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Anna Freud's Metapsychological Profile: Reflections on a Psychodynamic Assessment Model.

Summary:

Anna Freud's metapsychological profile is presented, and its possible application to daily clinical work with children, as well as its use in an evolutive approach to adult psychopathology, is discussed. The author points out that diagnosis is a dynamic process, and thus can be applied to most of the technical questions useful in psychoanalytic treatment. Theoretical and general issues are further discussed such as: the conditioning by the deterministic vision of reality upon the clinical practice, the heuristic value of infant observation, and the qualitative level of knowledge to which our diagnostic instruments lead us. The cultural and historical milieu from which the profile grew is illustrated, and the implications of its use in daily clinical practice are discussed.

There is an assessment tool designed to be used with children for assessment profiles of the psychiatric/psychoanalytic type. In her book Normality and Pathology in Childhood(1), Anna Freud propounds the "Metapsychological Profile". This Profile-an effective clinical and research tool-raises some interesting theoretical and practical issues. My own proposal for possible applications in adult psychopathology urged me to write this contribution.

1. Clinical Use of the Metapsychological Profile

My presentation of the metapsychological profile aims to highlight the usability of this tool in an everyday clinical practice. As with all clinical tools, we might use the metapsychological profile in a rigid, scholarly manner by strictly following its elaboration. For instance, we might consider those related to libido(2) and only afterwards deal with the requests from point **2. Aggression** in item **A. Drive Development**, to be found in paragraph V. **ASSESSMENTS OF DEVELOPMENT**, where item **B**. is titled Ego and **Superego Development** and actually consists of four sub-items. After this we would go on to paragraph **VI. GENETIC ASSESSMENTS**, where clinical material is seen from the viewpoint of regression and fixation points, and beyond to paragraph **VII. DYNAMIC AND STRUCTURAL ASSESSMENTS**, where the focus is on conflicts, and so on. Thus we may proceed all the way to the last paragraph, **DIAGNOSIS**. Such a systematic and pedantic procedure is necessary when one wants to become familiar with this tool and decode one language into another, the former being clinical-descriptive, the latter being metapsychological. This *modus operandi* is necessary when one is learning to use the profile. When one decides to learn a new language, a lot of practice (tedious at times) is essential in order to familiarize oneself with this language. In much the same manner, we actually have to train ourselves in order to become more familiar with the metapsychological language used in the profile and be able to once again translate the structural diagnostic

frame we have reached in the end, back in the opposite direction-that is going from the psychoanalytic technical language to the descriptive we usually use in our clinical practice and in everyday life. An example of this difficulty is what the Draft of Diagnostic Profile requires with regard to **libido distribution**, which is one of the three items used to organize libido assessment of libido. The Draft requires one to

> Examine and state…
> 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 ensure self-regard, self-esteem, a sense of well-being, without leading to overestimation of the self, undue independence of the objects, etc.; state degree of dependence of self-regard on object relations (p.141).

Such a request to categorize the clinical material collected on each case usually leads to an immediate reaction of disconcertedness and bewilderment. In fact, we realize quite soon that in order to collect data for the various items in the profile, all we have to do is go back to the very basic things that can usually be found in clinical notes or, at any rate, can be easily acquired in subsequent interviews with the child or the parents.

I recall the case of a 9-year-old boy. In relation to aforementioned item **(b) libido distribution**, we could use a piece of information: this was a child who bathed without a fuss, who liked being neat and clean, but who might also keep on a soiled shirt that had been dirtied at play; once in awhile, this same boy might go to bed without brushing his teeth. According to these small details, we may speak of a normal level of narcissistic cathexis in his body, without the extremes of obsessive scruple or rhypophobic fears or, to the contrary, sloppiness or regressive pleasure aroused by dirtiness. This boy enjoyed playing soccer on a small local team-where he had established good ties with his teammates-and he was also a passionate fan (without any sort of anxiety) of a major A-series team, signs that indicate an adequate (both in quantity and in quality) libido cathexis in the outside world. Further ahead we will consider more examples of this translation work, from descriptive everyday discourse into the metapsychological profile language, and vice versa.
The latter process, going back from the profile to everyday life, is important for at least two reasons: The first has to do with the validation of a certain behavior's metapsychological interpretation. To this end, we must identify possible daily life episodes in which the subject's behavior-whether an adult or a child-proves to be what we expected, based on the idea we have been developing, while elaborating the profile, of the psychic functioning of that child or adult. The second reason is that, at the end of the diagnostic consultation, we should be able to speak to the parents or the patients themselves about our ideas on both (patients and parents), and we can make ourselves understood only if we use their own language and also, at least in certain cases, their point of view regarding the problem for which we have been consulted. These last elements are an aspect of the *therapeutic alliance*: formulating a diagnosis and passing it on to the patient or the parents of the designated-patient/child, both represent a critical moment of the alliance building process with the patient, whether we call it a "working" alliance as does Greenson(3) or a "therapeutic" alliance along with Zetzel(4), who was the first to write about it. Every alliance requires a clear and shared definition of the goal on which the alliance is based. The contract we formulate with our patients or their parents-when we take on the diagnostic assessment commitment-obliges us to furnish them with a precise response to whatever has been agreed upon. Any need for further diagnostic examination or reformulation of the original request must take place by mutual consent. According to Codignola(5), the client's motive in asking us to carry out the diagnostic investigation must be initially assumed to be "true" and is not, therefore, interpretable. This formulation allows the motives or the unconscious expectations behind the explicit statement to emerge *even during the diagnostic procedure*: in Codignola's idiom these non-conscious elements represent what we may consider to be temporarily "false" and therefore open to interpretative work. Since the issue here is diagnosis, we must wonder, in such a context, in what terms we may then speak of interpretation work. Greenson -in his discussion of "the analysis of patients' material"-indicates four distinct procedures that are included in the term "analyze": *survey*, *clarification, interpretation and elaboration*. In my opinion, during the diagnostic phase, interpretation work must be limited to the first two

steps. Gathering and clarification, with the patient or the parents, of some of the unconscious expectations and motives connected to the rational request, helps us collect-together, with our clients themselves-elements that are essential to defining the assignment we have been given, or its possible reformulation. For instance, if we have been consulted by a couple of parents because of their child's difficulties regarding school and learning problems, we must work together with them (with their "observing ego"(6)) if we want to explore the connections between the child's behavior and the dynamic situation of intra-family or couple relations. And in this route we will use survey and clarification procedures. Working in any other manner would have us carrying out an authoritarian manipulation of the relationship, the consequence being an interruption of the contact with the patient or her parents, or else-in a situation of total falsification of the relationship-we might see them deferring to what we think is right, based on our redefinition of the original request, which has been, however, formulated by us alone. Such a discussion about working alliances is an example of how many technical procedures commonly used in treatment prove to be valid and usable also in the diagnostic phase.

Use of the metapsychological profile in daily clinical practice obviously requires mastery of direct observation and clinical interview techniques, along with a good knowledge of so-called psychoanalytic psychology regarding developmental and clinical theory: therapeutic alliance, transference, counter-transference, interpretation construction, and validation, are issues constantly at play, both while collecting clinical material and while processing and systematizing it in the profile inventory. What has been said thus far has to do with the profile as a tool, an inventory to be applied to clinical material in order to define a structural diagnosis. One may notice how the connection between the metapsychological profile and structural diagnosis may be given in these terms: the profile is an operative schema, a clinical and research tool that uses the structural viewpoint by Freud as a conceptual reference. The expression "structural diagnosis" also entails the assessment of subjects' abilities-not only their deficiencies, limitations or insufficiencies-but also, precisely, their peculiar and positive modalities in facing distress and solving conflicts. Such a "positive-terms-diagnosis" is made possible because of the continuity, in psychoanalysis, between normality and pathology. It is thanks to this idea that we can work with the normal and the pathological using the same tools. Eissler(7) dates this achievement-which is cultural even more than scientific- back to *The Interpretation of Dreams*(8).

The profile works as a tool to highlight-first of all, to ourselves-our actual, true way of proceeding with a case; i.e., the metapsychological profile is an organizer of our clinical way of thinking, and therefore a highlighter of the same. Indeed, it makes us acknowledge-with ourselves, before we do so with others-which procedure we are thinking of following or we have actually followed (whether clinical interview with the patient or with other relatives, projective or level tests, or drawings, or direct observation etc.) and it leads us to ask ourselves the reason for our choices, as well as the value we ascribe to the material thus collected. Obviously, this effort at definition-even when it is done while working on clinical material in order to elaborate the profile-will often be enough to bring out the sequence of steps that are implied in our clinical work. Broken down as such, the clinical procedures that we have actually used (or that we anticipate using), allow for an easier identification of the theory references that are behind each methodological passage or the specific connection we have made.

The same goes for case supervision. When it is done in such a manner, supervision, above all, allows us to underline the empirical knowledge involved in each clinical act that is being discussed. Such knowledge may then be further refined, as mentioned above, by identifying the theoretical frames of reference that are implied in each step of the clinical procedure followed in dealing with the case. Thus organized, case supervision truly offers a privileged outlook on clinical reality, meaning not only the variety of cases coming under observation but, above all, the whole variety of solutions in methods and clinical procedures offered for the various different cases; the entirety of these solutions actually represents the true diversity with which psychoanalytic technique may be applied. To the extent that case supervision accepts this diversity, it actually becomes a privileged observation point for the variety and vitality of the links between clinical practice and the use of theory, avoiding the same from the rigid rules of a school viewpoint that distorts the nature of supervision by turning it into a means of control for the practical application of a psychoanalytic corpus that is supposed consistent and compact. Whenever a clinical assessment is expressed, a prediction is made, based on a small amount of data; and this implies that we also indicate the necessary elements of

verification for the given prediction(9). Therefore such an operation is absolutely rational and verifiable; what seems to be intuitive and unfathomable in the immediate is actually often identifiable and can be broken up into a sum of the diagnostician's conscious and pre-conscious perceptions and estimations, which can therefore be brought to a stronger level of definition and rational identification. By working in such a manner, it becomes possible to make these special data registration and interpretation skills-the substratum for clinical intuition-available for learning, thus uprooting clinical intuition from the dimension of ineffability in which it has been placed occasionally.

From this point of view, the metapsychological profile may be viewed as a contribution-maybe somewhat too technical and reifying-towards learning and refining clinical skills. We are quite aware of how closely related diagnostic and prognostic assessment are: with the metapsychological profile, their connection becomes even stronger, if that is at all possible. Diagnosis and prognosis are connected in a determining relationship following a cause-effect principle; such a principle reached its most extreme expression in rational mechanics, the paradigm of which is: "Given the initial conditions of a system, it is possible to predict its future states". Yet this link makes us risk becoming prisoners of determinism, and a rigid and scholarly application of the rules of psychological analysis often leads us to an arid, partial, mechanical and ultimately presumptuous outlook on the subject. On the other hand, deterministic ideal has been in turmoil for quite some time, to the point that it is now being called "deterministic chaos". In fact, today we no longer say we "predict" that a given phenomenon will take place, but rather that we are trying to define a map of the possible developments of the phenomenon. Hence the acknowledgement of reality's irreducibility seems to be definitive. Yet this landing point poses quite a few problems to our diagnostic procedures, which imply the possibility of knowing and reducing reality. Spence(10) sought a way out of this blind alley and suggested pursuing the "psychoanalytic truth" within a narrative dimension rather than in the subject's history-biography-and such a perspective may well be valuable for diagnosis, as well as treatment. Much in the same way Sergio Moravia suggested(11) the phenomenological-"persono-logical" dimension as a way out of mechanistic reductionism, to which psychiatry and psychoanalysis seem to be doomed by their original positivistic statute.

Therefore the validation of the interpretative hypothesis for clinical material is an issue in the diagnostic phase also and thus proves to be paramount even when using the metapsychological profile. For some time now, themes such as psychoanalytic interpretation of clinical material, its validation or lack of grounds, its historical-biographical or narrative-metaphorical truthfulness, have undergone so much debate-both in our field and in other human sciences-that Jerome Bruner says

> future science and culture historians, looking back at our times, will most certainly be tempted to call them "the epistemological awakening", or discuss them under some similar title. Because ours is a generation that-perhaps more than any other since Descartes' times-has struggled not only with "nature" or the "mind", but the way we become aware of them, in what sense we may have access to their "reality" and what the limits of our knowledge are.

2. The cultural and historical context in which the metapsychological profile developed

Reflections on the cultural and historical roots that led to the development of the profile help us better understand the general questions about psychoanalytic interpretation, the boundaries of its applications, and its validation.

The development of what we usually call Ego psychology is based on Freud's revision of his theory on anxiety and on the organization of the psychic apparatus in *The Ego and the Id*(12) and in *Inhibitions, Symptoms and Anxiety*(13), when he went beyond his topical view of personality and his resulting toxic theory on anxiety. The psychic apparatus was hence organized according to the three psychic parts: the Id, the Ego and the Super-ego. Both unconscious and conscious parts were acknowledged in the Ego and the Super-ego; the Ego was defined as the site of defense functions and anxiety. The latter was then described as

the consequence of a conflict (within the psychic parts or between one of them and outside reality) to which the Ego reacted as if it were a signal calling for defense. Symptoms were seen as compromise, the ultimate outcome of a dynamic game between anxiety and defense. Heinz Hartmann's works-*Ego Psychology and the Problems of Adaptation*(14) in particular-are universally indicated as the basis for Ego psychology(15). In this work we find the themes, that would then be developed during the decade between 1950 and 1960, from which I would mention "Comments on the Psychoanalytic Theory of the Ego" (1950) and "Mutual Influences in the Development of the Ego and the Id" (1952), in which Hartmann discusses the notions of undifferentiated stage and primary autonomy for their relevance in establishing certain definitions and notions, such as that of *Self*. The fundamental ideas introduced by Hartmann are the same to which Anna Freud and her group from the Hampstead Clinic referred in developing and using the metapsychological profile for children. In order to better appreciate the novelty in Hartmann's ideas, it is useful to recall that Freud, from a genetic point of view, had conceived the Ego as a product of the encounter between the Id and external reality. Hence, according to Freud, the existence of the Id is primary, and instinctual drives are within it, while the Ego-although it detains the perception-consciousness apparatus, which keeps it in connection with the external world-appears only secondarily, as the result of a transformation of the Id. Contrary to such a formulation, Hartmann states that the Ego and the Id become differentiated from the same undifferentiated condition both at the same time. The Ego is thus assigned *primary genetic autonomy*; it is also defined, above all, through the functions it serves ("a personality substructure, defined by its functions", in the words of Hartmann himself). The other crucial differentiation is achieved by assigning not only defensive activities to the Ego, but also neutralized ones; that is to say there are *conflict-free areas* in which rational processes appear and undergo no interference on behalf of the Id. The development of the Ego is thus influenced not only by instinct and external reality but also by the biological hereditary apparatus that becomes the basis for the *Ego's primary autonomy*. According to Freud external reality was mainly social, organized in absolute contrast with the individual's drives and therefore a source of unresolvable distress; in Hartmann it becomes a neutral environment, quite similar to a natural habitat. By means of *neutralization* and the process of *function changing*, neutralized instinctual energy should be made available to the Ego. Thus *secondary autonomy* is achieved: Ego activities previously conditioned by instinctual drives become free of them and autonomous and can be used for goals that are not influenced by drives. Here the pleasure principle seems to be replaced by the reality principle. Ultimately, Hartmann points out the existence of *intrasystemic conflicts*-conflicts within the Ego expressed by the opposition between different interests or different functions of the same Ego.

Considered from a historical and cultural perspective, Hartmann's contribution to psychoanalytic theory offers the opportunity for some considerations. Hartmann has perhaps been the most acute innovator of Freudian psychoanalysis, having kept it open to debate with other humanistic disciplines-fighting, to that end, against the American psychoanalytic *establishment* which was inclined to turn psychoanalysis into a strictly medical profession. The arrival of nazism in Germany had first caused the dispersion of the strong Berlin psychoanalytic group(16) and then of the Viennese. Originally, the German psychoanalysts sought refuge in countries close to Germany, such as Czechoslovakia and Denmark. Later on, most of them moved to the United States, followed in their choice by Viennese colleagues, after 1938. This was the premise for "the Americanization of Psychoanalysis". Obviously this was not just a matter of the major group of psychoanalysts moving geographically, it had to do with the transformations that took place in Psychoanalysis in the years between the 1930s and the 1950s when this group of immigrants was exiled for political and racial reasons. After WWII, they became a leading group in the world of Psychoanalysis. Yet this was not a homogeneous group; at least till the end of the 1970s, the leadership was in the hands of one segment of the American group, the one in which Hartmann was the most outstanding figure. The opposing group was represented by the "biological advocates" whose main characteristic was their firm belief in instinct theory at a theoretical level; they therefore discredited Hartmann's hypothesis on the genesis of the Ego from an undifferentiated instinct matrix as well as his suggestions about thinking in terms of autonomous functions of the Ego, either primary or secondary. At the cultural level, this group viewed psychoanalysis mainly, if not exclusively, as a therapeutic means, and believed that it should be limited to physicians.

Another group was strong within the psychoanalytic sphere: the so called neo-Freudians or culturalists. They

appointed the center role to interpersonal relations in determining individual development, both normal and pathological. According to these authors, interpersonal relations are determined by the individual's social and cultural context, more than instinctual drives. Harry Stack Sullivan, Frieda Fromm-Reichmann, Karen Horney, and Erich Fromm were in this group. Finally, there was a fourth group-the so called "committed Freudians"-headed by Otto Fenichel. They criticized the biological advocates for favoring the medicalization of psychoanalysis and for giving up on culture and humanism; however they did agree on its anchoring to the unconscious level and to sexuality. On the other hand, they shared the same idea of psychoanalysis as a discipline open to discussion with human sciences, even though they criticized Hartmann and his group for misrepresenting psychoanalysis' subversive force, diluting it-in their opinion-into a half-hearted doctrine for gradual social betterment. The story of Fenichel and the committed Freudians is told in an interesting book by Jacoby(17) on "the Americanization of Psychoanalysis" which, according to the author, is nothing more than the outcome of the "repression of psychoanalysis"-as the book's original title reads.
The dispute between these two groups gave way to the major drives that influenced psychoanalysis even outside the US, in the period between 1940 and 1960. A brief analysis of such a confrontation can define the cultural and historical context in which the metapsychological profile developed. It satisfied the need to systematize and formalize the wealth of ideas and knowledge psychoanalysis had accumulated at that time. Such a need was strongly felt by Hartmann, so that he himself represented the psychoanalytic position in the debate Sidney Hook organized in 1958 on psychoanalysis' scientific attributes(18). David Rapaport, however, gave a major and keen contribution in this field, beginning with his 1960 essay *The Structure of Psychoanalytic Theory*(19). Such methodological (and therefore also terminological) rigor, so strongly advocated by Hartmann and Rapaport, was one of the characteristics Ernst Kris conveyed to the work group he put together at the Yale Child Study Center. We can find a direct connection between the works of Rapaport and Kris and also a direct influence of the study group-one of the roots of the metapsychological profile-Anna Freud set up for the development of the Psychoanalytic Index.
This group began working around the year 1954, under Joseph Handler's leadership, with the task of defining an indexing model for the clinical material produced during the hours of psychoanalytic treatment at the Hampstead Child-Therapy Clinic. The task involved an evaluation of notions commonly used in psychoanalysis in order to provide therapists with precise formulations to work with in recording and indexing clinical material. They immediately noticed that

> many definitions, which in the past had seemed satisfactory, now seemed to be ambiguous and a number of notions that were used regularly in theoretical discussions on clinical material, proved to be lacking in clarity and theoretical rigor. Hence it proved to be necessary to re-examine a great number of such notions, (…) and find some new formulations that would allow for clinical material to be described in a theoretically appropriate manner(20).

Rapaport had felt the need for the same revision and systematizing of psychoanalytic ideas and had initiated this task. Writings containing the Hampstead Index study group's critical revisions appeared in different journals through the years. In these works we find the theoretical formulations that have sustained the development of the metapsychological profile.
Ii is quite difficult to weigh the pros and cons of psychoanalysis' social incisiveness due to Hartmann's hypotheses on Ego genesis and on the definition of the psychical apparatus mostly in terms of functions rather than conflict. On the one hand, many of the ideas he introduced have in fact proved to be greatly useful in clinical practice. For instance, his reference to primary autonomy and the non-libidinization of its functions, such as motility or vision and hearing, is valuable in interpretung infantile autism from a psychoanalytic viewpoint. Also his reference to the neutralization and consequent secondary autonomy of a function has proven crucial for the interpretation of many learning disorders in latency. On the other hand, hypotheses of Ego genesis from an undifferentiated matrix, of an Ego endowed with both primary autonomy and neutralization abilities, which is then able to create "conflict-free areas" within the same Ego, allow the image of an individual whose wellbeing is primarily linked to intrinsic capacities (natural and acquired) to adapt to external reality, rather than providing the capacity to modify a social environment that is far from

satisfying the subject's instinctual drives. When Hartmann and the culturalists relinquished their anchoring to biological-drive roots, they weakened-or indeed actually denatured-Freudian theory's inherent potential to produce radical social change. This is exactly the criticism that Fenichel and the "committed Freudians" directed at the culturalists. Today we cannot measure the radical position of psychoanalysis against that of revisionism; yet this issue has been settled. Anyway, the terms of this discussion have reappeared in a critique Cushman directs against Stern's study(21) for having spoken of his child development theories as if universally valid, when in fact he deals with the development of children who live in the Western world. Thus he claims that Stern worked in a decontextualized manner, without realizing that

> by not considering political structures as causal factors, decontextualized theories legitimate, justify, and perpetuate the current balances between power and privilege(22)

Therefore, the basic notions of Ego psychology and the post- WWII cultural landscape represent the frame of reference that Hartmann and Anna Freud had in common. Anna Freud proceeded to make her own original contributions and tried to differentiate their positions, even though in attempting this she was not always able to maintain total consistency between her clinical proposal and the theoretical principles she held. Regarding the former, in her 1936 essay *The Ego and the Mechanisms of Defense*(23), apart from framing repression as one of the defense mechanisms that work at the Ego level, she listed and defined nine other defense mechanisms. Two points must be stressed: the first is that in this essay the Ego is presented as being defined by the defense activity it carries out, which consequently implies a conflicting view of its origins and its functioning, therefore perfectly coinciding with Freud's view. A quite different stance-more aligned with Hartmann's-is however expressed by Anna Freud in 1966. In the preface to that year's edition of The Ego and the Mechanisms of Defense, in which mechanisms of defense had been presented and discussed 30 years earlier, she indicates her other essay *Normality and Pathology in Childhood*(24), as the text where they are more vastly reconsidered

> in relation with some of its [the Ego's] other aspects, that is with its primary deficiencies, its apparatuses, and its functions, its autonomy and so forth

This statement seems to reincorporate the initial positions within the Ego psychology perspective. Anna Freud's own contribution was always clinical in nature, more than speculative-theoretical. Her suggestion to read children's behavior according to *developmental patterns* implies a viewpoint of *continuity between normality and pathology* in behavior which re-establishes a connection with the original psychoanalytic position and, with respect to clinical reasoning, makes it decidedly flexible yet methodologically equipped in diagnostic definition. The idea of *developmental patterns* supported the definition of developmental tasks to which children and adolescents must conform at various developmental stages. Such normativity has received strong criticism, as it does not respect context and individual peculiarities in defining-perhaps in a conflictive manner-the content and timing of developmental acquisitions, as well as their modes of expression. This criticism of child development decontextualization is similar to the above mentioned criticism quoted from Cushman.

While the critique of the idea of developmental tasks is justified, it does not seem that the idea of developmental patterns can be subject to such criticism-because of the flexibility and dynamism it entails in evaluating children. Rather, in Anna Freud's focus on children and adolescents' natural developmental spur, one may retrace a vitalistic attitude which is colored with optimism, when it is read in the background of a neutral milieu, such as the one defined by Hartmann. In this case, once again we find a contradiction between on one hand a clinical proposition of major operative value, implying strong cultural openness, such as that of the developmental patterns, and on the other hand anchorage to drive theory (the Id as vital force) and, in third place, contextual references to other concepts-in this case, Hartmann's reference to external reality-which, on the theoretical level, are unlikely to be compatible with those previously recalled. The contradiction between clinical and theoretical levels was not however Hartmann's: he provided himself with

novel operative concepts in order to proceed with radical modifications of the original Freudian theory. This contradiction was instead typical of Anna Freud and some other authors-such as Edith Jacobson-who held onto their reference to drive theory, although they accepted and applied new clinical ideas the metapsychological implications of which were incompatible with that theory.
Conclusively, Anna Freud's contributions have an operative use in the clinical psychoanalytic field for ideas of diverse origin that, analyzed from a theoretical viewpoint, are irreconcilable(25).
Finally, historical facts associated with Anna Freud's basic professional training may be recalled to outline the work that led to the formulation of the metapsychological profile. With Dorothy Burlingham she founded a residential nursery in Hampstead at the beginning of WWII, within an American aid program for England. The three houses that made up Hampstead Nursery admitted very small children for whom

> the conditions of war -fathers in the army, mothers working full-time in factories, children's evacuation from the cities as a preventive measure, destruction of many homes during bomb attacks- had made family life impossible(26).

In the book quoted here, ample space is dedicated to *direct observation of the behavior* of children in an environment that is quite different from a psychoanalytic setting; and a psychoanalytic reading is given to this directly observable behavior. From this experience Anna Freud also gathered proof of the significance of educators' work in the psychological development of children. In fact, in 1930 she had already written "Four conferences on psychoanalysis for teachers and parents". After the end of the war, when the Child Therapy Clinic replaced the Nurseries, a crèche and a nursery school were maintained as part of the facility in order to help complete research opportunities through children's psychoanalytic observation carried out directly by the psychoanalyst or indirectly by the educator. Anna Freud had graduated as a teacher and in 1937, together with Dorothy Burlingham, she had set up in Vienna a psychoanalytically oriented day care center for poor children. For Anna Freud-a qualified teacher-the relationship between pedagogy and psychoanalysis, between manifest behavior and its potential for interpretation outside the traditional setting, created natural grounds for reflection right from the start of her psychoanalytic career.

3. Two Crucial Points

The first chapter of Normality and Pathology in Childhood is dedicated to the subject of psychoanalytic ideas on child development, based on direct observation or reconstructions from psychoanalysis with adults. It examines the areas to focus observations on, in order to obtain useful material for psychoanalytic diagnostic assessment. The first to be considered are the derivatives of the unconscious, which actually represent what the analyst's therapeutic work deals with. At the same time, though, Anna Freud writes

> break-throughs from the depth and irruptions into the conscious mind are not confined to analytic sessions; (p. 14)

this material is therefore open to direct observation, and in children

> there are simple fulfillment dreams which reveal the underlying wishes; there are also the conscious daydreams which give information about the daydreamer's libidinal development with minimal distortions (p. 14-15)

Defense mechanisms also lend themselves as observation material:

> reaction formations which, by definition, bring the repressed counterpart of the overtly displayed manifestation to the observer's notice. The overconcern of a little boy "whenever his father has to leave the house at night, in fog conditions" etc., is a certain pointer to his repressed death wishes. (p. 16)

Furthermore, useful observation material may be drawn from some aspects of *infantile behavior* such as play activities, behavior towards food, clothing and from observation of the Ego. At this point, Anna Freud preliminarily remarks that

> So far as Ego and superego are conscious structures, direct, i.e., surface, observation becomes an appropriate tool of exploration, in addition to and in cooperation with exploration of the depth.

An example of such an application of direct observation has to do with Ego functions, as Anna Freud continues:

> The child's Ego control over the motor functions and his development of speech, for example, can be assessed by simple observation.

Regarding the crucial question, as to the validity of psychoanalytic interpretation of surface material (such as behavior, attitude, and recounts) beyond the traditional psychoanalytic setting, Anna Freud's stance has always been clear. She saw the possibility of validating psychoanalytic interpretation of a surface element, through correspondence between that element and a defined unconscious conflict, a correspondence ascertained by data from previous individual analyses. In other words, according to Anna Freud, interpretation that stems from analytic work in the therapy room represents the source of validity for the interpretation of surface material(27).
Two issues are key points in subsuming the specific area of child psychoanalysis under the more general disciplinary context of psychoanalysis. In the past few years, a debate has arisen regarding the interconnection between psychoanalysis and human sciences. I am referring to *the heuristic value of direct observation* and to the definition of the *type of knowledge about the individual we attain through the use of the metapsychological profile*. I discussed the first issue in a work in which we examined the models used by Esther Bick, Kris(28) and Stern(29) for direct observation, and we concluded by pointing out how all three authors acquire, from their research, data that are highly significant in supporting the various clinical theories each of them subscribe to: Kleinian theory, Ego psychology, Kohut's self-psychology. Data collected through direct observation are strongly conditioned by the clinical theory to which the researcher subscribes. Therefore, *through the facts*, the authors, having used direct child observation, propound its subalternity to interpretation. Contributions deriving from direct observations therefore continue to be quite limited and do not have the necessary penetration power to let them significantly cut into psychoanalysis' *corpus doctrinae*. Rapaport-referring to investigations carried out with the direct observation method-wrote:

> The trouble with these studies is that either their relevance as independent evidence for theory has not been established, or their relevance for theory has not been established.

Yet direct observation, just as it propounds its subalternity to interpretation, becomes independent of the clinical method and acquires a license to carry out research in the psychoanalytic sphere. Without a locus, to compare data collected from direct observation against those derived from clinical methods, the tendency to confer to direct observation the same importance afforded to interpretation becomes progressively stronger. I believe that Anna Freud's stance is the most acceptable: if one wants to remain within the psychoanalytic thought, interpretation must be assigned a major value, in comparison with direct observation. This reconfirms the centrality of clinical work even as regards the construction of a general and developmental

psychology(30), but this also keeps psychoanalysis distinct from psychoanalytic developmental psychology. Such a distinction is supported by methodological criteria whereas clinical experience tends to entangle the two levels and offer contradictory elements with respect to theoretical systematization. These contradictory elements are signs of a persisting opportunity we have to dialectically reconcile empirical data-whether clinical or observational-with the method and theory the data stems from; method and theory which, conversely, are interrogated by the empirical data in a search for its own meaning. Today, the alternative to such a contradictory state of psychoanalysis is actually its debasement to blind empiricism or the suffocation of experience within entrenched theoretical canons.
The second crux is the type of knowledge our diagnostic tools bring us. They are in fact means for knowing reality, and here we come across ontological problems. Which reality do we think we may reach through a *diagnosis*? What truth do we think we are pursuing? In Western culture, Euclidean geometry has always been the model of reference for assessing the degree of scientific reliability in each discipline or each individual argumentation; in fact, the Euclidean model inspired the notion of philosophic truth itself. Richard Trudeau(31) recalls a metaphor by Morris Kline and calls this conception the "theory of truth as a diamond". Kline in fact writes:

> The loss of its sacred characteristics, on behalf of the truth, seems to eliminate an ancient question concerning mathematics' own nature. Does mathematics exist independent of man, as do the mountains and the seas, or is it an entirely human creation? In other terms, in his work does a mathematician bring back to light diamonds that have been hidden in the dark for ages, or is he producing a synthetic stone?

Kant had great interest in the nature of geometric truth, in his attempt to define propositions that could be adjudicated true and able to increase our knowledge. He believed that synthetic a priori statements held such characteristics: being synthetic, they should be more than a re-elaboration of what is already known, at least implicitly, and therefore should bring truly new information and, being a priori, they should have the certainty Kant held to be inherent in all knowledge independent of our senses. Kant believed that Euclidean geometry theorems are synthetic a priori statements: a refined theory of truth as a diamond.
Therefore, deductive geometry did not originate the diamond theory; but it was the main reason why the diamond theory lived on, as an ingrained habit: once the world stopped talking directly to mankind, the latter had to turn to philosophy and science. Statement 2) ["diamonds-truths that are certain and endowed with common knowledge content as regards the world-do exist"] has been, from Plato to Kant, the main argument in support of statement 1) ["Euclidean geometry theorems are diamonds"], and since mathematicians had discovered a diamond mine, this not only demonstrated that diamonds exist but, also, that the human mind was capable of finding them. Therefore there was no reason why investigation in other fields-such as cosmology and ethics-should not have the same success. Objective truth was supposed to be everywhere, waiting to be discovered, and the hunt for diamonds was open (Trudeau).
Rapaport(32) reminds us that:

> in one of his few references to philosophy, [Freud] characterizes psychoanalysis (and specifically the idea of unconscious determination) as the psychological counterpart for Kant's philosophical viewpoints(33). Therefore the epistemological implications of psychoanalysis are quite close to Kant and quite far from Anglo-Saxon empiricism.

Freud had in fact totally embraced the scientific ideal of his times that viewed the objective of every rational investigation to be the discovery of truths that exist independent of human contribution, just as diamonds do(34). Freud's conviction that interpretation carries us to the discovery of the subject's historical-biographical truth is an example of his adherence to the diamond theory.
The possibility of a non-Euclidean geometry(35) unsettled Kantian doctrine on space and the status of "synthetic a priori statements" assigned to Euclidean postulates and theorems. In this context Trudeau writes(36):

The onset of new geometry marked the slow decline of the diamond theory-a process that is still at work. Nonetheless, non-Euclidean geometry remains, in my opinion, the main destabilizing factor as pertains to the diamond theory: First of all, because it removes the grounds for what had always been its point of strength-i.e. the objective truth of Euclidean geometry-and, in second place, because it does not prove that that geometry is false, but that is simply not certain. If the non-Euclidean revolution had bequeathed at least this certitude to us, that is the proof that old geometry is false and the new-hyperbolic, or any other-geometry is true, we could always get by with some sort of self- acquittal: "We were mistaken, but now we see the light of truth". The Euclidean revolution does not grant such a possibility, because it leaves the question open as to which geometry is true. We may think that the sum of the angles in every triangle is 180°, without fear of logical contradictions or conflicts with everyday experience but, if we prefer, we may also think that the sum of every triangles angles is less than 180° without thus fearing -in this case- neither logical contradictions nor conflicts with everyday experience. Hyperbolic geometry is more complicated than Euclidean geometry, but it is an equally valid description of experience. This fact makes one think that also in other situations "the truth" may not be one and only, and in that case there are no diamonds.

The loss of objective truth criteria has opened a serious crisis in geometry also-that for over two thousand years had been considered a model of validity. The way out of such a crisis seems to be-for this discipline also-through hermeneutics or, as Trudeau puts it in the conclusion of his book, the

theory of truth as a story, the premises of which are: 1) Diamonds do not exist, 2) we tell the story of our own experiences, 3) everyone's stories are true.

This epistemological crisis also applies to the so-called exact sciences, and, in this case also, the way out is sought for in shared narratives of our experiences-in a total analogy with psychoanalysis.
My opinion is that our tools do not lead us to "discover" the true, natural, real psychic functioning of the human being, but they only show us the image we ourselves have created of it. The same goes for what we know today about numbers and their relations: they do not exist in a world outside us but they are our creations. Going back to the discussion on direct observation of child behavior (but, in general what I am saying is true also for adults), I believe that what our methods bring us is a "narrated child". Therefore, there should no longer be the usual juxtaposition between the *observed child*, the one offered by direct observation and therefore the true one, and the *narrated child*, the one clinical reconstruction supplies us with, which is supposedly purely *hypothetical*. Such a juxtaposition fails in that both are constructions, neither of which can show greater absolute credibility than the other. Once again the problem is of method and coherence in its utilization; in that case, the experimental method cannot be said to be superior to the psychoanalytical method. To lose this equalitarian methodological measuring stance is to put psychoanalysis in a position of inferiority in which it is forced to justify every single step through methodological criteria of a naturalistic science, because such are considered to be "more scientific". Much of the present debate between psychoanalysis and neurosciences is vitiated in this sense.

4. Using the Metapsychological Profile in Various Clinical Situations

Two good descriptive examples of the profile are offered by Nagera(37) and by Bolland and Sandler(38). In the first chapter of his book, Nagera presents every item in which the profile is articulated, and each is specifically illustrated and commented on with reference to the case material of an eleven-and-a-half-year-old boy(39), whereas Bolland and Sandler present a successful analytical treatment with a two-and-a-half-year-old child(40) through the weekly reports the therapist wrote. This case material is the basis of the indexing process the application of which is detailed in the second part of the publication. Thus, while maintaining our reference to the above mentioned books as an example of a "complete" use of the profile, I will show how this tool may also be correctly used in everyday clinical activities when the patients' modes

of access, their requests and their needs, as well as our schedules and working conditions, rarely allow for a formally complete use of the profile. The metapsychological profile may nonetheless be useful in situations in which we do not have all the necessary information to adequately fill in all the items that make up this instrument.

In such cases the profile becomes very useful as a guide-a compass-to guide the collection of clinical data, right from the first contact with the patient. In such conditions of partial availability of case material, we cannot expect to reach a diagnostic conclusion that completely illuminates the subject's entire personality, but we can expect ourselves to formulate a precise and articulated evaluation, from a psychodynamic viewpoint. I had the opportunity to compare-with the same case material-a diagnosis formulated according to DSM-III criteria against the one using metapsychological profile criteria, and decided in favor of the latter-due to both the greater richness and dynamicity of its framing and its allowing, thanks to such characteristics, better possibilities of formulating treatment plans and prognostic hypotheses.

Referring to the profile's layout also in everyday clinical situations gives us a guide in arranging the material available to us in any case and, at the same time, it lets us trace our own position in the field of relations that the clinical situation involves, that is to say, our position with regards to the material and the task we have been explicitly assigned by the client, or the aim we have set ourselves. I have already discussed the various issues that must be dealt with in the interconnection between patients', or parents', explicit requests and the answers we give. I will now discuss a factor linked to a type of conditioning that we might exert on case material.

On the occasion of an extensive re-organization of a Child Neuropsychiatry Unit, it became necessary to reassess all the cases in charge, in relation to the possibility of discharging them or redefining their treatment program. This reassessment was carried out utilizing the metapsychological profile; it provided us with the dynamic frame of the intrapsychic and relational situation of all the children examined, and with its third point ("milieu and personal history") it also became a guide for reconsidering the family and social context, and for anamnestic updating. We then tried to focus on the factors in favor of protracting psychotherapeutic treatment and those that, instead, recommended a shift to a welfare or educating program. On these premises we discussed various cases. Davide, for instance, was 13 years old at the time; he had been diagnosed as autistic and the Unit had been in charge of him for the past ten years (he had been admitted at the age of three for "language problems"). In analyzing his personality structure, in particular as to the assessment of his libido and Ego development, it was determined that it would be more useful to continue with support work for his teachers and regular consultations with his parents, whereas the individual sessions with the boy were to end soon after.

We came to the opposite conclusion in the case of 12-year-old Paola. She had been admitted to the Unit at the age of five. The diagnostic assessment given at that time pointed out a serious delay in her psychomotor development, behavior modifications and communication disorders. A speech therapist took her into treatment, while the child neuropsychiatrist was to continue regular clinical checkups. In the following years, support for her teachers and periodical consultations with her mother were provided. The year before our assessment (Paola was then 11) she had showed a change in her symptoms: apathy and disinterest for any type of activity dominated; at school she was quiet and isolated, often mocked by her schoolmates because she was slow and awkward. Out of our discussion came the picture of a development block with ensuing immaturity both on the behavior level and, most of all, on the level of her skills for affective and cognitive working through reality. Her characteristic reactions when confronted with stimulation from the inside or the outside were refusal and escape. Nevertheless, some positive skills surfaced from case material analysis: suitable answers to interaction and performance requests from her social context. Such abilities were visible only under certain circumstances (dual relationships) and with certain people (such as her literature teacher). Our final diagnosis gave evidence for a permanent libidinal regression to previously established fixation points, accompanied by simultaneous Ego and Super-ego regressions. We located this case in the fourth of the six prearranged categorizations from the profile(41). At the same time, we estimated that the capacity to give suitable answers was an indicator that the situation was not yet completely blocked, but such that it allowed an actual developmental thrust. Therefore we settled for initiating psychotherapeutic sessions.

Thus the profile also lends itself to specific purposes, starting from a general dynamic framework. The risk in using this diagnostic tool in such cases stems from the necessity to accentuate one aspect of the problem

over the rest: in our case it was the part pertaining to the elements regarding the patient, the analyst, and the context, generally defined as analyzability. Consider that the “reason for referral” (which is the first point in the profile schema) in this case was the need to revise all cases; the health service-by way of the re-assessment of clinical organization it required of its staff-was its own client. This was evidently another complication as, in such situations, it is quite natural that unconscious factors enter to defend the institutional structure under scrutiny. In our case, this aspect was clearly expressed to the group, and it became a part of the clinical assessment itself. By including the staff’s attitude toward the case within the diagnostic picture, it was possible to maintain a dynamic view of the same; working differently would have distorted the use of the profile itself, turning it into a commonplace tool for the application of a static criterion to case selection.
The metapsychological profile provides a solid network within which case material can be arranged. This network has various layers linked together by many cross-references, and only its weave can hold it together. The various layers of the network come from the different levels or angles according to which we may read clinical data: libidinal development, Ego functions and defensive organization, types of conflicts (internal, internalized, or external). Reading the clinical data simultaneously on these different levels-and therefore grasping the cross-references from one to the other-ensures our interpretation with suitable complexity and verification levels in terms of correspondence between such different points of view so that the diagnostic hypothesis we reach through our procedure is credible. If we apply this complex data reading procedure to all the clinical information we have, it will provide consistency and substance to our clinical reasoning, just as the thread-knots in a tapestry. The mental image from the profile-like the weave in a tapestry the design of which is initially unknown-gives concrete proof that case material will be arranged in the various parts of the weave and in its various layers, thus suggesting a draft of the design in which, along with our first data, some empty areas will also appear. From the perspective of defining a dynamic diagnostic formulation, such empty areas take on a positive value, as indicators of the type of clinical information we still need to continue our clinical exploration, and we will also learn from who and how we can get more information: Whether from the child through play observation or interviews, whether from one parent or the other, or even from teachers if they are the source to be interviewed.
The profile is a schema that sums up the developmental approach to child psychology and psychopathology. Such an approach can be useful also with adults. Such an attempt plainly implies that psychopathology is in direct continuity with normal psychic functioning: As A. Freud(42) says, the developmental perspective brings us “to consider abnormal outcomes as more or less significant deviations from this channel”. When discussing psychopathological patterns regarding adults, the idea is basically to associate their symptoms (or the framework of the case, in general) with the developmental phase in which the behaviors or expressions, which today are considered anomalies with symptom value, were instead suitable and appropriate for that phase. Thus implicitly this approach sees present symptoms as an expression of massive regression in the psychiatric patient. The developmental approach offers a case framework that enhances the comprehension of regressive manifestations within normal developmental patterns. Anna Freud, together with others, presented a “metapsychological assessment of adult personality”. This presentation holds some suggestions for collecting and evaluating case material, but I will refer here only to the notion of developmental patterns(43) and, in general, to psychoanalytic developmental psychology. A discussion about a 20-year-old patient who had been in treatment in a psychiatric unit for some time because of delirious and hallucinatory manifestations and severe behavioral alterations such as aggressiveness and self-infliction of pain was conducted in such a way. The conclusive evaluation we came to pointed out that the level to which the patient had regressed was mainly that of the separation-individuation phase(44). In reference to this hypothesis-which gave meaning to many of the symptoms and behaviors of the patient presented-the treatment program was also reassessed.

5. Risks related to partial use of the profile in everyday practice

The use of the metapsychological profile in everyday clinical work involves more risk of distortion than might happen when one considers all the necessary material-the time and the opportunity to collect it. Hence, we take into consideration a few precautions which one should adopt in order to avoid or limit such risks. First of all, one must maintain a global and conflictive outlook on each case. This pertains not only to the children but also to their milieu. To this end, it is necessary to organize a framework in which the

elements pertaining to the large areas in which data are put together are purposely and provocatively kept in conflict with each other. Therefore, we must-in coming to the conclusion of our diagnostic work-highlight and confront (for example as regards the reason for the consultation) the manifest part, that the parents or the child have propounded, with what has been unconsciously repressed; afterwards, as regards the child's development, we should put into contradiction the modes of relation of libidinal and aggressive investment with the Ego functions and also with the evaluation of some general characteristics, such as attitude toward anxiety or frustration tolerance; ultimately, we put forward all the elements we have regarding the family context, and school and social context. Thus we will obtain complexities (and complications) that are certainly close to real, though with the risk, of making our diagnosis truly quite limited in its simplicity. This is a paradox, but it is one of the conditions that may help us to avoid distortions in using diagnostic tools. Indeed, through diagnostic procedures, we wish to reach a precise and solidly grounded clinical assessment; that is why we try to have the greatest number of elements come together in an orderly way within the patterns defined by the syndromes (for instance, in one of the categorizations listed for the item profile "Diagnosis"). Yet, at the same time, we are suspicious of this order among elements which is too harmonic, well knowing that the outcome is a forced harmonic construction of reality, produced by our diagnostic tool. The precaution against the risk of distortion thus come from putting the diagnosis in a frame of great complexity: this forces us to remain aware of the fact that a diagnosis does not thoroughly describe the reality of the people in front of us, sometimes not even their clinical reality.

Even though everyone agrees on the complexity of the reality in which we work, a widespread sacral notion of psychoanalysis endures along with a priestly vision of those administer it. On the contrary, our work is a *function*, rather than a *mission*. The notion of analysts at work(45)-distinguishing the analyst as a person and the task he carries out-allows us to consider the various aspects of the analytical process, such as the analyst's involvement with the patient, with greater precision. What can be maintained as to the therapeutic process is true also regarding the diagnostic phase, at least when one sees it as a process, as it has been presented here.

Pointing out other paradoxes of our clinical work can be used as a further precaution in our diagnostic procedures. In our relationship with patients we find ourselves continuously oscillating between intense emotional and rational participation in what they tell us and equally strong contextual detachment from the same. This movement accompanies another oscillation of ours: from a peak of maximum credibility attributed to what we hear to the opposite, extreme mistrust. Such paradoxical oscillation does not, however, concern our global persona, but only our function as analysts, and it is one of the guarantees for our neutrality. Regarding the credibility of the elements we gather for diagnosis, the important thing is not so much to establish whether the information given to us is true or false, but to *organize the diagnostic phase as a dynamic process* in which certain patients can be actively involved and at the end of which they will find they can evaluate together with us the meaning and the possible implications of our diagnostic hypotheses. This is the exact opposite of the medical procedure which consolidates roles, knowledge and competencies and thus also consolidates patients in a passive position in which they can only accept or refuse our point of view; certainly not converse with us.

Finally, reconsidering the complex and contradictory frame we work in, one knows how crucial it is in constructing diagnostic assessments, to repeatedly try considering various developmental patterns, among the various critical developmental points and among the character aspects that are in the process of definition in children (or are typical of adults) and their correspondence or compatibility with the hypotheses of development and psychic functioning we are developing.

The metapsychological profile is an instrument that is not only technically reliable, but also respects of the equal and dynamic relationship between the client and the diagnostician in all its complexity; it fits the needs that arise when one considers diagnosis as a process.

Notes:

1 Anna Freud, Normality and Pathology in Childhood (New York: International Universities Press, 1965),

2 Anna Freud, Normality and Pathology in Childhood, cit., p. 141.

3 R.R. Greenson (1967), Tecnica e pratica psicoanalitica, Vol. I (Milan: Feltrinelli, 1974).

4 E.R. Zetzel, “Current concepts of transference”, Int. J. Psychoanal., 1956, 36, pp. 369-376.

5 E. Codignola, Il vero e il falso. Saggio sulla struttura logica della interpretazione psicoanalitica (Turin: Boringhieri, 1977).

6 Cf. R. Sterba, “The Fate of the Ego in Analytic Therapy”, in Int. J. Psychoanal., 1934, 15, pp. 117-126. Otto Fenichel, Problems of Psychoanalytic Technique, (New York: Psychoanalytic Quarterly Inc., 1941).

7 K.R. Eissler (1985), “Un addio a “L’interpretazione dei sogni” di Freud”, Psicoterapia e Scienze Umane, 1, 1991.

8 On the subject Eissler wrote: “On July 24, 1895, when Freud got the idea got the idea of breaking his dream up into various elements and collecting the associations that came to mind with respect to each of them, he gave life to a new technique for psychological investigations. In the nine pages of The method of dream interpretation (which is precisely the title of chapter 2) preceding the analysis of a sampled dream, Freud spoke of the history of his interest in dreams and told how he came about this specific technique. Therefore it did not take but a step-he writes-to treat dreams themselves as symptoms and apply the interpretation method already developed for symptoms to dreams (1900). This step-which Freud, in great modesty, seems to have considered a small one-actually was a purely creative act, foreboding much larger consequences than those originally anticipated. By that step, Freud created a bridge between psychopathology and psychology. What proved to be useful as a key of interpretation and comprehension of the pathological, with equal validity and practicality could also be applied to the functioning of the normal mind. The wall between the field of scientific investigation of man and that of humanistic investigation had been knocked down. Thus the groundwork (/) for an operation (/) that would prove to be highly productive was done, and this was possible because we had been able to put an end to the tendency, in studying the human being, to keep separate explanation and comprehension, the fields of scientific discipline and humanistic discipline”.

9 Pier Francesco Galli,” Psicoterapia e scienza” in Psicoterapia e Scienze Umane, n. 2, 1967.

10 Donald P. Spence, Narrative Truth and Historical Truth (New York: W.W.Norton, 1982).

11 Sergio Moravia, “Homo persona: dalla scienza della mente all’ermeneutica dell’esistenza” in Psicoterapia e Scienze Umane, n. 4, 1990.

12 Sigmund Freud (1922), The Ego and the Id, SE, XIX, pp. 12-60.

13 Sigmund Freud (1926), Inhibitions, Symptoms and Anxiety, SE, XX, pp. 84-172.

14 Heinz Hartmann (1939), Ego Psychology and the Problems of Adaptation (London: Imago, 1958). This paper came out in German in the Internationale Zeitschrift für Psychoanlyse in 1939 as an expanded form of some lectures held in 1937 at the Vienna Psychoanalytic Society; the English edition came out only in 1958.

15 Heinz Hartmann (1950), “Considerations on the psychoanalytic theory of the Ego”, Essays on Ego Psychology (London: Hogarth Press, 1964).

16 In the 1930s Jacobson, Annie Reich, Wilhelm Reich, Melanie Klein, Otto Fenichel, and Karen Horney worked in the Berlin institute.

17 Russell Jacoby, Il disagio della psicoanalisi (Rome: Astrolabio, 1987).

18 Sidney Hook, ed., Psychoanalysis, Scientific Method and Philosophy. A Symposium (New York: New York University, 1959).

19 David Rapaport (1960), Struttura della teoria psicoanalitica (Turin: Boringhieri, 1969).

20 J Sandler, ed., (1980), La ricerca in psicoanalisi. 1: Il Super-io, l'ideale dell'Io e altri scritti (Torino: Boringhieri. ***
J Sandler, ed., (1980), La ricerca in psicoanalisi. 2: Verso un nuovo modello concettuale. Torino: Boringhieri. ***

21 David Stern, The Interpersonal World of the Infant (New York: Basic Books, 1985).

22 P. Cushman, "Ideology obscured. Political uses of the Self in Daniel Stern's infant", in American Psychologist, 1991, 46, 3, pp. 206-219. ***

23 Anna Freud (1936), The Ego and the Mechanisms of Defense (London: Hogarth Press, 1937).

24 Normality and Pathology in Childhood, cit.

25Cf. M. Eagle, Recent Developments in Psychoanalysis (Cambridge; London: Harvard University Press, 1984).

26 Anna Freud & Dorothy Burlingham, (1943), Infants Without Families: The case for and against residential nurseries (New York: International Universities Press, 1962).

27 For more extensive historical information on the dawn and development of what is called psychoanalytically informed direct observation, refer to two Italian publications. V. Bonamino, A. Di Renzo, "Osservazione diretta del bambino e psicologia psicoanalitica infantile", in Neuropsichiatria Infantile, 1977, pp. 192-3.

28 Ernest Kris (1975), Gli scritti della psicoanalisi (Turin: Boringhieri:1977).

29 Stern, The Interpersonal World of the Infant, cit.

30 See Pier Francesco Galli, "Le ragioni della clinica" in Psicoterapia e Scienze Umane,n. 3, 1988.

31 Richard J. Trudeau, The non-Euclidean revolution (Boston : Birkhäuser, 1987).

32 Rapaport (1960), cit.

33 Sigmund Freud, (1915), "The Unconscious", SE, XIV, pp. 164-202.

34 This stance was the same as his mentor's, the physiologist Ernst Brüke-one of the founders, along with Hermann von Helmholtz, of the German Physics Society. In opening a conference that took place in 1870, Helmholtz himself thus expressed his opinion: "The fact that a science might exist and be developed as has happened in the case of Euclidean geometry has forever aroused the liveliest interest in those who investigate questions regarding the bases of knowledge theory. Among all the branches of knowledge, there is not one that, like this one, is born of Minerva, fully armed, from Jupiter's head; not one in front of whose mortal aegis, doubt and incoherence have dared to look up so little. It escapes the boring and complicated task of collecting experimental facts -domain of natural sciences, in its literal sense; deduction is its only scientific method. Conclusions are drawn from other conclusions, and yet no one endowed with common sense doubts that these geometric principles must find a practical application in the true world surrounding us. Topology such as architecture, mechanical technology, no less than mathematical physics, continuously

calculate a variety of spatial relations based on geometric principles; one expects that the results of their constructions and experiments will concur with the calculations; and in no case we are aware of has this expectation not been satisfied, as long as calculations were carried out correctly and based on sufficient data" [H. von Helmholtz, (1962), Popular Scientific Lectures, quoted in R. Trudeau, cit..

35 Four mathematicians came to the discovery of non-Euclidean geometry independently between 1813 and 1830: the German Gauss (who coined the term "non-Euclidean"), the Swiss Schweikart, the Hungarian Bolyai (who published the first treatise on non-Euclidean geometry), and the Russian Lobacevskij. The posit of this geometry is the negation of Euclid's fifth postulate, the one pertaining to the definition of parallel lines.

36 Richard J. Trudeau, The non-Euclidean revolution, cit.

37 Humberto Nagera, The developmental approach to childhood psychopathology (Northvale: J. Aronson, 1981).

38 J. Bolland & Sandler, The Hampstead Psychoanalytic Index (New York: International Universities Press, 1966).

39 Arthur -that's the name of the child-had been referred, in 1954, to the Hampstead Clinic because he kept sucking his thumb, something he didn't however do in school, where on the other hand he had difficulty in learning and socializing; also, he often had a fevers and stomach pains, with no definite organic basis, which kept him home from school. Cf. Nagera, The developmental approach to childhood psychopathology, cit.

40Andy "had been referred to Hampstead Child Therapy Clinic because he presented some symptoms that made his mother very anxious: at night he didn't want to go to bed until very late, and every night he would wake up and get into his parents bed, which was in the same room. In the presence of other children he was greatly excited, and became hyperactive; the mother was afraid he would have a breakdown. She said she had been anxious about her son in the past, especially when he had been sick. Recently she had noticed she felt a certain ambivalence toward him that she experienced with deep guilt feelings: often she would be so irritated she wanted to hit him but, immediately afterwards she felt great remorse and remembered how the child had had a "bad start" in life". Cf. Bolland and Sandler, The Hampstead Psychoanalytic Index, cit.

41?There is a permanent libidinal regression to previously established fixation points, accompanied by simultaneous Ego and super-ego regression, that carry to infantilism, border-line disorders, delinquency or psychotic disorders". Cf. Anna Freud, cit., 1965.

42 Anna Freud, "Psychopathology Seen Against the Background of Normal Development" in Brit. J. Psychiat., vol. 129, 1975.

43 Cf. Anna Freud, H. Nagera, W.E. Freud, "Metapsychological assessment of the adult personality: The adult Profile", Psa Study Child, 1965, 20, pp. 9-41. W.E. Freud, "Assessment of early infancy: Problems and considerations" in Psachoanalytic Study of the Child, 1967, 22, pp. 216-238. And also Peter Fonagy., G.S. Moran, "Understanding psychic change in child psychoanalysis", Int. J. Psychoanal., 72, 1991, pp. 15-22.

44 Cf. Margareth S. Mahler, F. Pine, A. Bergman, The Psychological Birth of the Human Infant (New York: Basic Books, 1975).

45 Cf. Hans Loewald, "On the therapeutic action of psychoanalysis", in Int. J. Psychoanal., 1960, 41, pp. 16-33.