THE KLEINIAN PSYCHOANALYTIC DIAGNOSTIC SCALE (KPDS): A DIAGNOSTIC SCALE FOR INTERDISCIPLINARY RESEARCH

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Summary

Aims

Our group at the Fundació Hospital Sant Pere Claver (Barcelona, Spain) formed by psychoanalysts (Sociedad Española de Psicoanálisis/ IPA), psychiatrists and psychologists of strong psychoanalytic orientation and long experience in clinical psychiatry, together with Servizio d'Igiene Mentale dell'Etá Evolutiva (SIMEE) number 9 from Milano (Italy), directed by Dr Carla Marzani, undertook the task of constructing a psychoanalytic scale, which was named the Kleinian Psychoanalytic Diagnostic Scale (KPDS). It was intended to be an assessment instrument based on the theory of object relations, with the aim of introducing the patient's intra-psychic and relational dimensions into studies of clinical, psychotherapeutic, epidemiological and psychiatric diagnostic research.

The KPDS attempts to be a cross-sectional diagnostic approach to aspects of mental functioning, based on the assessment of the patient's object relation founded on transference and counter-transference phenomena. This instrument is able to detect psychic change processes (from Paranoid-Schizoid position to the Depressive position).

The scale is composed of 17 items that intend to define the subject in relation to some of the most central parameters in the Kleinian-Bionian psychoanalytic model.

Methods

The design and study of the statistical properties of the KPDS, regarding its inter-rater reliability, test-retest reliability and Cronbach's alpha construct validity (internal consistency) was completed between 1991 and 1995 and published by Aguilar, J (et al), in Acta Psychiatrica Scandinavica (1996); 94: 69-78.

We are now working on a paper on the bi-factorial structure of the KPDS and the ability of its two factors (Integrated versus Paranoid-Schizoid and Reparative versus Persecutory Guilt) to discriminate between diagnostic groups obtained from DSM IV-R criteria.

We are also preparing a paper about the concurrence validity between the KPDS and the Rorschach Test. Results indicate that 11 Rorschach variables explain, in multiple regression analysis, 60% of the variance of factor 1 of KPDS, named the "Integrated versus Paranoid-Schizoid" factor.

Finally, we have recently (June 2004) designed a study that tries to evaluate the relation between some biologically rooted personality dimensions, some genetic polymorphisms (DRD4; 5HTTLPR and COMT) and the KPDS psychoanalytic structural profiles, in a group of 100 patients with Major Depressive disorder and 120 normal controls.

The objective of this study is to evaluate whether the KPDS has a predictive value regarding response to antidepressant treatment, considering a subgroup of depressive patients that due to their psychodynamic structure will not improve with psychopharmacological treatment only. We will also investigate whether biological personality dimensions, in agreement with the TCI-R of Cloninger et al, and genetic polymorphisms have any correlation with the structural dimensions of KPDS.

Results

Click on the links for the results of the component studies of this research program.

See Component study 1: The Kleinian Psychoanalytic Diagnostic Scale (revised version): presentation and study of reliability

Implications for psychoanalysis

We think that our scale could be useful for psychoanalysts in the following ways:

1. As an educational and formative instrument for psychologists and psychiatrists who have initiated their education as psychoanalytic psychotherapists or who are taking their first steps in a psychoanalytic institution.
2. As a conceptual research instrument.
3. As a tool for interdisciplinary dialogue.
4. As a critical instrument to overcome a possible trend to produce over-inferences.

1. As an educational and formative instrument.
We have developed a method of using the KPDS as a didactic instrument, following five steps:

a. The members of a group of psychiatrists and psychologists assist in a video-projection in which two consecutive interviews have been recorded with the same patient. They do not have access to any other information besides what is given through both recordings. The interviews last for approximately 45 minutes each.
b. Once the video has been projected, the members of the group independently rate the 17 items of the KPDS.
c. Afterwards, the members of the group together with psychoanalytical supervisors proceed to a clinical psychoanalytic discussion about the information contained in both interviews, in terms of the quality of anxieties, prevalent mechanisms of defence, unconscious fantasies, pathological organisations of the personality, and so on.
d. Once the process of clinical study has finished the ratings of KPDS are reconsidered, analysing the agreements and disagreements produced on those ratings by each member.
e. The agreements and disagreements for each of the 17 items of the KPDS are now analysed according to the clinical comprehension previously obtained with the supervised clinical discussion.

We believe that this method enables clinical discussion to enter dialogue with the information taken from a psychoanalytic scale, primarily thought to be useful for empirical research. It also enables careful consideration of whether the scores given to each of the 17 items are discordant with the clinical comprehension derived from the group discussion. Our experience is that this method enables a deep reflection process, which is generally felt as satisfactory for the group.

On the other side, the repetition of this process facilitates an internal exploratory pattern that could orientate people beginning their formation on psychoanalytically oriented grounds. If successful, it leads to a certain capacity of dialogue between the need to have good exploratory schemes and the

Bionian dictum of listening to the patient "without memory and desire".

2. As a concept-revising instrument.
KPDS, as a constant point of reference, that has defined in what sense the concepts present in each one of their 17 items are used, frequently enables us to see in which other ways raters are using psychoanalytic concepts.

We have not used KPDS systematically in this way, but we have detected on many occasions the possibility to do it. For instance, when we became aware that we had conceptualized Projective Identification only as a pathological mechanism of defense, (predominantly guided by hostile or idealized feelings), leaving out the possibility to see it as a basic psychological operation to obtain the possibility of having a theory of mind, in order to be empathic in our communication or to be oriented in relation to the social and interpersonal cues present in our relations.

Another clear example could be the use of persecutory superego. We realized thata persecutory guilt embedded in a melancholic structure is quite different from a persecutory guilt present in a schizophrenic patient.

All this has allowed us to discriminate some of the limitations of the KPDS as a clinical instrument. We have also learnt to consider it as a concept-making tool from which we can check our dynamic comprehensions.

3. As an interdisciplinary dialogue instrument.
One of our main concerns when elaborating a psychoanalytic assessment scale was to have an instrument that would allow an inter-disciplinary dialogue with other perspectives such as psychiatric, cognitive, biologist…..In fact, the scale was created in order to introduce the patient's intra-psychic and relational dimension into the clinical and epidemiological research of psychiatric diagnosis. Currently, we have designed a research project that copes with this concern. We summarize it in order to explain what we understand for interdisciplinary dialogue.

In this project we are going to study 100 patients with Major Depressive Disorder (MDD) and 120 subjects without MDD. We intend to study the possible relation between different genetic polymorphisms, depressive vulnerability and basic personality structure, studying the last one through KPDS and the personality dimensions of Cloninger: Novelty Seeking (NS), Harm Avoidance (HA), Reward Dependence (RD) and Persistence (P).

These 4 dimensions, as biologically rooted, could tell us about the relation between the personality and some genetic polymorphisms, while KPDS could shed some light on the question of whether there exists a particular profile of anxieties and defense mechanisms or a peculiar type of negotiation between Paranoid-Schizoid and Depressive positions in relation to Cloninger dimensions, or genetic polymorphisms. This study will also show whether KPDS has a sufficient capacity to predict if there exists a subgroup of patients with MDD, that because of their personality structure will not improve with pharmacological treatment only .

We think that a design like this could contribute to the creation of areas for interdisciplinary dialogue between psychoanalysis and biologically oriented research. Actually, this design is the result of a collaboration between psychoanalysts and psychiatrists belonging to one of the more biologically oriented psychiatric services in Barcelona (Spain). In fact, some of their professionals are coming near to more dynamic approximations, beginning to accept the idea that a psychoanalytical approach could help many patients that now are only treated with pharmacological treatments or with psychiatric support.

4. KPDS as an instrument to examine a possible trend to over-inference.
Analyzing the use of the KPDS by different professionals, we have seen a common trend among psychoanalytic investigators, to seek excessive coherence in the way the 17 items of the scale are

scored, as though psychoanalysts share a general scheme of comprehension that is frequently more implicit that explicit. This general scheme of psychoanalytical comprehension about the clinical material frequently represents an impediment to score each item of the scale independently from the others without too much contamination derived from the implicit general scheme. Thus, a predominant Paranoid -Schizoid position in a patient does not always mean the exclusion of well integrated psychological functioning in some aspects of his ego structure. The possibility to score each item of the scale independently frequently enables a much deeper analysis of the complexities and richness of the different levels coexisting in the same person.

Finally I would say that when we psychoanalysts do empirical research, we sometimes find it difficult to produce a hypothesis that time can confirm or disconfirm. The long period of time between the production of our hypotheses and their final confirmation or denegation, makes us more humble and conflicts with our desire to obtain the results that our hypotheses predict.

I think that this necessary humility is also important when we are working clinically with our patients. We believe that in a psychoanalytical therapeutic process it is very important to develop the capacity to produce hypotheses that can be confirmed or disconfirmed with time. This is a basic pre-condition for learning from experience.

Keywords

Depressive position, ego abilities, Kleinian-Bionian model, Kleinian Psychoanalytic Diagnostic Scale (KPDS), paranoid-schizoid position, persecutory type of guilt, projective identification, reflective function, reparative type of guilt

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COMPONENT STUDY 1: THE KLEINIAN PSYCHOANALYTIC DIAGNOSTIC SCALE (REVISED VERSION): PRESENTATION AND STUDY OF RELIABILITYACTA PSYCHIATRICA SCANDINAVICA (1996) 94: 69-78

Aims

1. To obtain a chart and profile of the intrapsychic and relational structure of the patients through the study of four basic dimensions named: 'Ego Abilities'; 'Projective Identification'; 'Paranoid-Schizoid'; 'Depressive'.

2. The study of inter-rater reliability, its stability over time lapse, as well as internal consistency.

Methods

Subjects: 57 adolescent patients (30 boys and 27 girls with a mean age of 14.4 years, range 13-17 years, with a predominance of the fringe ages of 13 and 14 years, which represent almost 60% of the cases).

Procedure: 3 unstructured interviews, at 1-week intervals, with each patient. Each interview lasted for 45 minutes with one interviewer (I) and one observer (O) present in each. Neither I nor O had any previous knowledge of the patient. I and O pairs were randomly formed from among the members of the research group, and if the same pair came up twice, then the person who had previously been I now became O, and vice versa. I and O scored the KPDS independently of each other and immediately at the end of the second (first assessment) and third (second assessment) interviews, rigorously refraining from exchanging information between themselves.

Statistical analysis: Pearson's Correltion Coefficients between the items of the scale, to study inter-rater coefficients among investigators and independent observers, and test-retest between I and O first and second assessment. The internal consistency of the KPDS was analyzed by calculating Cronbach's alpha coefficient and assessing the global reliability between the 15 items, as well as that existing between the items that constitute the four dimensions, in order to determine the degree of homogeneity.

Results

1. No significant differences in age ($t= 1.92$, NS) or sex ($X^2 = 3.80$, NS) were observed when Barcelona and Milan samples were compared.

2. Inter-rater reliability Pearson's Correlation Coefficients between I and O, after second assessment, for dimensions were: Ego abilities: $r = .62$; $p < 0.001$; Projective identification: $r = .63$; $p < 0.001$; Paranoid-Schizoid. $r = 0.43$; $P < 0.001$; Depressive: $r = 0.45$; $p < 0.001$.

3. Test-retest reliability Pearson's Correlation Coefficients between I after first assessment and I after second assessment, for dimensions were:Ego abilities: $r = 0.87$; $p < 0.001$; Projective Identification: $r = 0.77$; $p < 0.001$; Paranoid-Schizoid: $r = 0.70$; $p< 0.001$; Depressive: $r = 0.80$; $p < 0.001$.

4. Test-retest reliability Pearson's Correlation Coefficients between O after first assessment and O after second assessment, for dimensions were:Ego abilities: $r = 0.80$; $p < 0.001$; Projective

Identification: r = 0.74; p < 0.001; Paranoid-Schizoid: r = 0.65; p< 0.001; Depressive: r = 0.77; p < 0.001.

Conclusions

KPDS is a psychoanalytical scale that has obtained good inter-rater and test re-test reliability. Its internal consistency is equally good.These results permit us to initiate, in a near future, a process of validation of the scale.

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