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**ANNA FREUD'S DEVELOPMENTAL PROFILE**

Modifications and Present Form

(DRAFT OF THE DIAGNOSTIC PROFILE)

by

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**Note: This draft of the Diagnostic Profile can be used in any age group including adults. All that is necessary, is to correct in terms of the stage of development, age of patient, etc. One of the final lectures in this series will specifically explain how to do all that.**

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## INTRODUCTION

The "Developmental Profile" outlined by Anna Freud in her paper "Assessment of Childhood Disturbances"(1) has been applied and discussed at the Hampstead Child-Therapy Clinic for several years. This paper summarizes the modifications and developments in the Profile evolved during these years and follows on Dr. Nagera's paper "The Developmental Profile. Some Considerations Regarding its Clinical Application." (2)

Many staff members and students of the Child-Therapy Course have worked, as individuals and as members of groups, at this research, and we acknowledge our debt to them. The system of cross-membership of groups in the Clinic has meant that the central group working on the Developmental Profile, the Profile Research Group, has been able to collate material from all the other groups.(3)

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1) The Psychoanalytic Study of the Child, Vol. XVII, 1962.  
(International Universities Press, Inc.)

2) The Psychoanalytic Study of the Child, Vol. XVIII, 1963.

3) We are grateful to Dr. E. Koch and Miss P. Radford, whose Minutes of discussions in the Profile Research Group have proved invaluable in the preparation of this paper.

The general organization of the developmental profile remains unchanged, with one notable exception. This exception arose from the' expansion of section V. C (Development of the Total Personality) by Anna Freud.(1) As the Lines of Development were regarded as being on a different conceptual level from the other sections, they are now usually put as an appendix after section VIII, before the section on Diagnosis.

It is not surprising that the general organization has remained almost unaltered, as it was based on psychoanalytic assumptions and propositions which have been well tested through the years. Equally unsurprising was the finding that when the Profile was applied to clinical material of the most diverse nature, many questions were posed.

The questions fell into two broad categories, firstly, those concerning concepts which are not adequately understood; secondly, those arising when it was found that the Profile in its present form was inappropriate or inadequate to formulate a convincing picture of certain groups of disturbances.

In an attempt to answer questions in the first category, Study Groups were started to study particular theoretical problems, or groups already in existence were asked to undertake such work where it seemed appropriate.

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1) Freud, Anna., "The Concept of the Lines of Development," The Psychoanalytic Study of the Child, Vol. XVIII, 1963.

The second category arose inevitably from our methodological approach. The Profile, while it aims ultimately at classifying the individual within a diagnostic schema, also aims at a more detailed examination of the "internal picture of the child which contains information about the structure of his personality; the dynamic interplay within the structure; some economic factors concerning drive activity and the relative strength of id and ego forces; his adaptation to reality; and some genetic assumptions." It was appreciated that the Profile was best suited for the study of the normal and neurotic personality. Nevertheless, we were also interested in the problems of assessing the development and disturbances of the blind, the "borderline" patient and the delinquent personality. Because we are at present largely ignorant of the intimate nature of such developmental problems and their relation to normal or neurotic development, we believed it to be methodologically sound to start studies on the basis of the basic Profile in each of these Groups. This approach has led to attempts to prepare Profile Drafts specific to each group. Some specially important hypotheses have been made about the blind and the borderline cases, and work is proceeding in the delinquent group. References are made in another paper to all these contributions.(5)

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5) Nagera, H., and Bolland, J., "The Present Form of the Developmental Profile."

In addition to these three groups, the Profile has also been adapted to meet the special problems of assessing the disturbances of later years. One adaptation was for the assessment of the adolescent personality and its psychopathology.(6)

A Profile for the assessment of the adult personality was similarly prepared to facilitate comparative studies between children and parents.(7)

Finally, modifications and amplifications have been found necessary in the preparation of the Terminal Profile.(8) This is set up at the end of treatment.The modifications will be found under the appropriate sections below, but it should be noted that the aims of the Terminal Profile are as stated in "Assessment of Childhood Disturbances",i.e.," not only...the completion and verification of diagnosis but also...to measure treatment results..."

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6) Laufer,M., "Assessment of Adolescent Disturbances-The Application of Anna Freud's Diagnostic Profile."

7) Freud, A., Nagera, H., and Freud, W.E., "Assessment of the Adult Personality-A Diagnostic Profile." Published in The Psychoanalytic Study of the Child, Vol XX, 1965.

8) The Terminal Profile is based on the whole treatment material, whereas the Diagnostic Profile is based only on the usual diagnostic investigations. The Terminal Profile should also note: a) the child's age at the beginning and end of treatment; b) the frequency of sessions and total duration of treatment; and the nature, frequency, etc. of the contact with the parents of the child.

DRAFT OF DIAGNOSTIC PROFILE (9)

I. REASONS (AND CIRCUMSTANCES) FOR REFERRAL. DESCRIPTION OF SYMPTOMS.

To include Arrests in Development, Behavior Problems, Anxieties, Inhibitions, Symptoms etc.

It is to be noted that quite often the most important symptoms (diagnostically speaking) are not given as reasons for referral. Further, motivations and urgency of referral do not necessarily coincide with the intensity of the symptoms at the time of referral. It may be important to note who is the initiator of the referral.

The application of the Profile to a large number of cases has highlighted the importance of making a distinction, whenever possible, between the manifest reasons and the latent reasons for referral. In most cases, only the manifest reasons can be noted at the diagnostic stage, the latent reasons becoming apparent mostly during treatment. In the Terminal Profile such a distinction is possible.

Whenever possible, the section is to be subdivided as follows:

- 1 - The parents' reasons for the referral, manifest and latent, their report of the symptoms, and

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9) The present draft is a modification and amplification of some aspects of the draft published by Anna Freud in her paper "Assessment of Childhood Disturbances" already referred to.

2 - The child's reasons (if any, including when such is the case manifest and latent) as well as the child's attitude to his symptoms, his illness and treatment. Include the child's attitudes to the referral if known.

## II. DESCRIPTION OF THE CHILD.

To include personal appearance, moods, manner, usual behavior etc., in everyday life as well as during the diagnostic interviews. Refer specially to any specific reactions to the interviews and interviewers, noting any discrepancies in the interviewers' descriptions of the patient. Although these discrepancies may derive from different reactions of different interviewers, it may be that these reactions are initiated by the patient through behavior or attitudes. Such behavior or attitudes may be diagnostically significant if understood as the patient's methods of coping or reacting, e.g: to male or female interviewers, in structured situations (e.g. psychological testing) or comparatively unstructured situations (e.g. psychiatric interview).

Similarly, changing behavior in the child as between the first and subsequent interview(s) should be noted. This may be due to increasing familiarity and diminution of the initial anxiety and fantasies about the unknown situation, and may, therefore, be of diagnostic significance.

Responses to any verbal intervention by the interviewer to lessen anxiety, should be noted. These may be of importance diagnostically and may also be helpful in assessing treatability.

III. FAMILY BACKGROUND (PAST AND PRESENT) AND PERSONAL HISTORY.

IV. POSSIBLY SIGNIFICANT ENVIRONMENTAL CIRCUMSTANCES: (10)

- A. For the timing of the referral. The timing of the referral may show for example what part the child plays

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(1) In the Terminal Profile this section may be particularly relevant in the discussion of important genetic considerations. In the Terminal Profile the section is called "Significant Environmental Circumstances", since it describes those circumstances that were found to, or confirmed to, play an important role in the development of the patient's personality. Thus, this point in the Terminal Profile should be in two parts:

- a. A final assessment of the importance of environmental factors postulated as significant in the Diagnostic Profile, together with a description of factors found during the course of treatment to have been significant, but which were not known or noted at the diagnostic stage;
- b. The specific effects of the significant environmental factors on the child, taking into account the fact that there may be basic differences between the way the child sees, understands and experiences situations and events, and the way outsiders would rate these events.

In both the Diagnostic and Terminal Profiles it should be remembered that the child's external reality or circumstances are made up of

- (a) the parent's psychic reality (as an important environmental factor for the child) and
- (b) other external circumstances which do not include the parents

in the family life. Inasmuch as one may be able to deduce the child's reaction to the part allocated to him (e.g. compliance, refusal), this may tell one something about his personality.

B- For the causation of the disturbance including when possible:

1. The external precipitating factors of the patient's illness at the time of the apparent beginning of it and at the time of the referral (if they do not coincide).
2. Those other relevant factors that during the course of development and/or at specific points of it may have contributed to shape the personality in its psychopathological as well as in its normal aspects.

C. Possibly favorable and stabilizing influences:

Whenever the material is available, it has proved valuable to describe the possibly stabilizing influences, to pinpoint what has been, and is, favorable and healthy as opposed to the pathogenic factors. It should also include an assessment of those environmental factors which may favor the treatment process, in addition to the factors that may favor the illness. The parent's ability to sustain the treatment process and their capacity to accept and adjust to changes in the child during

and after treatment should be assessed. A note should be made of the relevant "healthy" aspects of the parents.

**V. ASSESSMENT OF DEVELOPMENT.**

A- Drive Development:

1. Libido, Examine and state:

a. Regarding Phase Development:

- whether in the sequence of libidinal phases (oral, anal, phallic; latency; pre-adolescence, adolescence) the child has ever proceeded to his age-adequate stage, and especially beyond the anal to the phallic level;

- whether he has achieved phase dominance on it;

- whether, at the time of assessment, this highest level is being maintained, or has been abandoned regressively for an earlier one.

This sub-section has remained on the whole unchanged, but a few words are required in relation to the assessment of the of the latency phase that has proved particularly difficult. This phase is different from earlier phases in so far as it is mainly through observation of the child's direct drive activity that we are able to establish the position

reached. But it is one of the hallmarks of latency that such direct drive activity is much diminished.

Furthermore, while during earlier phases ego development is impressive, the capacity for neutralized, aim inhibited and sublimated activities is restricted. During latency, the scope of ego-performance is much increased. This, coupled with the decreased direct drive activity, facilitates important progress in development, in the process of neutralization, in learning and in mastery of the internal and external world.

A similar situation exists in the level and complexity of object relationships. These range from the relatively simple at the oral and anal stages, through the more complex relationships of the phallic oedipal stage, to those of latency. In latency there is an increased impetus towards extending relationships beyond the family into the wider community.

Though it is important to approach the assessment of each developmental phase from multiple and simultaneous points of view, it is even more essential to do so in respect of latency. We should examine (i) the degree and quality of the drive activity; (ii) the degree of ego-development reached and how drive activity, conflicts, etc. are affecting either ego-development and/or the possibilities of

ego-performance; (iii) how both drive activity and ego-development are influencing and partly determining the form and type of object-relationships. (11) Disturbance at the latency stage may be seen as affecting any or all of these three aspects of the child's development. Most often, all are affected, but it is diagnostically important to assess the relative degrees of involvement.

b. Regarding Libido Distribution:

i) Cathexis of the self:

(1) whether the self is cathected as well as the object world, and whether there is sufficient narcissism (primary and secondary, invested in the body, the ego, or the superego) to insure self-regard, self-esteem, a sense of well-being, without leading to over-estimation of the self, undue independence of the objects, etc.;

-state degree of dependence of self-regard on object relations.

Such an assessment proves troublesome and a number

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11) Cross-references to the sub-section "Cathexis of objects" and the section "Ego and Superego Development" may be necessary.

of unclear and contradictory assessments could result. This is a reflection of the lack of clarity about the questions involved in the very early stages in ego development, in the development of the concept of the self and the basic ideal conditions

required for such development, in the cathectic processes involved, in the conditions necessary for, and the mechanisms used in, the maintenance of a psychological state of well-being and in the regulation and maintenance of a sufficient level of self-esteem and self-regard.

A study group has undertaken the further clarifications and study of the problems involved in this sub-section.(12) The following general comments are made in order to clarify some of the problems of assessment involved.

Primary narcissism, as we understand it, refers to a specific libidinal position which pertains to the first few months of life. As a phase, it is never completely abandoned, although it is normally largely superceded. During the state of primary narcissism the cathexis of the self can be referred to as primary narcissistic cathexis. Certain basic conditions are essential, in order to ensure that the earliest experiences of the self during the phase of primary narcissism can take place

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12) The question of self-esteem regulation, problems involved in the maintenance of a state of well-being, etc., have long been an area of interest of the Index Research Group in the Hampstead Child-Therapy Clinic, and especially of its Chairman, Mr. J. J. Sandler, Ph.D., D.Sc.

normally, making their essential contribution to the development of the personality. The maintenance of an indispensable minimum of positive narcissistic feelings during the first few months of life depends on the adequate ministrations of the mother (or her

equivalent) as a provider of food, comfort, physical and psychological warmth, as a stimulator in appropriate ways for libidinal, ego and object-relationships growth, and as a protector from inappropriate, undesirable and disturbing stimuli. Without such support, the early experiences of the self during the phase of primary narcissism and the basic cathectic processes of the period are of a negative, distorted and inappropriate type, leaving clear imprints in the personality structure. Furthermore, these basic experiences form the background against which further development has to take place. Where the foundations are not right, all later development and further experiences will be influenced in a negative way, to a greater or lesser degree according to the circumstances of each individual. Thus, these basically defective experiences may largely influence or even determine the type of cathexis of the self later on, as well as the mechanisms used for self-esteem regulation and for the regulation of feelings of well-being. We refer here to extreme examples of disturbances such as some forms of narcissistic disorder, some atypical personalities, some borderline cases and deprived institutionalized children. Clearly, it is not only serious neglect of the child's basic needs at the beginning of life that will lead to these results. Children who have suffered excessive pain or certain severe forms of illness may develop along similar lines.

Secondary Narcissism pre-supposes object-representation

and involves the use of the object by the child to increase his self-esteem. Supplies of "good" feelings towards him must be sufficient to allow this secondary narcissistic cathexis. At an early stage these supplies come from (and are still dependent on) the external objects. In normal development, in the process of internalization, stable and important internal sources of narcissistic supplies are acquired, although there remains a need for external supplies to some extent. At the same time, the internalizations have led to further ego, ego-ideal and superego development. Assessment should, therefore, determine at what point or points along the developmental continuum "from external to internal" the difficulties existed and from which they are still exerting influence.

It is by no means infrequent that children who have been positively cathected by the mother during the first few months of life (primary narcissistic stage) and babyhood find themselves in difficulties with their object as their drive-development progresses. It may happen, for example, that the child's anal impulses or phallic strivings are unacceptable to the objects (because of their own conflicts). Such a situation may lead to a de-cathexis, or in some cases a negative cathexis, of the whole child during the "objectionable" period or from that period onwards. What we are describing applies more especially to those cases of marked rejection of the child; there will be a different outcome if the whole child remains positively cathected despite objections to particular phases.

The effects on the child of such a lack of positive secondary narcissistic supplies are of two kinds: (a) affective and immediate, e.g. anxiety, distress, fear of loss of love, fear of loss of object; (b) structural and ongoing, namely the imprinting of such experiences on the child's personality through the processes of internalization, introjection, ego-identifications, contributions to ego-ideal and superego formation. The degree to which these effects operate depends on several factors, for example the age of the child and the stage of development already attained, in terms of the current degree of internalization and structuralization. Obviously the earlier in development the more vulnerable the structures. The intensity and duration of the object's reaction is another factor. Ultimately these effects will influence to differing extents the later styles of self-esteem regulation and the level and nature of the cathexis of the self.

When internalization and structuralization are complete, or almost so, it is largely in this area of secondary narcissistic supplies that neurotic-processes tend to interfere. This interference is most marked in individuals who have high ego-ideals and/or strict and demanding superego structures. Thus neurotic conflicts only too often disturb the basic minimum feelings of well-being, interfere with self-esteem regulation and lead to feelings of low self-regard and self-esteem. That is, the disturbances of narcissism are, in these cases of a secondary nature resulting from the tension and struggles between the ego, ego-ideal and the superego. In fact, the

cathexis of the self in terms of primary narcissistic cathexis is essentially normal and healthy in many such neurotic cases, although this fact may be blurred to the inexperienced observer by the notably low self-esteem and self-regard. If it can be ascertained that primary narcissistic cathexis is adequate, we have a useful prognostic indicator, not only of the severity of the disturbance, but also of the outcome of treatment. The analysis of conflicts interfering with self-esteem and self-regard is likely to free the basically healthy progressive tendency, whereas in the cases of disturbance of primary narcissism we are dealing with a more fundamental distortion of the self-representation itself.

Once one has established the fundamental distinction between primary and secondary narcissistic cathexis, and has recognized the possibility of interaction between the two, a number of apparently contradictory combinations become understandable, such as a very low self-esteem accompanied by extremely high cathexis of the self.

It is clear that although the theory of narcissism (primary and secondary) was formulated on the basis of the libidinal drive and libidinal cathexis, a correction must be made to include the aggressive drive and the possible cathexis of the self by large quantities of aggressive rather than libidinal energy, or by mixtures of them. For profile-making purposes, cross-references should be made between this section and the section on aggression in such cases.

Further it must be noted that certain defensive attitudes may give a misleading picture in cases where an apparently high evaluation of the self serves to hide basic feelings of inferiority and low cathexis of the self, coupled with low self-esteem. Here a careful assessment in the sections on "Defences" and "Conflicts" will help in the differential diagnosis.

To summarize, distinguish when possible:

-if the disturbances in the-cathexis of the self and in self-esteem regulation are the result of insufficient or unsatisfactory "primary narcissistic cathexis" of the self (during the first few months of life) leading to an absence of the indispensable minimum of positive primary narcissistic feeling on which so much hinges for later normal development. State the reasons for the above, i.e. inadequate ministrations of the mother in terms of food, comfort, physical and psychological warmth, lack of provision of appropriate stimulation required for libidinal, ego, and object-relations growth, lack of protection from inappropriate, undesirable or disturbing stimuli, or excessive pain, severe forms of illness etc.

- if the disturbance in the cathexis of the self and in self-esteem regulation are due to distorted, insufficient and/or unsatisfactory "secondary narcissistic cathexis" of the self. In those cases try to distinguish if the problems experienced are fundamentally based in the attitude of the object or objects of the child towards him or if they result from the nature of the child's conflicts and the tension between ego, ego-ideal and

superego (or its precursors), guilt and shame etc. Take into account that the child may be actively cathected by the objects with what can be called a negative cathexis" (of an aggressive nature) at some, all, or any particular stage in his development and that such an attitude taken from the object outside may become a part of the superego attitude in its relation to the ego. Give some indication as to the proportions of the different admixtures of libido and aggression going into the cathexis of the self.

- if the disturbances of the cathexis of the self, self-esteem regulation etc. result from a combination of the above factors in different ways and proportions.

(2) if possible, describe the main mechanisms used for the purposes of regulating self-esteem and well-being.

(3) Cathexis of objects (past and present; animate and inanimate):

- whether in the level and quality of object relationships (narcissistic, anaclitic, object constancy, preoedipal, post-oedipal, adolescent) the child has proceeded according to age;

-whether, at the time of assessment, the highest level reached is being maintained or has been abandoned regressively;

-whether or not the existent object relationships correspond with the maintained or regressed level of phase development.

2. Aggression. - Examine the aggressive expressions at the disposal of the child including not only overt or direct forms but also indirect and covert forms.
  - a. according to their quantity, i.e. presence or absence in the manifest picture. If the overt forms are absent in the manifest picture, describe the covert and indirect forms of expression observable.
  - b. according to their quality, i.e. correspondence with the level of libido development for the overt and/or covert forms of expression.
  - c. according to the direction of the-overt and/or covert forms of expression of aggression toward either the object world or the self.

The profile-maker is also expected to distinguish, whenever possible, between the aggressive outburst as a defence and the primary expression of aggression. A special problem in this section concerns the assessment of the defence mechanism "turning aggression against the self."

B. Ego and Super-ego development:

(a) Examine and state the intactness or defects of ego apparatus, serving perception, memory, motility etc. In case of defects state if possible the nature, extent and cause of it. State if it was congenital or acquired and if acquired give the timing of it.

(b) Examine and state in detail the intactness or otherwise of ego functions, i.e. perception, memory, concentration, attention, reality testing, reality adaptation, reality

awareness, synthesis, integration, control of motility, speech, the type and quality of thought processes, orientation as to person (to include the appropriate establishment of the concept of the physical and psychological self, self-boundaries etc.), orientation in respect of time and place etc., always taking into account the age of the child. Look out for primary deficiencies. Include intelligence tests. Note any unevenness in the levels reached, not only in terms of levels of performances but, especially in the younger child, in terms of the developmental unfolding of functions present at any particular age and its degree of integration, interaction and complexity.

(c) Ego reactions to danger situations:

- whether the danger is experienced by the ego as lodged in the external world, the id or the super-ego and
- whether the resulting anxiety is felt predominantly as fear of annihilation, separation anxiety, fear of loss of the object, fear of loss of the love of the object, castration anxiety, etc.

(d) Examine in detail the status of the defence organization

- (to include not only specific defence mechanisms but also more complex defensive maneuvers) (12) and consider:
- whether defence is employed specifically against individual drives (to be identified here) or, more

generally, against drive activity and instinctual pleasures as such;

- whether defences are age-adequate, too primitive, or too precocious;
- whether defence is balanced, i.e. whether the ego has at its disposal the use of many of the important mechanisms or is restricted to the excessive use of single ones;
- whether defence is effective, especially in its dealing

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12) Under this same sub-section it is necessary to re-assess in the "Terminal Profile" each defence noted in the original profile, pointing out if there has been a quantitative and/or qualitative change in the defence organization in general and/or the specific defence mechanisms. It is further necessary to note if there have been quantitative or qualitative changes in the danger and conflict situations which were partly responsible for the defence structure of the patient. Since the above may be described under section "VII. ASSESSMENTS OF THE CONFLICTS," a reference to that section will frequently be sufficient in order to avoid repetition.

with anxiety, whether it results in equilibrium or disequilibrium, lability, mobility or deadlock within the structure;

- whether and how far the child's defence against the drives is dependent on the object world or independent of it (super-ego development);

(e) Note any secondary interference of defence activity with ego achievements, i.e. the price paid by the individual for the upkeep of the defence organization. Try to differentiate between interferences due to quantitative factors such as excessive expenditure of energy in counter-cathexis and qualitative factors such as use of projection that interferes with the ego function of reality -testing, or withdrawal into fantasy that may interfere with concentration., memory, attention etc.

Whenever significant and possible an assessment should be included of the "gains" to the personality through the specific defence organization and resultant symptom formation. The balance between the "secondary interference", the illness as a whole, and these "gains" should be examined. Such considerations are frequently a significant factor in estimating the advisability and possible response to treatment.

(f) Affective states and responses:

(This is a provisional subsection still in an experimental stage. The profile-maker should only attempt to deal with

those items for which he is in possession of the relevant clinical material).

To include a description of main affective states and affective responses observed such as sadness, joy, anger, hate, love, disappointment, shame, guilt, etc.

1. The range of affects : With special emphasis in noting if a wide and rich variety of affective responses are available to the child, or if the range is restricted specifically to one or only a few of them. Within the range available to the child, describe those that seem more important and constant than the others.
2. Situation in which they tend to appear: to include the reaction to negative or positive experiences, such as the reaction to frustration, failures in ego performance, disappointments in objects or as a response to personal achievements, presents, praise etc.
3. Availability or accessibility of affective responses: Describe if the child can, or cannot, experience and react with the appropriate affect in specific situations. A distinction should be made between the child's capacity to experience affects and his capacity to express them. It should be noted which ones may not be available to him and if possible the reason for this. Some children are not able to recognize and verbalize their feelings but may perhaps act them out in one form or another, or show them through bodily responses or other ways, a fact that should be noted, taking into account the age of the child. (Some of

the above behavior can normally be observed in the very young child before he has acquired sufficient capacity for verbalization).

4. Appropriateness of affective response: Describe if the affective response is appropriate in intensity and quality to the stimuli that provokes it. Notice too if it is too intense or too weak or if an inappropriate affect is the response such as when joy appears where the normal reaction should be sadness, etc.
5. Transience or persistence of the affective responses: Describe if there is enough flexibility (recovery within a reasonable time) once an affective response has been triggered off (such as sadness for example), or if there is an excessive tendency for the affect to persist and linger on unduly.
6. Tolerance of affects: Describe if the child's capacity to tolerate affects generally (pleasant or unpleasant) is within normal limits or not. Note the different tolerance for the different affects.
7. Defence against affects: Describe the defences, defence mechanisms etc., utilized against affects generally (when that is the case) or against any particular one.
8. Balance of affective response in respect of external or internal factors: Describe here for example if the affective response is more or less intense when reactive to super-ego criticisms than when reactive to external criticisms.

9. Notice if the child's ability to reflect about affects matches or not the capacity to handle them.
10. The child's reaction to his perception of other people's affective state: Notice the child's ability to perceive other people's affective state and his or her reaction to it. Notice too, any particular object orientation of affective responses, that is, is the reaction stronger in respect of any particular object or does it appear only in reaction to some objects and not to others, etc?

C. Super-ego Development:

a. Super-ego:

Examine and state:

-the degree of development reached by this structure which starts at nil, goes through the stage of super-ego precursors with all its possible variations until the organization of the final super-ego structure. In the older child consider the degree of super-ego structuralization pointing out if it is arrested, faulty, mature etc.

- its sources, where obvious.

- its aims (critical, aim-giving, satisfying).

(1) its characteristics (severe, lenient, uneven, corruptible etc.).

(2) its effectiveness (in relation to the ego and the id).

(3) its stability (under the impact of internal and external pressure).

(4) the degree of its secondary sexual or aggressive involvement (in masochism, depression, etc.).

Clearly, in the assessment of all the above the diagnostician must take into account the age and stage of development of each child (with its possible normal variations), and qualify his findings accordingly.

b. Super-ego ideals:

(This sub-section and the following ones are provisional and still at an experimental stage. The profile maker should only attempt to deal with those items for which he is in possession of the relevant clinical material).

The sub-section intends to cover those ideals (here referred to as super-ego ideals) that are established in a more or less permanent form at the time of, and in relation to the resolution of the Oedipus complex, that is, the time at which the super-ego agency becomes highly structured acquiring much of its final shape (though not necessarily all of it). Naturally, some of the elements that will become integrated in the final super-ego structure, when the massive step towards structuralization is taken with the resolution of the oedipus complex, may have been already present at the earlier stages, even though in some cases in a more primitive and less well defined form.

The diagnostician may find it useful for the purpose of differentiating these super-ego ideals from other types of

"ideals" (to be described in the next sub-section that is sub-section c) to pay attention to the child's ego response when he or she fails to fulfil such ideals. In the case of the super-ego ideals the response will be in most cases more intense, and will show different degrees of guilt and/or shame. This response may or may not be accompanied by some degree of anxiety which may further point to the existence of an ongoing and not yet resolved conflict.

i. Describe now the child's super-ego ideals and aims (conscious and unconscious) if known.

ii. Discrepancies between the super-ego ideals and ego potentialities that is for example the ego's ability or possibility to fulfil them.

iii. Source of the ideals:

- whether imposed on the personality by the external world or by the inner agencies.

(1) Reactions to the fulfilment of the ideals or to falling short of them.

c. Other types of ideal formation:

To include all other forms of ideals that in some cases and more properly speaking could be referred to as ego interests, aims, wishes etc. They may be of a temporary or transitory nature only, or in some cases have a more permanent character.

Clearly, much of what can be described under this subsection, belongs into the realm of the conflict free areas of the ego or the personality. Many (though not necessarily all) of these ideals are more flexible and can be altered according to circumstances and following the dictates of the need for adaptation. As in the previous sub-sections the following items should be explored:

i. Describe all other 'ideals' and aims of the child (conscious and unconscious) so far as they are known.

ii. Possible discrepancies between such ideals and the ego potentialities that is, the ego's ability or capacity to fulfil them.

iii. The sources of these ideals:

- whether imposed on the personality by the external world or the inner agencies.

iv. Reactions to the fulfilment of the ideals or falling short of them.

D. Development of the Total Personality.

(Lines of Development and Mastery of Tasks)

While drive and ego development are viewed separately for purposes of dissection, their action is seen as combined in the lines of development(13) which lead from the individual's state of infantile immaturity and dependence to the gradual mastery of his own body and its functions, to adaptation to the object world, reality and the social community, as well as to the building up of an inner

structure. Whatever level has been reached by a given child in any of these respects represents the end point of a historical sequence which can be traced, reconstructed, scrutinized for defects (this to be done during and after treatment), and in which ego, super-ego, as well as drive development have played their part. Under the influence of external and internal factors these lines of development may proceed at a fairly equal rate, i.e. harmoniously or with wide divergences of speed, which lead to the many existent imbalances, variations, and incongruities in personality development. (See, for example, excessive speech and thought development combined with infantilism of needs, fantasies and wishes; good achievement of object constancy combined with low frustration tolerance and primitive defence system; or complete dependence for feeding, defecation, etc. , combined with fairly mature intellectual and moral

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- 13) Freud, Anna, "The Concept of the Lines of Development, "The Psychoanalytic Study of the Child", Vol. XVIII, 1963, p.???, standards.) The lines of development are particularly relevant in the assessment of children up to the latency period.

At the time of diagnosis, the status of these developmental lines can be investigated by using for the purpose of examination any one of the many situations in life which pose for the child an immediate problem of

mastery. Although such tasks may seem simple and harmless when viewed from the outside, the demands made by them on the personality show up clearly when they are translated into terms of psychic reality. Such translations are the indispensable prerequisites for assessing the meaning of successful mastery as well as for understanding failure and for allotting it correctly to the right sources in either the drives or the ego agencies.

Examples of such situations as they may occur in the life of every child are the following:

separation from the mother;

birth of sibling;

illness and surgical intervention;

hospitalization;

entry into nursery school;

school entry;

the step from the triangular oedipal situation into a community of peers;

the step from play to work;

the arousal of new genital strivings in adolescence;

the step from the infantile objects within the family to new love objects outside the family;

Because the Lines of Development are of a different conceptual level to some of the other sections in the Developmental Profile, it is our present practice at the Hampstead Clinic to attach them as an appendix at the end

of the Profile after section "VIII. ASSESSMENT OF SOME GENERAL CHARACTERISTICS," just before the section on Diagnosis.

VI. ASSESSMENT OF FIXATION POINTS AND REGRESSIONS:

The section is meant to cover only those genetic aspects of the psycho-pathology and personality of the patient that relate to the existence of fixation points and/or regressions to them.

Since we assume that all infantile neuroses (and some psychotic disturbances of children) are initiated by regression to fixation points at various early levels, the location of these trouble spots in the history of the child is one of the vital concerns of the diagnostician. At the time of initial diagnosis such areas are betrayed:

- a. by the type of the child's object relationships, the type of drive activity and the influence of these on type of ego performance, if any of it is below the age adequate level;
- b. by certain forms of manifest behavior which are characteristic for the given child and allow conclusions as to the underlying id processes which have undergone repression and modification but have left an unmistakable imprint. The best example is the overt obsessional character where cleanliness, orderliness, punctuality, hoarding, doubt, indecision, slowing up,

etc., betray the special difficulty experienced by the child when coping with the impulses of the anal-sadistic phase, i.e. a fixation to that phase. Similarly, either character formations or attitudes betray fixation points at other levels, or in other areas. (Concern for health, safety of parents and siblings show a special difficulty of coping with the death wishes of infancy; fear of medicines, food fads, etc., point to defence against oral fantasies; shyness to that against exhibitionism; homesickness to unsolved ambivalence, etc.);

- c. by the child's fantasy, sometimes betrayed accidentally in the diagnostic procedure, usually only available through personality tests. (During analysis, the child's conscious and unconscious fantasies provide, of course, the fullest information about the pathogenically important parts of his developmental history);
- d. by those items in the symptomatology where the relations between surface and depth are firmly established, not

open to variation, and well known to the diagnostician as are the symptoms of the obsessional neurosis with their known fixation points. In contrast, symptoms such as lying, stealing, bed wetting, etc., with their multiple causation, convey no genetic information at the diagnostic stage.

For the diagnostician trained in the assessment of adult disturbances, it is important to note that infantile

regression differs in various respects from regression in the adult. As "temporary regression" it takes place along the developmental lines mentioned before, and forms part of normal development as an attempt at adaptation and response to frustration. Such temporary regression may give rise to pathology, but the latter will be short-lived and reversible. For purposes of assessment the two types of regression (temporary or permanent, spontaneously reversible or irreversible) have to be distinguished from each other, only the former type justifying therapy. Whenever possible, attention should be called to the necessity of a precise and accurate description of the specific points to which the regression has taken place or where the fixation points exist. Thus for example if a regression has taken place to the anal phase it is convenient to specify not only the proper sub-phase but even the specific component instincts involved. Similarly note and describe if the regressions and/or fixations concern essentially libidinal or aggressive components, or a given admixture of them and its possible proportions. (14)

#### VII. ASSESSMENT OF THE CONFLICTS.

Behavior is governed by the interplay of internal with external forces, or of internal forces (conscious or unconscious) with each other, i.e. by the outcome of conflicts. Examine the conflicts in any given case and take special care to point out if they are with the

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14) Some of the problems posed by this section were studied by Dr. H. Nagera, particularly those relating to the differential diagnosis of disturbances and general manifestations due to regressive processes, compared with the expressions of symptoms and pathology mainly due to fixations. The possible combinations of fixation and regression and some of its clinical manifestations were also studied. (See Nagera, Humberto., "On Arrest in Development, Fixation and Regression." The Psychoanalytic Study of the Child, Vol. XIX, 1964). A study group is now planning the publication of a monograph on the subject of the clinical assessment of fixation and regression, the relevant and reliable clinical pointers and indicators of specific fixations at the different phases of development as expressed in terms of symptoms, fantasies, drive activity, object relations and ego performances and reactions.

libidinal drives, the aggressive ones, or both and in what proportions. The conflict or conflicts should be described whenever possible not only in terms of the phases, levels, etc., at which they are taking place but in terms of the specific component instincts involved, i.e. positive or negative pliallic-oedipal strivings, oral aggression (biting, shouting etc.), anal sadism, looking, touching, etc.

On the above basis examine the conflicts and classify them as:

- a. external conflicts between the id-ego agencies and the object world (arousing fear of the object world).
- b. internalized conflicts between ego-super-ego and id after the ego agencies have taken over and represent to the id the demands of the object world (arousing guilt); include here conflicts between two internalized different ego-ideals.
- c. internal conflicts between insufficiently fused or incompatible drive representatives (such as unsolved ambivalence, activity versus passivity, masculinity versus femininity, etc.)

It is important to note that the assessment must not only determine the external, internalized or internal nature of the main conflicts observed, but it has to determine in each case the nature of the forces involved.

Thus, in cases of external and/or internalized conflicts, it is necessary to point out if the conflicts are predominantly with the sexual or libidinal strivings or with aggressive ones, or both. Whenever possible, the nature of the conflict should be specified further and reference made not only to the level at which the conflict is taking place, but to the specific component instincts involved, e.g. phallic-oedipal strivings, oral aggression, anal sadism, looking, and so on.

In some special cases the conflicts may be different from the usual ones between ego-super-ego and id agencies,

for example, they may be between two different ego-ideals which may be the aim-inhibited representatives of certain types of instinctual impulses. This form of conflict is by no means a rare occurrence, for example in adolescents.

According to the predominance of any one of the three types it may be possible to arrive at assessments of:

- (1) the level of maturity, i.e. the relative independence of the child's personality structure;
- (2) the severity of his disturbance;
- (2) the intensity of therapy needed for alleviation
- (3) or removal of the disturbance.

VIII. ASSESSMENT OF SOME GENERAL CHARACTERISTICS:

a. the child's frustration tolerance;

The construct of frustration tolerance refers to the immediate reaction that follows the postponement or total lack of fulfillment of an instinctual wish. The degree of the capacity to tolerate that kind of frustration is specific for each organism. It is an inner given, a primary tendency of each organism.

The section is on the whole a difficult one to assess because later conflicts and the ego's defensive measures usually blur the basic picture we try to investigate. For this reason, examples prior to the specific conflict

situation should be sought, to obtain an assessment of the basic tendency.

As we know, where in respect of the developmental age, the tolerance for frustration is usually low, more anxiety will be generated than can be coped with, and the pathological sequence of regression, defence activity, and symptom formation will be more easily set in motion. Where frustration tolerance is high, equilibrium will be maintained, or regained, more successfully.

An attempt should be made whenever possible to note what component instincts are involved, though the assessment may prove difficult at the diagnostic stage. Frustration of some component instincts in a certain personality may have more definite and observable effects than the frustration of others, thus giving information not only as to the strength of the different components in that personality but also as to the components where interference is least tolerable. Information also becomes available about those components in which aim-inhibition and sublimations are more likely.

Our experience has shown that the assessment is made easier if we examine the tolerance in regard to the frustration of (i) libidinal drives, (ii) aggressive drives, and (iii) in respect of those situations that require some degree of neutralization.

Clinical experience has similarly highlighted the following points in respect of frustration tolerance:

-The tolerance of frustration tends to be different in relation to the different component instincts.

- As many examples as possible are required before a final assessment is made in this respect. It is of course misleading to reach conclusions on the basis of isolated examples or incidents. It is important, to establish the frustrating character of the events under consideration, before attempting the assessment of the level of frustration tolerance.

-In the presence of important regressions to the oral phase the level of frustration tolerance tends to be very diminished.

- b. the child's overall attitude to anxiety (tolerance, defence and mastery).

Examine how far the child's defence against fear of the external world and anxiety caused by the internal world is based exclusively on phobic measures and counter-cathexes which are in themselves closely related to pathology; and how far there is a tendency actively to master external and internal danger situations, the latter being a sign of a basically healthy, well-balanced ego structure; when possible the methods of mastering anxiety should be connected with the level of anxiety tolerance. Distinguish as clearly as possible between anxiety tolerance and frustration tolerance. The former is the one to be referred to under this section.

- c. the child's sublimation potential:

Individuals differ widely in the degree to which displaced, aim-inhibited, and neutralized gratification can recompense them for frustrated drive fulfillment. Acceptance of these former types of gratification (or freeing of the sublimation potential in treatment) may reduce the need for pathological solutions.

It is important to distinguish those cases where though the sublimation potential exists it cannot be utilized or fulfilled and, if possible, to consider the reasons for it.

The sublimation potential of children as observed at the diagnostic stage may be obscured by the super-imposed conflicts or defence activity. Therefore, if possible, examples prior to these problems should be looked for to assess the basic sublimation potential.

(1) progressive developmental forces versus regressive tendencies:

Both are, normally, present in the immature personality. Where the former outweigh the latter, the chances for normality and spontaneous recoveries are increased; symptom formation is more transitory since strong forward moves to the next developmental level alter the inner balance of forces. Where the latter, i.e. regression, predominate, the resistances against treatment and the stubbornness of pathological solutions will be more formidable. The economic relations between the two tendencies can be deduced from ,watching the child's

struggle between the active wish to grow up and his reluctance to renounce the passive pleasures of infancy.

#### IX- DIAGNOSIS.

Finally, it is the diagnostician's task to reassemble the items mentioned above and to combine them in a clinically meaningful assessment. He will have to decide between a number of categorizations such as the following:

- (1) that, in spite of current manifest behavior disturbances, the personality growth of the child is essentially healthy and falls within the wide range of "variations of normality";
- (2) that existent pathological formations (symptoms) are of a transitory nature and can be classed as by-products of developmental strain;
- (3) that there are permanent regressions which, on the one hand, cause more permanent symptom formation and, on the other hand, have impoverishing effects on libido progression and crippling effects on ego growth. According to the location of the fixation points and the amount of ego-super-ego damage, the character structure or symptoms produced will be of a neurotic, psychotic, or delinquent nature.
- (4) that there are primary deficiencies of an organic nature or early deprivations which distort development and structu-ralization and produce retarded, defective, and non-typical personalities;

(5) that there are destructive processes at work (of organic, toxic, or psychic, known or unknown origin) which have effected, or are on the point of effecting, a disruption of mental growth.

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