect agreement) together with a statement (P) of the significance of the agreement, derived from the fact that $k(n-1)W$ is distributed as χ^2 with $n-1$ degrees of freedom, where k is the number of judges and n the number of entities (subjects) being judged. The coefficients of concordance (W) and their associated probabilities appear in Table 1, where it can be observed that the ordering of all but five items differed significantly from chance. In view of the consistent pattern of these results on such a small sample, we decided that results from all the items should remain in the data set for further consideration. A small number of items were less reliably rated, but their inclusion would introduce a conservative bias into the subsequent analyses.

Dimensionality

The PRP was designed to assess a particular, theoretically informed aspect of psychological functioning. The prediction was that scores on the items characterising paranoid–schizoid functioning would correlate highly with each other, and that scores on the items characterising depressive position functioning would show similar high intercorrelations: but the two clusters of item scores would manifest negative correlations with each other, because they represent the two poles of a single dimension. In fact, we reverse-scored the paranoid–schizoid items so that our prediction became that scores on all items would intercorrelate in a single cluster.

Although the preferred method of testing such a prediction is to conduct a factor analysis of the pattern of intercorrelations among item scores, this is problematic in the present instance because a relatively large number of ratings were made on a small number of subjects. The danger is that such an analysis might yield spurious evidence for a factorial structure. To reduce the risk of this, we condensed and analysed the data in the following way.

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Table 1 Interrater reliabilities among six judges in rating items of the personal relatedness profile

Item no.	Kendall's W	χ^2 (d.f.=13)	$P<$
1	0.35	27.3	0.02
2	0.31	24.1	0.03
3	0.32	25.0	0.03
4	0.29	22.4	0.05
5	0.34	26.8	0.02
6	0.35	27.2	0.02
7	0.46	35.5	0.001
8	0.26	20.6	0.09
9	0.27	21.0	0.08
10	0.38	29.9	0.01
11	0.40	31.3	0.01
12	0.21	16.5	0.23
13	0.31	24.3	0.03
14	0.30	23.4	0.04
15	0.42	32.6	0.01
16	0.33	25.4	0.03
17	0.40	31.2	0.01
18	0.48	37.1	0.001
19	0.24	19.0	0.13
20	0.34	26.3	0.02
21	0.26	20.6	0.09
22	0.32	25.2	0.03
23	0.34	26.8	0.02
24	0.53	41.2	0.001
25	0.54	42.0	0.001
26	0.39	30.3	0.01
27	0.47	36.5	0.001
28	0.53	41.5	0.001
29	0.60	46.9	0.001
30	0.29	22.5	0.05

We began with our predicted outcome (rather than analysing the data from scratch), and divided the items into those 15 items that were intended to tap paranoid–schizoid functioning and those 15 items that were intended to tap depressive position functioning. We reverse-scored the former items, so that for all items, a high score represented more integrated and less paranoid functioning. Second, we arbitrarily divided each subset of items into two. The point was to determine whether the intercorrelations among scores on the resulting four 'variables' would suggest whether only one factor was required to account for most of the intercorrelations observed, or whether more than one factor was identifiable. The issue was whether there was only one dimension to the psychological functioning underlying the correlations among scores, in which case all items should correlate with each other, or whether there was little or no correlation within and between the composite paranoid–schizoid and depressive position variables.

Thus, the condensed data set comprised four composite scores for 14 subjects. Each composite score was the sum of the mean item scores within the newly-created variable, where the mean item scores were calculated across the six judges. Two of the composite scores related to the paranoid–schizoid position and two to the depressive position. It was on this data set that we conducted a factor analysis, using the maximum likelihood method of extraction, to test the prediction that a single factor would account for the intercorrelations among scores. The result of this factor analysis was that a one-factor solution fitted the correlation matrix, with a single factor (eigenvalue 3.24) accounting for 76% of the variance. The χ^2 test of the fit of the reproduced matrix to the obtained matrix yielded a value of 2.45, d.f.=2, NS. Thus, there was no evidence that a further factor was involved in accounting for a substantial part of the variance.

Ill-fitting items

The next task was to eliminate from consideration those items on which scores failed to correlate with other scores on the PRP. The approach we adopted to exclude items was to conduct a principal components analysis using all 30 items to establish whether any items had low loadings on the first component. It was considered that such an approach was justifiable despite the high ratio of variables to subjects, on the grounds that we were seeking low loadings, and the bias would be towards the generation of high loadings.

Six items proved to have low loadings (<0.3) in the factor analysis (items 16, 19, 22, 23, 25, 27, 28 and 30), all but two of which are concerned with judgements of the subjects' predominant affective state. It is of note that with the exception of item 19, these items were judged as least as reliably as others (Table 1). Therefore it is quite possible that the judgements on the items are clinically significant for other purposes, even though for the present sample of subjects in the videotaped interview setting of this study, they do not correlate with other aspects of paranoid–schizoid/depressive position functioning.

For the remainder of the paper, we shall exclude the ill-fitting items from consideration. This will enable us to focus on those items that appear to represent paranoid–schizoid/depressive position functioning.

Plot of individual subjects' scores

The next question is how individual subjects scored on the paranoid–schizoid and depressive position items. An initial step here was to consider separately the mean ratings of all six judges on the two subsets of items, and on both the paranoid–schizoid subscale (Cronbach's reliability coefficient alpha=0.91) and on the depressive position subscale (reliability coefficient alpha=0.97), there were acceptable levels of inter-item agreement.

The pattern of individuals' scores on the two subsets of items is illustrated in Fig. 1. Each point represents an individual's mean score out of five on the paranoid–schizoid items (reverse scored so that a high score signifies a low degree of paranoid–schizoid functioning, which is expected to correspond with a high depressive position score), and her mean score out of five on depressive position functioning. It can be seen that the majority of individuals do exemplify the positive correlation between the (reverse-scored) paranoid–schizoid and depressive position scores that emerged from the initial factor analysis, but that there is some variation in this respect. For example, three subjects were judged at least as paranoid–schizoid as the individual with the lowest score on the depressive position items (Fig. 1).

Between-group differences

Our final approach to analysing the data was to test the prediction that the two subject groups would be discriminable according to their scores on the PRP. This

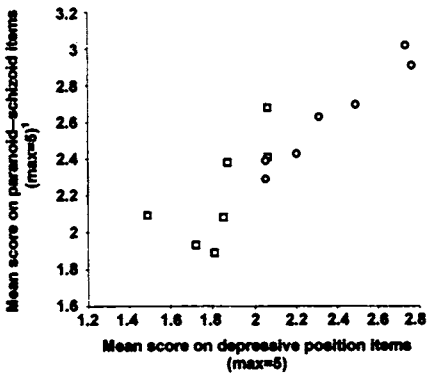


Fig. 1 Scores on paranoid–schizoid and depressive position items. □, Individual with borderline personality disorder; ○, individual with dysthymia.
†. Reverse scored so that high scores mean less 'paranoid–schizoid'.

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was accomplished by conducting a *t*-test for between-group differences in subjects' mean scores per item across all items (except those that had been excluded earlier on the basis that they were ill-fitting). We should emphasise once again that paranoid–schizoid items were reverse-scored, so that a high score per item overall represents psychological functioning towards the depressive position end of the dimension.

Our prediction was that the subjects with borderline personality disorder would tend to be rated towards the paranoid–schizoid end of the dimension. Although we anticipated that there would be variability among the subjects with depression, some of whom might be expected to function in a paranoid–schizoid way, at least at times, we also predicted that the two groups would be discriminable in this respect.

When subjects' mean scores per item were calculated on the basis of ratings across all six judges, the results were as follows: subjects with borderline personality disorder 2.01 (s.d.=0.21) and subjects with dysthymia 2.47 (s.d.=0.27), a highly significant group difference (t=3.51, d.f.=12, P<0.005, one tailed). The degree of separation between the individuals of the two groups is captured graphically in Fig. 1. Here it may be observed that there was only a modest overlap between the groups.

DISCUSSION

Research strategies developed in the past two decades have led to renewed optimism that psychodynamic concepts and clinical phenomena might be measured and evaluated by objective methods (Luborsky & Spence, 1978; Luborsky *et al*, 1986; Horowitz, 1991; Barber & Crits-Christoph, 1993). Although novel in design, our study belongs to this tradition of work. In spite of the small sample size, it yielded evidence in keeping with each of our hypotheses about the objectivity and clinical validity of certain psychoanalytic concepts.

Independent judges were able to rate a range of items concerned with psychoanalytically meaningful events within a psychodynamic interview with acceptable interrater reliability. The factor analysis on four specially constituted 'composite variables' suggested that on the items under consideration, a single factor corresponding to the dimension ranging from paranoid–schizoid to depressive position functioning accounted for a substantial part of the intercorrelations among item scores. This result is in keeping with the view that the constellations of clinical phenomena identified in psychoanalytic writings represent clinically coherent states of intrapsychic–interpersonal psychological functioning. The borderline personality disorder and dysthymia groups were significantly different in their scores on the PRP, with the subjects in the borderline group tending to be rated more highly on paranoid–schizoid and less highly on depressive position functioning than were the subjects in the dysthymia group. This provides suggestive evidence that the psychodynamic ratings were not only reliable, but also clinically valid (Westen, 1990).

Methodological issues

A number of doubts may be raised in relation to the findings. If the subject groups had manifested a very wide range of psychodynamic or other features of psychopathology, this might have inflated estimates of the reliability with which judgements can be made, and brought into question the psychoanalytical specificity of the present findings. For example, almost any ratings of 'seriousness of psychopathology' might prove to be reliable in relation to such groups. In fact, we deliberately selected groups that were not widely divergent in the seriousness of their clinical presentation. All were on the waiting list for out-patient psychotherapy, with significant but not debilitating interference with their day-to-day and interpersonal functioning. In a previous study with similar borderline and dysthymic groups from the same clinic (Patrick *et al*, 1994), levels of current depression and reported past traumata were comparable across groups. As the outcome of the factor analysis indicated, scores on the PRP captured the quality rather than quantity of these subjects' psychological functioning. There is no *prima facie* reason why 'more seriously' troubled (e.g. depressed, anxious, schizoid) people should have controlled–controlling relations with others, nor should experience others as more or less malevolent or untrustworthy, and so on.

Another possibility is that if the specific items of the PRP corresponded closely with certain of the clinical criteria used to establish the two subject groups in the first place, then one could be following a circular course and revealing nothing of substance. It is indeed the case that a small subset of the diagnostic criteria of DSM–III–R such as unstable relationships and affective instability map almost (but not quite) directly on to a small subset of the PRP items. This is as it should be, following the psychoanalytic view that patterns of interpersonal relations reflect configurations of internal object relations. On the other hand, the majority of the DSM–III–R criteria do not map on to PRP items, and the majority of PRP items find no obvious counterparts in the DSM–III–R criteria. Paranoid–schizoid configurations of 'internal object relations' are broader in psychodynamic scope and narrower in behavioural anchorage than the clinical features detailed in the DSM–III–R scheme. Also, depressive position qualities such as the capacity to appreciate and have concern for people, have little to do with the kind of depressive phenomenology associated with dysthymia. As it turned out, in keeping with our expectation, paranoid–schizoid functioning was more marked in but not restricted to subjects with borderline personality disorder.

Finally, it might be argued that some of the items of the PRP should be associated with or dissociated from each other simply because they describe rather similar (or in some cases contrasting) things. Although this possibility cannot be ruled out, it is implausible that the majority of the paranoid–schizoid and depressive position items could be grouped *a priori*, without reference to any psychodynamically or clinically informed knowledge. Of course, this raises a further question in the present context, whether the psychodynamically trained judges were led by their preconceptions to score some PRP items with reference to other items that they had already scored. Although not all of the items of the PRP that we had expected to differentiate between paranoid–schizoid and depressive position functioning were judged to do so, it requires a further study with psychoanalytically naive judges to assess the importance of this possible bias.

Future prospects

To date, our focus has not been on the PRP as a measure, with the requirement that this should satisfy the usual criteria for psychometric adequacy, but rather on the more specific issue of whether paranoid–schizoid and depressive position states of mind can be identified. It would need much additional work to modify and validate the PRP so that it might be used for such tasks as assessing the potential significance of

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object-relational patterns for our understanding of conventionally defined psychiatric disorders, identifying indications and contraindications for psychotherapeutic intervention, or serving as an outcome measure for evaluating the effect of psychotherapy. Having said this, there would seem to be scope to develop the present approach in order to complement the other measures of interpersonal functioning currently used in psychotherapy research, not least because of its systematic coverage of the clinical features characteristic of paranoid–schizoid and depressive position functioning.

From subjectivity to objectivity

Far from being esoteric and abstruse, psychoanalysis always has broadened and will continue to broaden the compass of 'common-sense' understanding of the mind (Auden, 1966). One of the principal aims of this study has been to illustrate how certain psychoanalytic ideas that are often portrayed as fanciful or absurd are grounded in clinical phenomena that are available to public scrutiny and appraisal.

We agree with Eysenck that science cannot be based on (merely) subjective interpretations. However, if trained judges can agree in their subjective interpretations, then we move into the realm of the objective (Sargent, 1961) – and certain prejudices about the pseudo-scientific status of psychoanalytic ideas may need re-examination in this regard. The evidence from the present study suggests that it is possible for independent judges to agree in rating psychoanalytical aspects of interpersonal relatedness, and that such judgements have clinical relevance.

CLINICAL IMPLICATIONS

- Psychoanalytic judgements can be objective as well as subjective.
- Klein's concepts of paranoid–schizoid and depressive positions represent coherent ways to characterise modes of interpersonal relatedness.
- Subjects with borderline personality disorder and dysthymia are partly discriminable according to their degree of paranoid–schizoid/depressive position functioning.

LIMITATIONS

- The sample sizes were small.
- There were relatively informal and only partly independent case note diagnoses.
- A few of the diagnostic criteria for borderline personality disorder might logically imply paranoid–schizoid functioning.

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APPENDIX

Personal relatedness profile

Personal relatedness

On this first part of the scale, we would like you to consider the quality of what the patient experiences to happen between him/herself and others, or in some cases between other people (as reported), and to make judgements on the extent to which each of the following characterise the individual's overall functioning. The quality of relatedness between patient and interviewer should also be considered in making a judgement.

Characteristic 'relatedness patterns' involve:	Very uncharacteristic			Very characteristic		Unclassifiable
1. Mutuality allowing freedom for (and potentially loving links between) participants	1	2	3	4	5	U
2. Vengefulness, retaliation, operating by the 'law of talion'	1	2	3	4	5	U
3. Participant(s) able to benefit from the capacities and contributions of others	1	2	3	4	5	U
4. Lack of concern, use of people as things	1	2	3	4	5	U
5. Intense, univalent, black-or-white exchanges, perhaps wonderful or awful	1	2	3	4	5	U
6. Clear or subtle indications of locked-in hostility, abuse, victimisation, and/or controlled–controlling relations (including sado-masochism)	1	2	3	4	5	U
7. Genuine, appropriate concern between participants	1	2	3	4	5	U
8. A capacity for ambivalence, in which the participant(s) grapple with the complexities of relationships	1	2	3	4	5	U
9. The potential for forgiveness, with a tendency to seek resolution of difficulties and reparation of harm done	1	2	3	4	5	U
10. Destructive envy, spoiling, devaluation and/or contempt	1	2	3	4	5	U

Characteristics of people ('objects')

In this second series of scales, we would like you to consider the nature of the people that the individual feels he or she encounters (possibly reflecting internal objects). The characteristics may be inferred from behaviour during the interview, or from the patient's own descriptions. The picture may contain apparent contradictions (that is objects of very differing natures, for example of very good and very bad figures). Ratings may also apply to a patient's experience of 'self', as well as of others. Once more, we would like you to judge the extent to which the following characterise the individual's overall experiences of people.

The figures are experienced as:	Very uncharacteristic			Very characteristic		Unclassifiable
11. Loyal, committed, 'straight'	1	2	3	4	5	U
12. Narcissistic, self-preoccupied, unattuned, using others for self gratification	1	2	3	4	5	U
13. Emotionally available and caring, with recognition of the needs and wishes of others	1	2	3	4	5	U
14. Able to acknowledge dependence and helplessness without overwhelming anxiety, possibly genuinely grateful	1	2	3	4	5	U
15. Benign, benevolent, helpful to development	1	2	3	4	5	U
16. Omnipotent, feeling no need of others	1	2	3	4	5	U
17. Persecutory, dreadful, malevolent, gratuitously nasty	1	2	3	4	5	U
18. The picture that emerges is of 'three-dimensional', substantial, coherent, defined and integrated people	1	2	3	4	5	U
19. Betraying, untrustworthy, abandoning, deserting	1	2	3	4	5	U
20. The picture that emerges is of ill-defined, 'thin', fragmented and/or amorphous figures	1	2	3	4	5	U

Predominant affective states

Please rate the degree to which the following characterise the individual's consciously experienced affective states. We would again encourage you to use your intuitive and clinical skills in judging what the material expresses about overall functioning, as well as basing ratings on explicit evidence.

	Very uncharacteristic			Very characteristic		Unclassifiable
21. Integrated feelings of loss and mourning	1	2	3	4	5	U
22. The experience of solitude as at times rewarding and beneficial	1	2	3	4	5	U
23. Intolerable frustration or sense of deprivation and/or extreme emotional 'hunger'	1	2	3	4	5	U
24. Feelings of claustrophobia and/or intrusion	1	2	3	4	5	U
25. Overwhelming depression	1	2	3	4	5	U
26. Feeling gratified, enriched, satisfied or nourished	1	2	3	4	5	U
27. Flooding anxiety	1	2	3	4	5	U
28. Uncontrolled rage	1	2	3	4	5	U
29. Pleasure in sustained closeness and/or intimacy	1	2	3	4	5	U
30. Profound empty aloneness	1	2	3	4	5	U

For the purpose of this paper: the 'paranoid–schizoid' items are numbers 2, 4, 5, 6, 10, 12, 16, 17, 19, 20, 23, 24, 27, 28, 30. The rating procedure was introduced with examples and videotape material, and we would not support its use without adequate training.

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