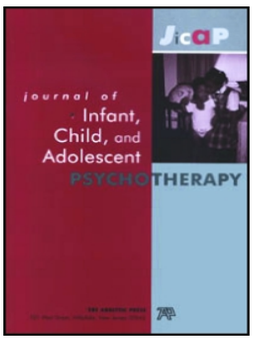

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Revised Provisional Diagnostic Profile: 2016

Jennifer Davids, M.Sc, Viviane Green, B.Ed Hons, MA, Angela Joyce, B.Soc.Sc. (Hons), M.Sc, CQSW, and Duncan McLean, B.A, M.B, B.Chir, MRCPsych

ABSTRACT

In Anna Freud's and other previous versions of the diagnostic profile, drive theory and the structural model were the central organizing concepts. Though these are retained in the current version, greater emphasis has been made of other conceptual perspectives. In particular, the importance of understanding the impact of the child's external world and the child's attachment security; also the central importance of affects, both their recognition and management. These changes are seen in such sections as those on the ego which has been expanded to include a section on play and affects. The developmental line of anxiety and the concept of theory of mind have also been added.

General considerations

The Provisional Diagnostic Profile is an instrument for ordering diagnostic information on a child. It is termed provisional since information at this stage will always be incomplete, and in particular, understanding of unconscious processes can often only be elucidated through therapy/analysis. Despite this limitation, the Profile aims to capture both the child's psychopathology, the developmental level he/she has reached, and his/her healthy functioning. A developmental framework and normative stages of development are implicit, and knowledge of this is essential. The age appropriateness of any aspect of the profile needs to be commented on, and especially when the child deviates from this. Psychopathology is conceptualised as arising either through the operation of a deficit or because of conflict. A deficit implies a child has not reached an age-appropriate level of functioning in a specific area, which gives rise to their

CONTACT Jennifer Davids kapjen@btinternet.com Flat 1, 75 Cromwell Avenue, London N6 5HS, UK.

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Guide to the Diagnostic Profile Anne Hayman, 1977, unpublished.

Modified in 2001, by Jennifer Davids, Viviane Green, Angela Joyce, and Duncan McLean at the Anna Freud Centre, and again in December 2016.

Jennifer Davids is an Adult, Child and Adolescent Psychoanalyst, Fellow of the BPAS, IPA, Supervising analyst for child and adolescent psychoanalysis, Member of the Association of Child Psychoanalysis, and Member of the Association of Child Psychotherapy.

Viviane Green is a registered practicing psychoanalytic psychotherapist (BPC, ACP) working (in English and French) with children, adolescents, and adults. She was recently appointed as Foreign Expert by the People's Republic of China to develop the Sino British Project: a child and adolescent training for mental health professionals in China. She is Senior Lecturer and Program Manager for the MSc and Diploma in Psychodynamic Counseling with Children and Adolescents in the Department of Psychosocial Studies, Birkbeck College, University of London. She was the former Head of Clinical training at the Anna Freud Centre (1999–2009). She is widely published. Green, V. (Ed.). (2003). *Emotional Development in Psychoanalysis, Neuroscience and Attachment Theory - Creating Connections*. Hove: Brunner-Routledge.

Angela Joyce is a Fellow and Training & Supervising Psychoanalyst at the British Psychoanalytical Society; also a child and adolescent psychoanalyst trained at the Anna Freud Centre, and Consultant Parent- Infant Psychotherapist. She is a training and supervising analyst with the Association of Child Psychotherapists in the UK; Honorary Senior lecturer at University College London; Chair of the Winnicott Trust and trustee of the Squiggle Foundation. She has published in the field of parent infant psychotherapy, child analysis, Psychoanalytic developmental psychology and Winnicott Studies. She jointly edited (with Lesley Caldwell) *Reading Winnicott* (New Library of Psychoanalysis Teaching Series 2011) and contributed the Introductory essay to Volume 6 of the *Collected Works of D W Winnicott*, Oxford University Press, 2017.

Dr. Duncan McLean is a Consultant Psychiatrist in Psychotherapy and Adult and Child & Adolescent Psychoanalyst currently working in private practice at the Anna Freud Centre where he has a special interest in parents with personality disorder.

difficulties. Conflict is understood in the usual psychoanalytic sense, as a clash between different agencies in the mind. It may often have to be accepted that it is not possible at the diagnostic stage, to determine whether psychopathology arises out of deficit or conflict, and to be prepared for the fact that often, too, it may be a mixture of both. When writing a Profile, all inferences should be backed by evidence, and the two should not be conflated. Speculation or giving alternative hypotheses is often helpful, though they should always be clearly indicated as such. The profile can easily become over long. It is important to be succinct. Sections where there is no useful commentary should be left out, though it may be helpful to note why this is the case.

Family considerations

This section contains a largely factual account of the family makeup, including those members living together, with ages, relationships, occupations. In addition, there should also be information of significant others in the extended family, such as grandparents, cousins, and so forth, or members of the family living away, such as a parent or half siblings. A family tree might be useful.

A fuller description of cultural and social factors in the family should be included, such as education level attained, racial and class origin and place of birth, religious affiliation, if relevant, and membership of social and cultural groups in the community. The name of the school the children attend belongs in this section.

The referral

How, why, and when the identified child was referred; who was the source of the referral; and what are the various manifest and latent attitudes and feelings in the family, as well as the child's, are important to the referral. Specific attention should be paid to the phenomenology of the symptoms, their onset, whether there seem to have been any precipitating factors, the duration, intensity, and defining examples of what is causing concern.

Description of the child

This is intended to provide an impressionistic description of the child. It should include as many views as possible, such as those of the different family members, friends, school, and other professionals. An impressionistic description refers to the child's appearance, dress, manner, and carriage; attitudes in different situations, moods, predominant affects, anxiety, competences, interests, and life-style generally; and possible temperamental factors (Freud, 1980b). It is therefore a pen-picture of the young person, noting the differences and similarities in the range of views represented. This section might also include counter-transference responses to the child in the diagnostician, a sense of the initial unconscious communications from the child to the clinician.

Environmental factors

This section concentrates on the context of the child's development and the first attempt to hypothesize the possible impact of various external factors upon it. Consideration is to be given to the child's and the family's history, which might be identified as significant in shaping development. In addition, and providing the context for this, an attempt should be made to formulate the nature of the family system in which the child is growing up and, in turn, the place of the family within the community and in a cultural context.

The functioning capacity of the parents as parents and in their individual interactions with this child and his/her siblings is to be described, in its healthy and pathological manifestations. Possible correlations between the child's life development and parental character/pathology should be noted. The parents' functioning as adults in their own right is also significant. Consideration should be given to the presence of family myths, unconscious value system secrets, the predominant

communicative style of the family, and any possible intergenerational traumas. The possibility of family resilience should also be attended to.

Details of the history which might be relevant are unique crises or more chronic features of the family history, for example, early separations or death of a family member, parental mental or physical illness, long-standing parental disharmony and/or divorce, accidents or serious illness in the child or a sibling necessitating hospitalization, chronic and persistent maladaptive unconscious cathexis of the child or excessive parental anxiety or overprotectiveness, severe sibling hostility, and bullying at school.

Psychic development

Object relations

This section attempts to draw together a picture of the child in the domain of his/her relationships to others, both internally and externally, and how he/she experiences himself/herself in relation to others. While the child's subjective psychic world is of paramount importance, others' views are crucial in putting together the final picture. It is essential to remember that the internal world of object relationships is not identical to the external world. Internal representations are colored by a variety of processes, including wishes, defenses, and so forth.

The child's relationships will be gleaned from the following:

External sources

(a) Accounts given by the parents or caregivers about relationships to themselves and siblings, significant others, teachers, and so forth are important now in terms of how the child represents them in his/her mind: how the child takes in these accounts and his/her fate internally. For example, does the child feel that the parents' description of him/her derives from feeling that another sibling is favored and the view therefore is unjust? Does the child feel that the parent is genuinely concerned about him/her, or does the child feel undermined and criticized?

(b) Mode of relating to the diagnostician, psychologist, and others at the Anna Freud Centre, for example, the receptionist. Reports from school about teacher and peer relationships. This section can be an elaboration of impressions described in the "Description of the Child" section: what the diagnostician constructed from encounters with the child and also accounts from others of the way the child relates in different circumstances to different people.

(c) Parents and significant others. What are the parents like as far as one can tell from the assessment; what other figures are there in the child's life for internal representation? Does the way the child represent these figures fit with the assessor's experiences or do they seem in some particular way to be altered in the child's mind by internal factors.

The quality of attachment as manifested in observable behavior/symptomatology and as reported by others as well as the child

It is important to consider that the quality of attachment describes a property of a relationship represented internally and evident externally in the way the child relates to particular others. Attachment categories are secure, insecure/resistant, insecure/avoidant, and insecure/disorganised. Also, the child will have different and varied experiences of individual attachment relationships; are these discriminated or is one kind of attachment generalized?

The child's sense of safety and object relations

Is there a basic sense of safety from which to explore the world and engage in relationships in an age adequate way? Do his/her attachments offer safety, reassurance when necessary? What does the child do psychically or who does he/she turn to in order to enhance his/her sense of safety? Who/what

makes the child feel endangered? If the child's central objects are also a source of danger or anxiety how does the child try to cope psychically and what is the cost?

What the child consciously and unconsciously believes, thinks, and feels about other people externally, and how this is evident internally as object representations

While this is likely to center on immediate family members, it is important to include, where relevant, extended family, significant others, and peer group relationships. It is also important to include what is unconsciously communicated, for example, in play, projective tests, mode of relating to the diagnostician, and so forth. Have particular states of mind emanated from object relationships, for example, anxiety? Is there a recurrent affective tone associated with object relationships, for example, child is frightened or aggrieved? Give a qualitative description of the sort of figures that inhabit the child's internal world and the accompanying affects and ph/fantasies, and how these are represented and elaborated in fantasy, play, games, and so forth. Are they indicated in age-appropriate ways such as fantasy play in young children, displaced form of stories in latency children, and so forth?

What are the structural aspects of object representations/external relationships?

Does the child relate at a predominantly part-object (or need satisfying), whole object, dyadic, or triadic level? Has the child moved on, in an age-appropriate way, through this developmental line? Is the child able to benefit and contribute to peers in a group setting in an age appropriate manner? Do predominant affective states indicate that the complexity of triadic structures is manageable and experienced as offering developmental potential rather than prompts to more regressive processes (see ego section/anxiety/defense)?

Capacity for object relationships: Intensity of investment in others, that is, the child's "emotional temperature"

This may be particularly important to consider with atypical children, for example, with Asperger's syndrome or autistic spectrum disorder. Capacity to relate: Does the child seek to engage with others, in what way, and for what purposes? Is the child able to sustain this, or does it fall away? Where engagement is within the normal spectrum; do any particular features characterize the child's capacity to relate? Does he/she tend to elicit specific capacities in others, and what does this mean? Capacity to be alone: Is the child able to be on his/her own (age-appropriately) in a creative way or is this suffused with anxiety? Include any relevant details about what the child does/feels/thinks about when on his/her own.

Self-development

Self-representation: How is the child "within his/her own skin"

The child's self-representation in relation to identifications with key figures, ideal self: Describe marked attitudes to self, for example, humiliation, disappointment, indifference, grandiosity, and reality tempered appraisal. In what way is the psychic self a source of pleasure/pain or conflict; what sort of person does the child feel he/she is, and how does the child feel about that?

Development of self-representation

Is there an increasingly differentiated and complex sense of self progressing with age? Is there incorporation of reality testing?

Self/other representation

Do aspects of self-representations suggest the incorporation of features of a relationship, for example, maternal hostility? When considering the self-representation, are there traces of the nature of parental investment, for instance, healthy narcissistic investment? Consider the child's capacity to question and disentangle his/her view of the self from how others' view the child and how age-appropriate this is (this is particularly relevant in adolescence).

Relationship to bodily self and drives

Use of the body

This section should discuss the degree to which the child has developed a capacity for the acceptance and pleasurable use of the body. It should pay attention to tension states that might arise and how these are manifested and dealt with, also how particular states of mind or affects are expressed through the use of the body. To what extent has the child claimed ownership of his/her body and its functions? If there are disabilities or limitations because of illness or poor endowment, then the child's attitude to this and ability or otherwise to accept or overcome them, is important to note. There may also be the possibility of psychosomatic illness and some judgment about the psychological component of this. In all of the above, fantasies about the body and how it functions and interrelated other aspects about how the child views himself/herself should be discussed.

Sexual development and psychosexual status

This section should include a discussion about the child's gender identity, highlighting any gender identifications that seem problematic or conflictual. This should be addressed within the context that some cross-gender identifications are part of normal development.

This section should also include a discussion of the psychosexual status, of oral, anal, phallic, and oedipal organization (Freud, 1980c). The persistence or regression to pathological organizations of these stages that may impede development should be highlighted, for example, greediness demonstrating an oral organization that is inappropriate to the child's developmental stage. Where there is symbolic expression of drives, such as controlling behavior, that may suggest pathological anal organization; consideration should be given to whether this is primarily a drive manifestation or more appropriately seen in the context of an object relationship, for example, control as an expression of separation anxiety.

Aggression

This section should discuss how the child expresses aggression—physically, verbally, in play, or fantasy. To what extent does the child accept and own its own aggression, and to what extent can its expression be modified or appropriately inhibited? Is aggression turned against the self, either physically or mentally? How does the child understand how others express or manage their aggression?

Ego functions/general development

This section describes and considers the ego functioning of the child. It is particularly important to consider whether the ego functions are consonant with the developmental stage and age of the child.

Physical apparatus subserving ego functions

Describe the intactness or defects of ego apparatus, serving perception, memory, motility, and basic senses. It is relevant to consider early trauma, including birth trauma.

Basic psychological functions

Describe in detail the quality of ego functions: short and long-term memory, reality testing, speech, control of motility, synthesis or intactness, and secondary thought processes. Look out for primary deficiencies. Note unevenness in the levels reached (consulting Anna Freud's Developmental Lines may be helpful; Freud, 1980d).

Cognitive development

This includes cognition, thinking, perception, and intelligence. Describe the quality of the child's thinking: is it concrete, functional, or abstract? Is the child able to entertain hypotheses? Comment on the ability to construct and pursue a line of thought or argument. Does fantasy interfere with the capacity to think? Do conflicts interfere with thinking? Can the child symbolize: can he/she use

metaphor, understand humor, play with thought, make associative links, and be imaginative? Can the child make sense of his/her world? Is there evidence of obsessional thinking? Describe the ability of the child to perceive and sense the nature of things in his/her world.

Can the child perceive thoughts, feelings, bodily states, and danger? What is the nature of the dangers? Describe the clinical impression of intelligence. Are there signs of multiple intelligence (Gardner, 1993), for example, emotional, social, or sports intelligence? Are there signs of lateral thinking and divergent thinking? Describe the problem solving of the child. Intelligence tests may be included in detail (note scatter analysis and discrepancies) as well as observations of the psychologist. Projective tests may provide clues as to the child's ability to create a narrative, as well as the atmosphere of the internal world. The style of the responses should be commented on.

Modification of omnipotence

Comment on the child's reliance on and use of an omnipotent stance. Does fantasy obscure the child's view of reality? Can the child distinguish between wish and reality? Can the child distinguish between pretend and reality? What is the child's view of his/her own capabilities? Is there grandiosity/denigration? Describe any magical thinking. Does the child lie/distort reality? Describe the level of reality appraisal.

Play: Describe the child's play (Anna Freud's Developmental Line [Freud, 1980d] may be helpful)

Compare and contrast what is seen versus what is reported. Are there solitary/parallel shared activities? What are the predominant themes of the play? Is there a story line? Describe the quality of the play: is it repetitive imaginative/rigid? How object related is the play? Is there movement in the role assignment? Can roles be switched easily? Describe the quality of the self-object differentiation.

Can this child play and symbolize? Is there an absence of the capacity to play? Are conflicts interfering with the capacity to play/imagine? What are the child's attitude transitional objects and phenomena? Comment on any interests, hobbies, and sublimations.

Defense organization

This section is designed primarily to describe defense against drives, against anxiety, and against guilt. It may also include how the child copes with lowered self-esteem or with external miseries. Defense against a specific painful affect(s), for example, depression and/or shame, can also be included if this is of special significant and distinct from the understanding that all defenses are used against painful affect.

Describe the central defenses used, as well as what is being defended against, and whether defense is mainly against the drives or against anxiety. Consider the effective use of the defense organization, its balance, and age-appropriateness. How rigid are the defenses? Does the ego show signs of flexibility? Is there splitting in the ego? Is the ego in a traumatized state of helplessness, and is there evidence of dissociation or withdrawal? Is there a lack of defense?

Anxiety

It may be helpful to consider the Developmental Line of anxiety from vegetative states to signal anxiety (Yorke & Wiseberg, 1976). This Line details states of anxiety from the most primitive anxieties about survival, nameless dread, primitive agonies, annihilation, engulfment, abandonment, panic, and breakdown, to more appropriately mature signal anxieties, which constitute alarm systems that trigger defense. What are the central anxieties? How diffuse or how specific are anxieties?

Describe the quality of the anxiety: how primitive as described above or how organized, for example, signals, as described above? Describe associated fantasies. Consider specific situations of anxiety, for example, separation, loss of body parts, loss of self, fear of loss of object, fear of loss of the love of the object, loss of self-esteem, bodily threats including illness and castration fears, bodily damage, fear of punishment, or moral anxiety. It should be noted that object relations can also cause anxiety, what Anna Freud termed objective anxiety.

Affects

Can the child acknowledge, recognize, and distinguish among affects? Is the child in touch with his/her feelings? Are affective states experienced as overwhelming or disorganizing? How are the affects modulated? Describe the range of experienced emotional states. Comment on the global versus diffuse nature of the affects. Describe how the affects are expressed: swallowed, cut off, projected, talked about. Are there explosions of affect? Are affects expressed bodily, in play, in behavior? How does the child think about his/her feelings?

Theory of mind

Describe the child's theory of mind: how he/she is able to understand the mental states of others and of himself/herself. Comment on the child's ability to reflect on both himself/herself and on the mind and behavior of others. Describe the level of self-other differentiation. Is the child able to take the perspective of another? Can the child distinguish between psychic and external reality? Describe the capacity to view the world in one, two, and/or three dimensions? Describe the child's different levels of representation. How does the child give meaning to his/her actions and the people in the world? Is the child able to apply multiple representations simultaneously to a single object?

General characteristics

This is a summary section, taking into account the ego functions described above and the comments on the areas of restriction and resilience. Comment on the age-appropriateness of the ego functioning. How well is frustration tolerated? How does the ego attempt to master anxiety, conflict, and pain: is there an active attempt to deal with these or a passive retreat? Is there a general wish in the child to progress, or is there a wish to cling to earlier modes of being?

Superego and Ego Ideal

Note superego precursors (Kennedy & Yorke, 1982) and how the child moves from outer conflict to inner conflict. The child initially locates blame for forbidden impulses in the other, for example, "She stole the biscuits! Not me," but then gradually can give up the impulses in order to be loved by the object. The outer policeman is gradually replaced by inner guiding figures who are aim-giving (e.g., better to wait to ask mom if I can have a biscuit or better to walk away and not hit my little sister. Aim-giving refers to a capacity for the child to set and follow goals to contain, delay, and express love and/or aggression inter alia) and even benign rather than punitive or severe. Note benign aspects of the superego, as well as the quality of the maternal and paternal superego. Hostility is likely to color the quality of the superego.

Are there signs of development and movement from a punitive superego to a healthier superego that helpfully modulates aggression and sexual desire? Is the superego shaming or humiliating? Is there a praising superego? Is there a quality of concern for the other and an appropriate sense of responsibility for actions? Is there excessive compliance, or are there signs of rebellion? How well is the superego structured? Are there signs of identification with the superego of the parents, the group, or with delinquent models? Is the superego corrupted? Do the external figures for identification, provide a template for a sufficiently socially integrated sense of right and wrong?

Ego Ideal is the set of ideals which the child aspires to. Heroes, games and dreams may all reveal aspects of the ego ideal. How realistic is it? Are there signs of development from overidealized narcissistic aspirations to social and ethical values that sustain meaning and purpose?

Diagnostic statement

This is the most important section since it should bring together the different sections of the profile to give a formulation of the child's development and psychopathology. A formulation is a narrative account which links different factors and attempts to assess their relative importance as well as the

ways in which they interact. One-word diagnoses such as "narcissistic" disturbance should be avoided. If such terms are used, they should be amplified and explained.

The diagnostic formulation should include the following broad headings:

A dynamic understanding of the child's presenting problems and other psychopathology

This should link together different sections of the profile to give an intrapsychic understanding of the child's symptomatology. It should attempt to be specific about the nature of the deficits or conflicts that underlie symptoms.

An attempt should be made to address the various etiological factors

This could include intrapsychic, biological, family systems, and so forth. It may be important to highlight the interaction between these various factors as well as their relative importance.

An understanding of the child's development, both normative and pathological

This last part should integrate the preceding two to give an understanding of and to what extent the child development is being interfered with and is therefore an attempt to assess the severity of the child's disturbance. In considering all the above factors in the formulation, it may be helpful to put forward speculative arguments or conflicting hypotheses if not sufficient information is yet known to be decisive.

Recommendations

The Provisional Diagnostic Profile has been designed with a view to those children who are likely to benefit from intensive and nonintensive psychoanalytic psychotherapy. However, in considering the recommendation, a much wider view must be taken to consider the possibility of other interventions, such as family therapy on the one hand or social intervention such as changing schools on the other. It is, of course, possible that no intervention at all is required. Whatever the intervention suggested, it should be backed by reasoned argument as to why this is the most appropriate one. In addition, the aims of the intervention, and approximate prediction about what may be achieved by it, should be attempted—for example, the recommendation for intensive developmental help for a child with Asperger's syndrome, with the aim of improving affect recognition and expression, with a prediction that this will enable the child to engage in symbolic play.

In some instances the Profile may not have answered sufficient questions to make a sound recommendation and it may be required to suggest further investigations to clarify diagnostic points. This could vary from family sessions to specific neurological investigations. When considering recommendations, multiple interventions should be considered where appropriate, so that a depressed adolescent might require nonintensive psychoanalytic psychotherapy, parent guidance, and consideration of the need for referral to a psychiatrist for anti-depressant therapy.

Having considered an ideal recommendation, modification may be necessary in the light of various practical and resource considerations. For example, intensive psychoanalytic psychotherapy treatment may be the treatment of choice but too demanding on a family or not an available resource, in a given context. Nonintensive therapy as the least necessary intervention needed for a therapeutic process to unfold, may be the recommendation.

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