

**Diagnostic Practice in Psychodynamic Therapy with Children and Adolescents:  
A scoping review**

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## Abstract

Within the field of mental health and psychological treatment, diagnostic practice is largely biomedical. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the predominant diagnostic system used in Aotearoa New Zealand. Non-medical practitioners working within government or medically oriented organisations are required to follow DSM-5 terminology and categories to maintain inter-clinician communication and inter-profession consistency. However, this may represent a philosophical conflict for practitioners offering non-medical treatments in mental health, such as psychodynamic therapy. This conflict may be exacerbated by the absence of a ubiquitous approach to diagnosis within the field of psychodynamic therapy.

This dissertation aims to present an overview of diagnostic practice within psychodynamic therapy with children and adolescents, and how this has been influenced by the philosophy and practice of psychiatric diagnosis. A preliminary literature review critiques the conceptual and clinical antecedents to the contemporary practice of both psychiatric and psychodynamic diagnosis. A scoping review of published psychodynamic case studies with children and adolescents then addresses the research question: what diagnostic frameworks are used within psychodynamic therapy with children and adolescents? The scoping review found a mix of diagnostic frameworks were used within the psychodynamic case studies reviewed. These ranged from referencing diagnoses from the DSM, the Psychodynamic Diagnostic Manual (PDM), through to structured formulation tools, and unstructured approaches to formulation. The discussion then pulls together learnings from the past and the results of the scoping review to describe principles of ethical and effective diagnostic practice, for both psychodynamic therapy and mental health diagnosis overall. Independent of diagnostic framework, a distinction is made between diagnostic label and diagnostic process and ultimately the need for a renewed balance between the two is called for.

### Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in acknowledgements), nor materials which, to a substantial extent, have been submitted for the award of any other degree or diploma or a university or other institution of higher learning.

*Jasmine Sawyers-Mullen*

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## Introduction

As a training child and adolescent psychotherapist, I learnt that we do not diagnose. This statement and all that it represents conceptually and clinically has had a significant influence on me throughout my training and as an emerging practitioner of psychodynamic therapy. This dissertation aims to unpack the nuance of this sentiment. A preliminary literature review critiques the conceptual and clinical antecedents to the contemporary practice of both psychiatric diagnosis and psychodynamic formulation. A scoping review of published psychodynamic case studies with children and adolescents then addresses the research question: what diagnostic frameworks are used within psychodynamic therapy with children and adolescents? The critique of the history of mental health diagnosis provides context around how contemporary diagnostic practice came to be. The scoping review then provides an overview of contemporary diagnostic practice within the field of psychodynamic theory with children and adolescents. The discussion then pulls together learnings from the past and the results of the scoping review to describe principles of ethical and effective diagnostic practice, for both psychodynamic therapy and mental health diagnosis overall. In simpler terms, these three sections can be equated too: how did we arrive here; where is exactly is 'here' for psychodynamic therapy; and what does this mean for diagnostic best practice. This dissertation holds considerable relevance to me as an emerging child and adolescent psychotherapist and I hope it will represent a valuable contribution to our understanding of diagnostic practice, specifically to the field of psychodynamic therapy and more broadly to mental health professionals overall.

### Rationale & Aim

In training as a child and adolescent psychotherapist, there was no standardised approach to diagnosis I was trained to use. I was versed in the diagnostic system of the DSM, and encouraged to use a formulation-based approach and a range of models to assess and conceptualise my client's presentations. My understanding of diagnostic practice did not deepen beyond the biomedical and I relegated all things diagnosis to the realm of psychiatry<sup>1</sup>.

In my clinical work as an emerging practitioner, I subsequently found myself lacking some guiding structure that helped me tolerate the anxieties I was being asked to hold. From the outside it appeared that psychiatric diagnosis offered a more prescribed path through supporting young people and whānau (family) with their difficulties, a path that would tell me what to do in times of uncertainty.

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<sup>1</sup> This was however my personal experience and may differ for other cohorts or training programmes.

In later exploring the literature, I was surprised to find that there was in fact a whole world of diagnosis beyond the DSM and a biomedical approach. These included a range of approaches within psychodynamic therapy: contemporary nomothetic approaches such as the Psychodynamic Diagnostic Manual (Lingiardi & McWilliams, 2017) and more idiographic approaches such as the Provisional Diagnostic Profile (Davids et al., 2017). Initial searches returned some contemporary literature comparing differing diagnostic systems (Phillips & Raskin, 2021). However, no such review had been conducted within the more specific context of psychodynamic psychotherapy with young people. There was also limited consideration of diagnostic best practice with people from different ethnicities, cultures, or worldviews. Over the last decade there has also been an emergence of diagnostic systems, alternative to the categorical and descriptive approach set out in the DSM. Due to the multitude of perspectives available and without a clear understanding of diagnostic practice within my own clinical work, I felt the absence of a resource that gave me an overview of diagnostic best practice. This dissertation aims to provide an overview of principles for diagnostic best practice for psychodynamic therapy with children and adolescents, and more broadly for mental health professions overall. This is done through critiquing the historical development of psychiatric diagnosis and psychodynamic formulation and reviewing contemporary approaches to diagnosis within psychodynamic therapy with children and adolescents.

### **Context**

My arrival at this piece of work has been informed by a range of contextual factors which I will describe here. I have a personal history through which I have come to align with holistic approaches to healing, in contrast to a biomedical model which I believe is only one piece of a very complex puzzle and is generally over-utilised in contemporary mental healthcare.

As a training psychodynamic therapist I have integrated the concept of defence against pain as primary. I have also been trained to attune to the subjective experience of the client over any objective measure, to prioritise health and wellbeing over the reduction of symptoms, and to understand symptoms functionally<sup>2</sup>. As a consequence, throughout this process I have continually been confronted with a critical part of myself which has been directed towards the biomedical model and biological psychiatry. This was important to acknowledge as I intended to enter into an open minded review of the literature.

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<sup>2</sup> This refers to the concept of functionalism which, in the field of mental health supposes that all symptoms serve a purpose or are an active adaption to the individuals current circumstances (American Psychological Association, 2023). Rather than the minimisation of symptoms, the therapeutic process focuses on understanding and addressing the cause underlying the manifest symptom (McWilliams, 2021).

I believe any given situation is multi-faceted and any perceived 'truths' are at some level subjective. I have a fundamental appreciation of the many perspectives and contextual factors that may exist simultaneously, even in the face of apparent contradiction. I feel that this has motivated my arrival and engagement with this piece of research. What is true about my criticism of biomedical diagnosis, what is true about the value of biomedical diagnosis which has resulted in its widespread use, and how can these exist simultaneously to inform best practice.

This dissertation has also been motivated by the current milieu of mental health. In Aotearoa (Wilson & Nicolson, 2020) and globally (WHO, 2022) we are facing a current and growing mental health crisis due to a range of historical (Paterson et al., 2018; Wirihana & Smith, 2014) and novel (Charlson et al., 2021; Gasteiger et al., 2021; Tan et al., 2019) challenges. In Aotearoa New Zealand many are unable to access support or face significant wait times due to under-resourced healthcare systems, are unwilling to seek support from mainstream healthcare providers, or find the support offered at best ineffective or at worst contributing to further dysfunction (Paterson et al., 2018). While I was on clinical placement at a government child and adolescent mental health service (CAMHS) in Aotearoa New Zealand my experience left me feeling, in many ways, disheartened and frustrated. My experience was impacted by many factors, however particularly poignant to me was the hegemony of a biomedical approach, the phenomenon of diagnosis (more specifically biomedical psychiatric diagnosis), and its apparent primacy as a treatment intervention.

Psychiatry's predominantly biomedical approach, diagnostic system, and an overemphasis on pharmaceutical treatments have been criticised (Allsopp et al., 2019 Frances, 2014; Suris et al., 2016). To use the natural environment as an analogy, monocultures do not result in healthy individuals or collectives. In contrast, an indicator of a healthy eco-system includes the complex interaction of a countless number of species who complement and compensate for each other's strengths and weaknesses, combining to form a productive and delicately balanced whole. In contrast, the mental healthcare landscape is currently dominated by a biomedical monoculture. Perhaps the celebration and discerning offering of a range of different modalities, a mental health polyculture so to speak, would contribute to a healthy and effective mental healthcare ecosystem. A system which is then capable of meeting the range of differing needs of individual patients and whānau.

There is a significant need for effective and collaborative practice in mental health and a hope for this dissertation is to support the effectiveness of diagnostic practice for both psychodynamic therapy with children and adolescents and mental health diagnosis more generally. This dissertation is in many ways, an ode to the middle way, a search for integrated balance between objectivity and subjectivity in clinical practice.

## Key Terms

*Client or patient* – Both are used interchangeably throughout (Fader, 2015).

*Psychiatric and Biomedical* – Are used interchangeably, both referring to the current system of psychiatric diagnosis which is biomedical. However, this does not intend to foreclose the possibility of contemporary psychiatry integrating perspectives beyond the biomedical into their diagnostic systems.

*Psychoanalysis and Psychodynamic Psychotherapy* – Psychodynamic therapy (PDT) is used throughout. Malberg & Mayes (2013) discuss the lack of a clear distinction between the two modalities. Both are guided by the same or similar theoretical principles, yet there are differences in frequency, technique, and treatment goals between the two modalities.

*Efficacy vs Effectiveness* – As standard within scientific research, efficacy is used in reference to clinical studies with controlled environments, whereas effectiveness is used in reference to real life contexts (Gartlehner et al., 2006).

*Categorical vs Dimensional* – Categorical diagnosis involves organising thoughts, feelings, and behaviours or more generally the subjective experience of mental illness and health into categories of disorder. The presence or absence of specific symptoms at certain thresholds are then used to qualify whether an individual meets the requirements of a category, and consequently a diagnosis for a specific disorder.

In contrast, a dimensional approach sees the expression of thoughts, feelings, and behaviours on a spectrum from normality to pathology. Rather than categorisation, diagnosis and the description of ‘symptoms’ is based on quantity or severity and the degree to which the individual is impaired by their presence.

*Child & Adolescent or Young Person/People* – These terms are used interchangeably throughout the dissertation. In the literature reviewed, child refers to a person aged 12 and under and adolescent to a person aged between 13 and 18. I personally find the transition from adolescent to adult at the age of 19 peremptory and prefer that the term young person/people indicates a person younger than age 24.

## Literature Review

As I begin to consider the research question, what diagnostic frameworks are used within psychodynamic therapy with children and adolescents and their families, elementary questions also arise. What is diagnosis, how is a diagnosis arrived at, what is the current climate of diagnosis within mental health, and what historical frameworks have informed the current phenomenon of diagnostic practice within psychodynamic therapy. The following reviews the literature in an attempt to answer some of these questions and to provide contextual understanding for the scoping review.

### Diagnosis Generally

From the Greek -gnosis to know, and -dia apart from another, diagnosis is defined as, “*the identification of the nature of an illness or other problem by examination of the symptoms*” (Oxford Languages, 2022). Diagnosis is a universal phenomenon and arguably a very natural human response when dysfunction or distress is experienced; helping the individual orient to their experience and provide a roadmap in the face of disorder. In example, anyone or anything may be diagnosed, a mechanical problem with one’s car or a soil imbalance preventing crop growth. However, for the purpose of this dissertation, diagnosis is considered within the context of mental health diagnosis and the human experience.

Diagnosis is both a label and a process (Blaxter, 1978; Jutel, 2009). The diagnostic label, the -gnosis or knowing, is given when an individual’s experience meets (or does not meet) those of a pre-determined set of characteristics and is placed within a diagnostic grouping, dimension, or category with an associated label. The diagnostic process, -dia to set apart from another, is based on similarity or dissimilarity to these pre-determined characteristics. The latter being termed differential diagnosis, diagnosis based on the absence of specific factors rather than the presence of specific factors. This is the process of classification that is required to arrive at the diagnostic label. In this way, diagnoses signify both, “*the identification of one disease or illness from another and the execution of a process by which to make this determination*” (Huprich, 2018, p686).

Jutel (2009, 2011) focuses on sociological factors and describes diagnosis as a socially agreed upon set of understandings that explain illness (either by aetiology or experience), identify treatments, and predict outcomes. All of which contribute to the experience of order in the face of discomfort, pain, and uncertainty. McWilliams (1994) discusses how with nuanced application diagnosis offers utility for treatment planning and prognosis, empathy and understanding, and can both support client commitment to treatment and offer protection to those within the mental health system.

Diagnosis is a significant tool used within medical practice (Blaxter, 1978). Psychiatry is the branch of medicine which focuses on the diagnosis, treatment, and prevention of mental, emotional, and behavioural disorders (American Psychiatric Association, 2022a). While the focus here is not on psychiatry specifically, it is on diagnosis, on which psychiatry has had a formative influence in Western culture, those it has colonised, and parallel fields of thought in mental health such as social work, psychology, and psychotherapy. Non-medical practitioners working within government or medically oriented organisations have inherited their diagnostic systems from biological psychiatry. Psychiatric diagnosis, its history, the impacts on current diagnostic practices, and alternatives systems are therefore considered throughout.

Historically and within contemporary mental health, diagnosis has several important functions. Arguably, the most salient of which would be to identify the nature of an individual's experience in the service of offering treatment (Rose, 2013). However, diagnosis has come to influence and be influenced by several systems, within which there may be opposing aims or ideal outcomes. These interconnected systems can be seen in the following list of ten functions of contemporary diagnosis, based in the United Kingdom (Rose, 2013):

*(1) A diagnosis is a condition of eligibility of an individual for treatment – if you have no diagnosis of pathology, there is no case for treating you. (2) In insurance based regimes, it is a condition of financial coverage of the cost of treatment. (3) For those who are employed, it is a condition of legitimate absence from work. (4) For those who are unemployed, it may be a condition for access to welfare payments. (5) For hospitals and medical establishments it is a central feature of patients records, and these records often shape the allocation of funding from those who commission services for different conditions. (6) For lawyers, it can be a condition for involuntary detention and treatment. (7) In the school system, a diagnosis may be the basis of allocation to special educational provision. (8) For epidemiologists, diagnostic categories are the very basis of their calculations, and of the estimates and predictions that are based on assessments of incidence and prevalence. (9) For planners of services, those estimates and predictions are the essential raw materials for their work. (10) For funders of research, especially charities focused on a particular disorder, it may delineate a problem that is really worthy of investigation (p1).*

This list illustrates how an individual diagnosis may be a result of a number of intersecting systems with priorities far beyond the treatment needs of an individual. Healthcare providers and systems, social support and social norms, government policy and duty, the political climate, private insurance and pharmaceutical companies, education, research and innovation, legal systems and criminal justice, all of which may influence the diagnostic framework and how diagnosis is experienced in clinical practice.

### **Predominant Diagnostic Systems**

The predominant system of diagnosis used in contemporary mental health is categorical, classifying illness into discrete categories with subsequent diagnostic labels. These diagnoses are also descriptive, meaning that the diagnosis is based on the description of symptoms which are either present or in the case of differential diagnosis, absent. The two predominant systems are the International Classification of Diseases and Related Problems, the most current eleventh edition published in 2019 (ICD-11) and the Diagnostic and Statistical Manual of Mental Disorders, the fifth and most current edition published in 2013 (DSM-5). A brief discussion of both systems is offered below.

The ICD-11 is freely available and is used internationally as a medical classificatory and categorical diagnostic system. The ICD is sponsored by the World Health Organisation and classifies all medical illnesses for “health data, clinical documentation, and statistical aggregation”, including mental health (World Health Organisation, 2022, p1). This contrasts with the DSM which is focused only upon mental disorder. One of the main functions of the ICD is the standardised and comparable collection and distribution of morbidity and mortality statistics internationally. The most recent edition, the ICD-11, was published in 2019 and came into effect 2022 (World Health Organisation, 2022). While there are some differences, diagnostic categories between the DSM-5 and ICD-11 are largely congruent (Cooper, 2014; Hayes & Hofmann, 2020). However, a significant change in the ICD-11 is a shift from discrete categories to a single dimension of personality disorder, categorised based on level of severity (Bach et al., 2022). This development reflects calls for a dimensional diagnostic system (Krueger et al., 2005).

Despite both being categorical systems, the ICD has been subject to less criticism than the DSM in the field of mental health. The ICD is published by a global health agency with international and multidisciplinary participation; whereas the DSM is produced by a single national association, the American Psychiatric Association and largely by psychiatrists (American Psychological Association, 2009). Another consideration may be the ICD’s focus on statistics and downstream functions such as,

“payment systems, service planning, administration of quality and safety and health services research” (Harrison et al., 2021, p1). In contrast, the DSM straddles both research and industry needs while also directly influencing clinical diagnosis and treatment. Due to its more limited application within mental health and Aotearoa New Zealand the ICD is not discussed further in this dissertation.

The DSM is the predominant diagnostic system used in the United States and, to a degree, the rest of the world (Cooper, 2014). The most current edition, the DSM-5, is the predominant system used by psychiatrists and psychologists to diagnose mental disorders in Aotearoa New Zealand (Mellsop et al., 2007; NZPsS, 2013). Consequently, other mental health professions such as psychotherapy and counselling, are required to follow DSM-5 terminology and categories to maintain inter-clinician communication and inter-profession consistency (Mellsop et al., 2007). Diagnostic labels provide convenient summary statements, albeit with a tautological tendency (Carey & Pilgrim, 2010). With an increasingly Americanised global culture, the DSM represents a significant degree of influence not only in psychiatry, but on the culture around mental health and wellbeing. This includes how mental health and mental illness are conceptualised and assessed, the language that is used, and in treatment planning and provision.

### **The Shift from Dynamic to Biological Psychiatry**

In the mid 20<sup>th</sup> century, psychiatry and psychiatric practice was largely psychoanalytic (Kendler et al., 2010). However, with the medical model’s increasing focus on empiricism and biological determinism, psychoanalysis became increasingly marginalised with its inability to produce empirical proof of its theories (Suris et al., 2016). In biological psychiatry, a parallel movement was occurring to categorise the various forms of mental illness. The intention being to estimate the prevalence of mental illness more accurately and to produce more consistent diagnosis among practitioners (Suris et al., 2016). With the methods available at the time, psychoanalysis was unable to be empirically validated, while also having an epistemological difficulty with categorical diagnosis. The decision to depart from dynamic psychiatry in favour of the biological was also likely influenced by the anti-establishment and anti-psychiatry movements from the 1960’s onwards, which criticised oppressive authority and conformity to traditional sexual and social traditions (Horwitz, 2020). This is evident in the highly visible controversy over the conceptualisation of homosexuality (Drescher, 2008). The APA warning its members that, “*our profession has been brought to the edge of extinction*” (Horwitz, 2020, p169). While oppressive sentiments were found in both dynamic and biological psychiatry, the increasing emphasis on empiricism likely provided hope of respite from the social, economic, governmental, and

political over-culture. The shift from dynamic to biological psychiatry is summarised by Horwitz (2000):

*During the 1960s, many issues converged to place the dynamic paradigm in jeopardy. Some of these factors stemmed from professional pressures: psychiatry's marginal status within the medical profession, the growing influence of biologically oriented psychiatrists, the need of clinicians to obtain reimbursement from the increasingly doubtful private and public funders of therapy, and growing threats from nonphysicians such as clinical psychologists, counsellors, and social workers. Others involved broader changes in the social environment: the anti-psychiatric attacks that discredited psychiatry in the general culture, the emergence of a youth counterculture that identified the profession with the social control of deviant behavior, the need of drug companies to target their products as treatments for specific disorders, and the problematic politics that surrounded the embattled NIMH [National Institute of Mental Health, US] (p184).*

These factors contributed to the intentional decision of various psychiatric and academic groups to move away from the theoretical explanations of psychoanalysis and to align with biological psychiatry. This was “*part of a larger movement...to re-medicalise psychiatry, grounding the field in empirical research*” (Suris et al., 2016, p5). The result being “*a paradigm shift that has had profound effects on the course of American and, ultimately, world psychiatry*” (Kendler et al., 2010, p140).

The atheoretical approach of biomedical psychiatric diagnosis is a divergence from the wider biomedical diagnosis of physical conditions. The latter are aetiological and where possible, group illnesses based on the underlying cause of the dysfunction. This is more like dynamic psychiatry than contemporary biomedical psychiatry. McWilliams further adds, “*because psychiatry is a young science, and there are few mental health problems for which experts agree about causes, the American Psychiatric Association has classified them by their manifest symptoms,*” (McWilliams, 2021, p566). This discord between medical and psychological diagnosis is amplified most significantly in psychiatry where biological mechanisms of illness are unclear, no biological diagnostic tests exist (Syme & Hagen, 2019), clear prognosis or adequate treatment is sporadic, and the experience of illness and health (and therefore the rationale for treatment) is largely informed by social norms (Bentall, 2014; Syme & Hagen, 2019) and relational experiences (Read et al., 2009). The latter of which are too often nil considered by biological psychiatry.

Neurology and neurological disease are the main area of intersection between medicine and mental health, with psychiatry straddling both (Carey & Pilgrim, 2010). Bohmer (2011) describes how while one impacts the other, the brain is not to be conflated with the mind, *“Life events, cultural processes and other factors influence and modify gene expression, brain anatomy and functioning”* and *“pharmacotherapy and psychotherapy may both lead to changes in the brain”* (p273). This attempt to straddle both neurology and psychology may represent an ideological conflict and a factor contributing to the inadequacies with the current symptom based categorical system (Huda, 2019; Sedler, 2016; SMCNZ, 2013; Vanheule, 2012).

### **DSM-3 to 5**

Where the early editions of the DSM were largely psychoanalytic (Horwitz, 2020), the current categorical systems became manifest with the publication of the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-3) published by the American Psychiatric Association in 1980. The published changes represented a paradigm shift in both the predominance of biology-based and empirical psychiatry and the systematic classification of mental illness in the form of categorical diagnosis. Both of which remain strong components in psychiatric practice and mental health assessment and treatment today. In contrast to previous editions, the DSM-3 replaced psychoanalytic formulations and terminology that were concerned with theory and causation, to the description of specific symptoms organised into categories of illness and diagnosis based upon thresholds of severity. In the words of Mayes & Horwitz (2005):

*...psychiatry reorganized itself from a discipline where diagnosis played a marginal role to one where it became the basis of the specialty. The DSM-III emphasized categories of illness rather than blurry boundaries between normal and abnormal behaviour, dichotomies rather than dimensions, and overt symptoms rather than underlying etiological mechanisms* (p250).

One of the original intentions for DSM-3 categories was valid and reliable diagnosis needed for empirical research, whereas clinical application and utility were retrospectively considered in later editions (Cooper, 2014; Suris et al., 2016). This continues to be a source of criticism and clinical failure, where systematic DSM categories provide ample benefit for research, insurance and pharmaceutical companies, and government social services; the benefit to clinical practitioners and to the individual's experiencing the illness remains more contested (Stein et al., 2013). The diagnostic validity and reliability which characterised the DSM-3 has also been questioned in later editions with

diagnostic inflation and over-medicalisation (Stein et al., 2013; Suris et al., 2016). Additional criticisms of the DSM system include:

- increasing financial ties between developers and the pharmaceutical industry, from 57% to 72% between the fourth and fifth editions (Suris et al., 2016)
- criteria do not sufficiently differentiate disorders leading to high rates of diagnostic comorbidity (Newson et al., 2021)
- genetics fail to distinguish psychiatric disorders, and no biological marker has shown to be diagnostically useful for making a DSM diagnosis (Hyman, 2002; Syme & Hagen, 2019)

DSM based diagnosis has been criticised for contributing to a reductionist and oversimplified quantification of an individual's lived experience; psychological and emotional distance between practitioner and client; pathologizing behaviour; medicalisation; high heterogeneity within disorders; and the fortification of social, cultural, racial, or economic stereotypes (Jutel, 2011; Newson et al., 2021). Rather than increased understanding or relief, diagnosis may result in stigma, prejudice, or a sense of invalidation (Carey & Pilgrim, 2010). The breadth and depth of criticism and clinical failure of categorical diagnosis and an over emphasis on empiricism have led to both calls for a shift in how we conceptualise mental illness and mental health (Capsi & Moffitt, 2018; Mayes & Horwitz, 2005) and resulted in the development of alternative diagnostic systems. While not a complete list, emerging alternative diagnostic systems include the Hierarchical Taxonomy of Pathology (HiTOP)(Hengartner & Lehmann, 2017); the Power Threat Meaning Framework (PTMF)(Johnstone & Boyle, 2018); the Psychodynamic Diagnostic Manual (PDM)(Lingiardi & McWilliams, 2017); Operationalised Psychodynamic Diagnosis for adults (OPD) and children and adolescents (OPD-CA)(Cierpka, et al., 2007; Kotan, 2018); the DC: 0-5 - the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Zero to Three, 2023); and process of change based diagnostic frameworks (Hayes & Hofmann, 2020).

Despite controversy and ongoing criticism, the DSM, and categorical diagnosis more generally, do offer benefit to psychological professions. This includes: the use of consistent terminology between professions; standardisation of diagnosis and subsequently treatment; replicable clinical research; and increased administrative, legal, and statistical clarity (Price-Robertson, 2018). Huda (2019, p467) discusses how diagnostic manuals state that they "*do not assume mental health problems exist in neat categories but use categories...*" for practical purposes, and do acknowledge the need for conceptual clarity "*...about how the diagnostic construct is classified and the nature of the condition being*

*classified.*" Huda (2021, p466) further discusses best practice diagnosis as an ongoing process, "Diagnosis is best viewed as an opinion on the optimum information set for the patient's predicament, is always provisional, and should be changed in the light of disconfirmatory information". However, in real life practice with time pressures, under resourcing, and discontinuity in care or practitioner; further reductionism and high levels of comorbidity may be more common than overall re-diagnosis (O'Connor & McNicholas, 2020). In the context of psychiatric institutions Rosenhan (1973, p256) simply states, "Something has to give, and that something is patient contact". The description of best practice psychiatric diagnosis described by Huda, may in the reality of modern-day practice, be more akin to a formulation-based approach.

### **Diagnosis within Psychotherapy**

From the 1950s, while psychiatry moved in the direction of the biomedical. Dynamic psychiatry and the fields of psychoanalysis and psychodynamic therapy continued to develop their own approaches to and understandings of diagnostic practice. The following briefly describes the approaches to diagnosis that have emerged from psychoanalysis through to contemporary psychodynamic therapy and follows with a discussion of the variety of diagnostic practice within psychodynamic thought.

Biological psychiatry classified illness into discrete categories with subsequent diagnostic labels, based upon the presence or absence of specific symptoms. In contrast, Sigmund Freud's approach to diagnosis was metapsychological and concerned with the structure of the psyche<sup>3</sup>. However, this was never delineated as a distinct nosology. Jacques Lacan, a Freudian psychoanalyst further set out the structural understanding of the psyche and its use in clinical practice. Lacan describes three universal psychic structures: neurosis, psychosis, and perversion. And the associated mechanisms of action: repression, foreclosure, and disavowal, respectively (Hook, 2020). Rodriguez (2004, p10) describes how, more than simply broader categories of psychopathology, these psychological structures are, "...three different subjective positions, three ways of being in the world".

Later theorists that diverged from classical Freudian psychoanalysis viewed metapsychology differently, instead positing three structures of psychosis, neurosis, and borderline. Where the term borderline had previously been used in the literature to describe a transitory state, it came to represent a stable psychological structure between psychosis and neurosis (Kernberg, 1967). The use of psychosis, neurosis, and borderline as psychological structures are used in contemporary diagnostic practice, evident in the Psychodynamic Diagnostic Manual (Lingiardi & McWilliams, 2017).

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<sup>3</sup> This refers to a metapsychological structure of the psyche, rather than Freud's structural theory of Id, Ego, and Superego.

This use of metapsychology points to an important distinction between a dynamic approach and that of biological psychiatry. Rather than attempting to describe the entirety of the experience of an individual with a list of symptoms, a structural approach is attempting to describe the meta-structure. Within which specific mechanisms are operating and in the case of suffering, results in symptoms which may be considered psychopathology. The attempt to diagnose based on structure and mechanism, rather than the description of manifest symptoms, attempts to allow more flexibility for how these structures and mechanisms manifest symptoms specific to the individual and their environment. Yorke (1996, p211) discusses, *"In the end, metapsychology is the only instrument that enables us to arrive at a picture of the whole person"*.

Further developing the Freudian approach to diagnosis in her work with children, Anna Freud (1970) discussed the conflict between metapsychology and diagnosis based on the description of observable symptoms which she termed, *"...underlying unconscious constellation"* or *"manifest symptom,"* respectively (p20). Anna Freud felt this conflict led to the unfortunate withdrawal of many psychoanalysts from diagnostic assessment altogether. In contrast to a structural approach, Anna Freud and colleagues came to focus on a developmental understanding as fundamental in conceptualising the presentations of their younger patients. Along with colleagues, Freud had developed the Diagnostic Profile at the Hampstead Child Therapy Clinic (Freud et al., 1962). This was an attempt to bridge the gap between these two perspectives, and to *"...draw the diagnostician's concentration away from the child's pathology and to return it instead to an assessment of his developmental status and the picture of his total personality"* (Freud, 1970, p38). The Provisional Diagnostic Profile (Freud et al., 1962) is a dimensional approach to psychopathology and has no diagnostic categories. Instead, the profile outlines a number of sections to be considered in assessing the presentation of the child based on psychoanalytic theory, each with several sub-sections. The clinician is then instructed to combine these into a *"...clinically meaningful assessment,"* and to discuss a number of diagnostic considerations. In 2017, a revised version of the Diagnostic Profile was published for contemporary use (Davids et al., 2017). This is followed with a diagnostic statement, which the authors also name as a formulation, and later a diagnostic formulation.

Categorical psychodynamic diagnostic systems have also been developed, Operationalised Psychodynamic Diagnosis (OPD) and the Psychodynamic Diagnostic Manual (PDM). OPD, a diagnostic inventory and handbook for clinical use, was initially intended to broaden ICD classification to include fundamental psychodynamic dimensions. Made up of psychoanalysts, psychosomatic specialists, and psychiatrists, a working party was founded in 1990 in Germany. The first edition was published in

2001 and the child and adolescent version in 2003 (Cierpka, et al., 2007; Kotan, 2018). The second edition, OPD-2, was published in 2008 and the child and adolescent version, OPD-CA-2, in 2017. Diagnosis is based upon four axes, Axis 1: Experience of illness and prerequisites for treatment, Axis 2: Interpersonal relations, Axis 3: Conflicts, Axis 4: Structure.

The PDM was developed to both augment and provide an alternative to the categorical system used in the DSM and ICD (Lingiardi & McWilliams, 2017). In addition to the description of manifest symptoms, the PDM is based on both empirical and theoretical literature and intends to support the clinician to formulate a psychodynamic diagnosis. This is based upon the following sections: personality patterns, unique mental profiles, social and emotional capacities, ways of relating, and personal experiences of the patient (Cooper, 2014). The first edition of the Psychodynamic Diagnostic Manual was published in 2006 and the second in 2017. PDM-2 diagnosis is based upon three axes: P axis for personality, M axis for mental functioning, and S axis for symptom pattern or subjective experience. Each axis has a modification for developmental stages through from infancy to elderly (Phillips & Raskin, 2020). The PDM-2 has been described as strengths-based, orienting from a holistic understanding of the person rather than just their symptoms (Jurist, 2018). Rather than seeing disorders as a phenomenon unto itself, the PDM attempts to focus on symptoms as attempts to cope with underlying distress which will flux, ebb, and flow throughout life based upon individual experience and circumstance (Huprich et al., 2015).

There are also many other concepts in psychoanalysis and psychodynamic psychotherapy that are used diagnostically in clinical practice, yet they have not been set out in a systematic diagnostic framework or are used independent of a systematic framework. Notable examples of these are not limited too but include: Melanie Klein's concept of the paranoid-schizoid and depressive positions (Reubins & Reubins, 2018); the concept of defences from primitive to mature (McWilliams, 1994); or Bowlby's internal working model and attachment styles (Levy et al., 2012).

There are therefore a great number of theories, concepts, and frameworks that are used diagnostically within psychoanalytic and psychodynamic practice. Rather than the absence of diagnosis, this speaks to the wide variety of diagnostic approaches used by psychotherapists, adult or child and adolescent. The absence of a single or universal approach which can offer consensus within the field may speak to the value of negative capability within psychodynamic thought (Civitarese, 2019): the value of not knowing or withholding judgement and instead attempting to stay with the present experience as it continues to emerge between the therapist and patient (Paglia, 2016).

The range of perspectives may also point to the importance of a formulation-based approach in psychodynamic practice. Arriving at a *“diagnostic formulation,”* as described by Davids et al., (2017, p156) allows the discussion of these multiple theories and perspectives, rather than an abbreviated diagnostic label which attempts to summarise a complex compendium of factors, experiences, and processes into a single term. While a diagnostic label offers a degree of certainty, it may also foreclose aspects of the patients experience or presentation. In comparison, a formulation allows for a complex and idiographic presentation, which is accompanied by a degree of uncertainty and ambiguity. As well as a possible lack of reliability or reproducibility, for which psychoanalytic and psychodynamic practice has been criticised (Bieling and Kuyken, 2003).

It is also possible for psychodynamic terms to function in a similar way to biomedical diagnoses and foreclose the patient’s presentation or process. Rodriguez (2004, p5) acknowledges the use of *“...universals, that is, terms that designate entire classes (hysteria, paranoia, Oedipus complex, drive, object a, etc)”*. Davids et al., (2017, p156) warns against the use of, *“...one-word diagnoses such as “narcissistic” disturbance... If such terms are used, they should be amplified and explained”*.

### **Formulation and Diagnosis**

Prior to the mid 20<sup>th</sup> century and the movement away from dynamic psychiatry, diagnostic labels played a limited role in psychiatric process or mental health treatment more generally. Rather than diagnosis, the focus was on formulation, *“This formulation is in dynamic psychiatry the real diagnosis; it refers to the understanding of the underlying dynamics of the maladaptive behaviour and is thus etiological”* (Bohmer, 2011, p274).

Johnstone (2017, p3) discusses formulation as, *“the process of co-constructing a hypothesis or ‘best guess’ about the origins of a person’s difficulties in the context of their relationships, social circumstances, life events, and the sense that they have made of them”*. Formulation draws on two equally important sources of evidence: the practitioner brings knowledge derived from theory, research, and clinical experience; while the patient brings expertise about their own life and the meaning and impact of their relationships and circumstances (Johnstone, 2017). In contrast to a diagnosis, a formulation is not about making an expert judgement, but an ongoing process of collaborative sense making (Harper & Moss, 2008).

While a formulation may look different depending on the therapeutic approach of the practitioner and the frameworks used - whether it be psychiatric, psychodynamic, or otherwise - a formulation will

likely contain similar key features. In many ways a formulation may be akin to a focus on the diagnostic *process*, rather than the arrival at a diagnostic *label*. Johnstone & Dallos (2013, p6) summarise the following core features of a formulation:

- summarise the client's core problems
- indicate how the client's difficulties may relate to one another by drawing on psychological theories and principles
- suggest, on the basis of psychological theory, why the client has developed these difficulties, at this time and in these situations
- give rise to a plan of intervention which is based in the psychological processes and principles already identified
- are open to revision and reformulation

These core features are not dissimilar to a thorough psychiatric interview needed for best practice categorical diagnosis (Puder, 2018). However, key points of difference lie in the connection to theory and aetiology, and a plan of intervention based in psychological process (rather than biomedical). Additionally, while in theory diagnoses are open to revision, in practice they are rarely removed and instead often high rates of comorbidity are seen (Newson et al., 2021). More structured approaches to formulation may include a biopsychosocial approach (Engel, 1981), the four P's (Winters et al., 2007), or a developmental focus (Gilmore & Meersand, 2014).

Bohmer's description of formulation as aetiological at the outset of this section is important, as it highlights a key distinction between formulation and categorical diagnosis. Carey & Pilgrim (2010) discuss this as an emphasis on theory. While formulation intends to make links both with psychological theory and aetiology, our current categorical diagnostic framework aims to minimise theoretical supposition and the associated possibility of subjectivity. With the publication of the DSM-3, an atheoretical approach was explicit. An attempt to move away from psychodynamic theories of aetiology and to move towards a more descriptive and empirical approach (Horwitz, 2020; Suris et al., 2016). Where diagnosis attempts to attribute psychological illness to the biological; formulation attempts to place psychological distress within a system of inter-relating causes that span from political, social, familial, temperamental etc. Where "*diagnosis is a system of classification, formulation is a process of explanation and understanding that links theory with practice*" (Brooke, 2004). Maté speaks to this in his statement, "*diagnoses are great as descriptions, but not as explanations*" (Maté & Kaufman, 2022, 46min).

The ability of categorical diagnosis and formulation to co-exist has been discussed throughout the literature. Johnstone (2017) describes the two as not only different but also contradictory; potentially leading to both patients and practitioners feeling confused, trapped, frustrated, or demoralised. She exemplifies the distinction between diagnosis and formulation respectively, *“you have a medical illness with primarily biological causes”* or *“your problems are an understandable emotional response to your life circumstances”* (p10).

Other authors believe the two are mutually enhancing processes, *“because current mental disorder nosology’s are descriptive rather than aetiological, formulation provides the link between diagnosis and treatment”* (Eells, 2002 In Carey & Pilgrim, 2010, p450). Scott & Sembi (2006, p491) suggest that, *“diagnosis acts as a lens, focusing attention on the range of cognitions salient to a case formulation and also highlights psychosocial and environmental factors that may affect treatment outcome”*. Persons (2005) discusses how case formulation facilitates the use of empirically supported treatments whose validity is based on research rather than real world settings. Bohmer (2011) also implies the two may co-exist:

*Thinking in a psychodynamic way and creating such a formulation does not mean that the psychiatrist will necessarily work in a psychodynamic therapeutic way with the patient. The psychodynamic formulation is primarily an attempt to reach a better understanding of the patient, which then can be used in different ways* (p275).

This perspective is also endorsed by Dale et al., (2022) at the intersection of neurology and psychology, who discusses the use of formulation for Huntington’s disease. A psychodynamic practitioner Aveline (1999, p199) states that, *“formulation and diagnosis have different and complementary functions”*, both of which are useful. The British Psychological Society also propose that both are an addition to each other. Formulations focus on the experiences, which may have led to a specific psychiatric diagnosis. However, it has also been argued that if sense is made of the experience, an additional psychiatric label is then redundant (DCP, 2011 in Johnstone, 2017).

It is often the case that patients expect a diagnosis, as this can provide a sense of reassurance, relief, and some abdication of responsibility (McWilliams, 2021; O’Connor & McNicholas, 2020). However, psychiatric diagnosis can also contribute to stigmatization and isolation (Carey & Pilgrim, 2010). A study evaluating the effect of diagnosis compared to formulation on lay attitudes to people with psychosis found that compared to diagnosis, formulation may reduce stigma-related attitudes and may lead to less medicalised treatment preferences (Seery et al., 2021). On the other hand, while

studies have shown formulations as increasing understanding and trust, empowering the patient, and providing a sense a relief (Redhead et al., 2015); formulations have also been shown to elicit responses of negative emotion (Pain et al., 2008). Psychological formulation has also been criticised for low reliability (Bieling and Kuyken, 2003). Although this has been shown to decrease with practitioner experience (Flinn et al., 2014) and may therefore be more related to the practitioner than the phenomenon of formulation. Formulation has also been criticised for subjectivity and a high frequency of differing formulations between practitioners of different theoretical orientations or geographical locations. This criticism being a significant factor in the move to categorical diagnosis in the 1980's (Suris et al., 2016). In addition to the need for a standardised system for inter-clinician communication, research, and insurance (Barnes et al., 2022; Fuller, 2017). Johnstone (2013) summarises:

*Of course, there is no guarantee that a formulation will avoid some of the same traps as diagnosis, such as being individualizing, pathologizing, excluding social contexts, or perhaps simply imposing a view with which the service user disagrees (p276).*

Johnstone (2017) further states, *"Like any intervention, it depends how it is done"* (p5).

## **Psychometric Measures**

Psychometric measures are tools used within a diagnostic framework to support the arrival at a diagnosis. While a detailed review of the varying psychometric measures is beyond the scope of this dissertation, a brief overview of some that have been developed to support a psychodynamic and relational approach to assessment of a patient's presentation is offered.

These are not limited to but include those developed with the PDM such as the Psychodiagnostic Chart-Child (PDC-C) (Fortunato et al., 2022); or with the OPD, such as the structure questionnaire (OPD-SQ) (Lorenzini et al., 2021).

The Structured Interview of Personality Organisation (STIPO-R) is a semi-structured interview that assesses identity consolidation, quality of object relations, use of primitive defences, quality of aggression, adaptive coping versus character rigidity, and moral values (Clarkin et al., 2021). The Shedler-Westen Assessment Procedure (SWAP) is a psychological test for personality assessment and clinical case formulation (DeFife et al., 2013).

Other commonly used psychometric measures with children and adolescents include the Child Behaviour Checklist (CBCL) (ASEBA, 2023) and the Strengths and Difficulties Questionnaire (CORC,

2023). More specific questionnaires include the Generalised Anxiety Disorder Assessment (GAD-7) or the Beck Depression Inventory (BDI) (CORC, 2023).

Outcome and feedback measures are also broadly related to the field of diagnostic practice. While they are also beyond the scope of this dissertation, it is important to note their function in offering ongoing outcome and assessment information which informs diagnostic practice throughout treatment. These include the Young Persons Clinical Outcomes in Routine Evaluation (YP-CORE) (CORE, 2023) or the Youth Outcome Questionnaire (YQQ) (OQ Measures, 2023).

### **Methodology & Method**

The aim of a scoping review is to establish the nature and range of a topic area in the literature; in a way that is both comprehensive and structured (Bowden & Purper, 2022). Tricco et al., (2016) describes the three most common reasons for conducting a scoping review. These are: to explore the breadth of the literature, to map and summarise the evidence, and to inform future research. More specifically Munn et al., (2018) lists the following five reasons: to identify the types of available evidence in a given field; to clarify key concepts or definitions in the literature; to examine how research is conducted in a certain field; to identify key characteristics or factors related to a concept; and as a precursor to a systematic review.

A systematic review addresses a very specific research question, compares studies of a similar design, and assesses the quality of included studies. In contrast, a scoping review allows a broad mapping of the literature independent of study type or methodological rigour, across different types of literature (Arksey & O'Malley, 2005).

The research question, what diagnostic practices are used within psychodynamic therapy with young people, is both broad and elementary. It intends to map out diagnostic practice within psychodynamic therapy and note any other points of interest or relevance to diagnosis within the field of psychodynamic therapy. This may be discussed in the literature in a range of different contexts such as primary research studies, clinical case studies, edited book chapters, training guidelines etc, and using a range of different study designs.

The breadth of the research question and need to understand the scope of the literature makes a scoping review the most appropriate methodology for this research question. A scoping review also provides a foundation for future research that may expand on best practice diagnosis or formulation for psychodynamic therapy with young people, in addition to identifying which research methods may be valuable to use in future research. Such as, what diagnostic frameworks are most appropriate for use with children and adolescents and how are these frameworks experienced by patients or practitioners (Munn et al., 2018).

Arksey & O'Malley (2005) first proposed an iterative framework for conducting a scoping review. The five stages are discussed below:

### **1. Identifying the research question**

The initial literature review discusses the variety of diagnostic practice within mental health and psychodynamic therapy. While a range of different perspectives may be utilised depending on the individual needs of the client, the approach used is likely to depend upon the school of thought to which the practitioner adheres to most. There is consequently a range of approaches to diagnosis and formulation across the range of practitioners offering psychodynamic therapy. While these diagnostic approaches are detailed within the literature, a preliminary search identified that there were no published comparative studies reviewing the use of differing approaches in psychodynamic therapy. Nor were there any studies found which reviewed how psychodynamic therapy interacted with a diagnostic system with fundamental differences in theory and practice, such as the DSM. This may be attributable, at least in part, to the relative paucity of research studies on psychodynamic therapy (Goodman, 2022).

### **2. Identifying relevant studies**

The search strategy followed best practice guidelines for a scoping reviewed set out by the Joanna Briggs Institute (JBI) (2022). This includes an a priori protocol which pre-defines the objectives, methods, inclusion and exclusion criteria, and how the data will be extracted and presented. These parameters, discussed throughout Arksey & O'Malley's (2005) iterative framework, were established before the search was conducted. This supports transparency throughout the review process (JBI, 2022). The JBI (2022) then describes a three-step search strategy. An initial search was carried out of two relevant databases: PsycINFO (Ovid), and CINAHL Complete (EBSCO). Key words from the titles or abstracts were collated. This coincided with the preliminary search that helped to actualise the research question and scope. This iterative approach allowed the development of a more sensitive search as familiarity with the literature developed (Arksey & O'Malley, 2008).

#### *Search Strategy*

The PICO search tool is a framework for conducting systematic literature reviews that organises search terms into main concepts. This is to ensure the search terms are both sensitive and comprehensive (Methley et al., 2014). These are listed below:

*Population:* child\* OR adolescen\*

*Intervention:* psychodynamic

*Comparison:* case

*Outcomes:* diagnos\* OR assessment OR formulation

The initial search showed that using the word '*diagnosis*' was not sufficient to identify studies that discussed the phenomenon of diagnosis, rather than the discussion of a specific diagnosis. The decision was therefore made to include the words '*assessment*' and '*formulation*'. Including the search term '*formulation*' also intended to capture articles with a psychodynamic orientation to diagnosis. Similarly, to focus the search results on articles that discussed the phenomenon of diagnosis rather than specific diagnoses, the decision was made to include the word '*case*' in the comparison category to pick up case studies, case reviews, or case reports.

The intention of the dissertation is to review the diagnostic practices (or absence) of practitioners offering psychodynamic therapy to young people. As the term psychotherapy can be applied to talk therapies with many different treatment interventions and varying theoretical foundations (CBT, IPT, DBT, PDT etc)<sup>4</sup>, the decision was made to limit the intervention category to the term psychodynamic, rather than both psychodynamic and psychotherapy. This attempted to limit the search results to psychodynamic therapy.

The second stage of the search process was to search using all the identified key words across all included databases: PEPWeb, PsycINFO (Ovid), and CINAHL Complete (Ebsco). Thirdly, reference lists of identified articles were manually searched for additional articles.

### 3. Study selection

The articles returned were organised into tiers of relevance to support an accurate and consistent process of sorting. Tier one contained psychodynamic child or adolescent case studies that also discussed the phenomenon of diagnosis or formulation. Tier two contained psychodynamic child or adolescent case studies generally. The distinction between tier one and tier two represented a direct discussion of preferred diagnostic system within child and adolescent psychotherapy in tier one; whereas tier two included studies from which I inferred the use of a diagnostic system (or not) from discussion within the case study. Tier three contained theoretical discussions of diagnosis in psychodynamic therapy with young people which may have contained points of interest. The final

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<sup>4</sup> CBT – cognitive behavioural therapy, IPT – interpersonal therapy, DBT – dialectical behavioural therapy, PDT – psychodynamic therapy (American Psychiatric Association, 2022b).

dataset consisted of tier one and tier two. Tier three was not included as papers did not include clinical material and therefore did not fit the parameters of the scoping review.

#### *Inclusion and Exclusion Criteria*

Studies published earlier than 2018 were excluded, this was done to both reduce the number of search results due to the scope of the dissertation and to focus the results on contemporary practice within the current milieu of emerging diagnostic frameworks.

Additional exclusion criteria included: whether the case studies were of patients older than 18 years of age, if the article was not published in English, if the article was not psychodynamic in orientation, or if the clinical material included treatment for psychological symptoms associated with an organic condition.

#### **4. Charting the data**

Charting is a process of synthesising, interpreting, and sorting material in relation to key concepts and themes. The data to be collected was described at the outset of the search process to focus the review process. This included whether diagnoses were used or discussed within the case studies and from which diagnostic frameworks. Additional categories were also added post-hoc as familiarity with the literature and themes developed. The data was manually collated into an excel spreadsheet by the author. Final data items in the structured matrix included:

- if a DSM diagnosis was referenced
- if psychiatric diagnosis was discussed
- if a psychodynamic diagnosis was referenced
- if a psychodynamic framework was discussed
- if formulation was discussed
- if a formulation was made
- a review of specialist psychodynamic diagnostic terms
- geographical location of clinical material

As with psychiatric diagnoses, psychodynamic diagnoses and formulations utilise specialist psychodynamic terms that speak to a more complex phenomenon. This process of collapsing an individual's experience into a single term or label has been a criticism of psychiatric diagnosis (Kriegler & Bester, 2013). To further understand the phenomenon of diagnosis in psychodynamic therapy and whether a similar over-simplification may occur, the use (or not) of specialist psychodynamic terms throughout the case studies was reviewed.

The country in which each the clinical material from each case study occurred was also collated. This was to review the heterogeneity (or homogeneity) of cultural influences that may or may not impact the frameworks used in conceptualising a client's presentation.

### 5. Collating, summarising, and reporting the results

A systematic review aims to evaluate the findings and generalisability of studies based on their quality or methods. While many studies may be reviewed, generally the findings of only a small percentage that meet criteria are published with a higher level of detail. In contrast, a scoping review aims to publish a broad overview of all the material reviewed (Arksey & O'Malley, 2005). However, to review a breadth of literature in a way that is both thorough and conclusive requires some form of thematic construction to be able to publish a readable narrative. The results were therefore presented in both a high-level summary of the search results presented in the results; as well as a narrative discussion of the results and any points of interest from the case studies, presented in the findings.

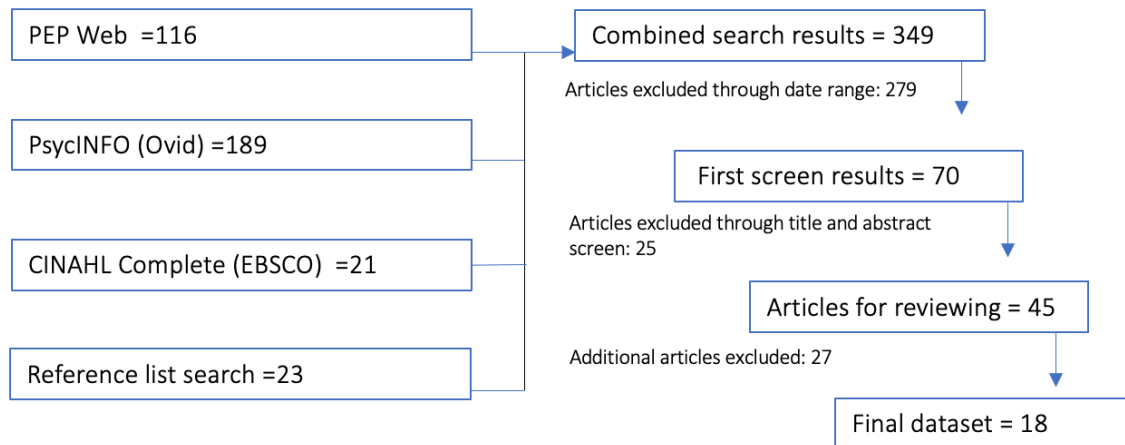
## Results

The search terms, parameters, and results from each database are summarised in Table 1 and the article review process is summarised in Figure 2.

**Table 1**  
*Summary of search results*

	PEPWeb	CINAHL	PsycINFO	Reference list
<b>Search terms</b>	((child* OR adolescen*) AND (diagnos* OR assessment OR formulation) AND case)	((child* or adolescen*) and psychodynamic and (diagnos* or assessment or formulation) and case)	((child* or adolescen*) and psychodynamic and (diagnos* or assessment or formulation) and case)	
<b>Search parameters</b>	Whole article, term or phrase bar	Abstracts	Abstracts	
<b>Initial return</b>	116	21	189	
<b>Return within date range</b>	18	5	24	23
<b>Tier 1</b>	5	0	2	1
<b>Tier 2</b>	5	1	3	1
<b>Tier 3</b>	2	0	0	0

Figure 2



**Figure 2: Summary of review process**

The final data set consisted of eighteen articles: two edited book chapters and sixteen published case studies. These were reviewed and charted alphabetically into an excel spreadsheet. Data items detailed in step four of the iterative framework described by Elo & Kyngas (2008) are summarised in Table 2 and described below.

Nine of the eighteen case studies did reference a DSM diagnosis in discussion of their client’s presentation (Atzil-Slonim, 2019; Bizzi et al., 2022; De Luca et al., 2021; Kurdziel et al., 2018; Levi, 2022; Sapountzis, 2020; Sharp & Rossouw, 2019; Sleiman et al., 2020; Tselika & Anagnostaki, 2019). Throughout the case studies this reference was made only briefly in the introductory or background information and rarely referred to again. In example, “According to the *Diagnostic and Statistical Manual of Mental Disorders (APA, 2013)*, *Lea’s preliminary diagnoses were as follows: 296.31 (F33.0) Major Depressive Disorder, Recurrent Episode, Mild; 300.4 (F34.1) Persistent Depressive Disorder; 300.23 (F40.10) Social Anxiety Disorder*” (Kurdziel et al., 2018, p318). When the psychiatric diagnosis was discussed more than once throughout the case study this was in reference to a psychodynamic understanding of the diagnosis. In example, “*Unmitigated terror might ensue, which Tustin sees as a crucial factor in the development of autism*” (Tselika & Anagnostaki, 2019, p359).

Only three of the case studies referenced psychiatric diagnosis more generally (Bisgani, 2022; Drisko, 2020; Gershy, 2018), all three of which did so only briefly. These were as follows: Bisgani (2022) refers to the *Textbook of Child and Adolescent Psychiatry (Wiener & Dulcan, 2004)* when discussing the

under- or misdiagnosis of childhood mood disorders, as well as high rates of comorbidity and the significance of developmental differences to an individual's presentation. Drisko (2020) discusses the diagnosis of narcissistic personality from the DSM-4, applied only to adults and speaks to the value of "...depth theories of personality" (p153) in therapeutic practice with children. In discussing the symptomatology of a psychotic presentation, Gershy (2018) contrasts the DSM-5 with the PDM-2.

Only three case studies referenced a psychodynamic diagnosis (Bagattini, 2021; Bizzi et al., 2022 and Malone et al., 2018). Bagattini (2021) uses self-report measures contained within the OPD-CA-2 and diagnoses a 12-year-old male with the descriptive diagnosis of an ongoing depressive/anxious disorder. Bizzi et al. (2022) investigates the use of two assessment measures which are included in the PDM-2 and used to diagnose a 10-year-old male with an externalising Oppositional-Provocative Disorder and a 15-year-old female with an internalising Somatic Symptom Disorder. Similarly, Malone et al., (2018) applies the PDM-2 to two clinical cases. A 13-year-old female diagnosed as follows: MA-Axis Neurotic, PA-Axis Obsessional, SA-Axis Feeding and Eating; and an 18-year-old male diagnosed as MA-Axis Emerging borderline, PA-Axis Anxious-Avoidant, SA-Axis Anxiety, sub-category Social Phobia. Four papers discussed a psychodynamic diagnostic framework (Bizzi et al., 2022; Bagattini, 2021; Gershy, 2018; Malone et al., 2018). The PDM-2 was discussed in three of these four case studies, making it the most referenced psychodynamic diagnostic framework (Bizzi et al., 2022; Gershy, 2018; Malone et al., 2018).

The other psychodynamic diagnostic system referenced was the Operationalised Psychodynamic Diagnosis in Childhood and Adolescence (OPD-CA-2). The authors felt that while symptom-based diagnosis as the predominant form of assessment is unreliable and does not lead to efficient treatments, it remains an essential part of practice. The OPD-CA-2 instead aims to offer a framework to be used alongside psychiatric diagnosis that supports psychodynamic and developmental assessment and treatment recommendations (Sieffge-Krenke & Hau, 2021).

Four case studies utilised a framework to enhance the formulation process (Dawson, 2020; De Luca et al., 2021; Eiron, 2021; Sharp & Rossouw, 2020). The formulation review tool (Dawson, 2020) was developed for use within the National Health Service (NHS) in Scotland and was intended to help clinicians articulate specialist psychoanalytic work into a common language and support the contribution of child psychotherapy within a multi-disciplinary CAMH service. The Plan Formulation Method (PFM) was developed through application of Control Mastery Theory (CMT) (Weiss, 1998). CMT sees mental health symptoms as expressions of pathogenic beliefs, developed in attempt to adapt to trauma and adverse experiences. The PFM attempts to outline and organise these

pathogenic beliefs as part of the assessment and formulation process to support further therapeutic work. Eiron (2021) uses a psychotherapy model called Experiential Dynamic Therapy (Osimo & Stein, 2013). In this model the diagram known as Malan's Triangles (Malan, 1979; McCullough et al., 2003) are used to visualise and identify the conflict occurring for the client. This provides the basis for the formulation, directs initial therapy goals, and outlines the expected therapy process. Sharp & Rossouw (2020) use an assessment and formulation format used within Mentalisation Based Therapy for Adolescents (MBT-A) developed at the Menninger Clinic (Sharp et al., 2009).

Of the eighteen case studies, all made a formulation about their client's presentation (Atzil-Slonim, 2019; Bagattini, 2021; Bisgani, 2022; Bizzi et al., 2022; Bonfatto & Crasnow, 2018; Dawson, 2020; De Luca et al., 2021; Drisko, 2020; Eiron, 2021; Gershby, 2018; Harwell, 2019; Kurdziel et al., 2018; Levi, 2022; Malone et al., 2018; Sapountzis, 2020; Sharp & Rossouw, 2019; Sleiman et al., 2020; Tselika & Anagnostaki, 2019). Two of the case studies presented the formulation explicitly in a defined section titled "*Discussion*" and "*Case Conceptualisation*", respectively (Bonfatto & Crasnow, 2018; Kurdziel et al., 2018). The other sixteen case studies discussed the formulations in a narrative style, either at the outset of the case study with developmental and family history or woven throughout the case study and discussed throughout the description of the therapy process (Atzil-Slonim, 2019; Bagattini, 2021; Bisgani, 2022; Bizzi et al., 2022; Dawson, 2020; De Luca et al., 2021; Drisko, 2020; Eiron, 2021; Gershby, 2018; Harwell, 2019; Levi, 2022; Malone et al., 2018; Sapountzis, 2020; Sharp & Rossouw, 2019; Sleiman et al., 2020; Tselika & Anagnostaki, 2019). In two of the case studies, while the criteria for formulation were met (summaries of the core difficulties, links to theory and timing, and a plan or reflections on intervention), the formulations were both brief and had little detail (Atzil-Slonim, 2019; Dawson, 2020).

In summary, eleven of the eighteen case studies reviewed referred to either a DSM or psychodynamic diagnosis (PDM-2 or OPD-CA-2). A further two case studies used a formulation framework. The remaining five case studies presented their clients formulation without the use of a diagnostic framework or structured formulation.

Examples of specialist psychodynamic terms, which may function as diagnostic labels, are reviewed and collated in Table 3. Table 4 presents the country from where the clinical material presented in the case study was carried out. All but one of the papers from the United States referenced a DSM diagnosis. All other data points showed heterogeneity between the result and the countries in which the clinical material was carried out.

**Table 2**  
*Summary of Data Items within Reviewed Papers*

Reference	Referenced a DSM diagnosis	Referenced Psychiatric diagnosis	Made a PDT diagnosis	Discussed a PDT framework	PDT Framework	Discussed Formulation	Formulation Made	Tool Used to Structure Formulation
Atzil-Slonim, 2019	✓						✓	
Bagattini, 2021			✓	✓	OPD-CA-2		✓	
Bisgani, 2022		✓					✓	
Bizzi et al., 2022	✓		✓	✓	PDM-2		✓	
Bonfatto & Crasnow, 2018							✓	
Dawson, 2020						✓	✓	Formulation review tool
De Luca et al., 2021	✓					✓	✓	Plan formulation method (PFM)
Drisko, 2020		✓					✓	
Eiron, 2021						✓	✓	Malan's Triangle of Conflict
Gershby, 2018		✓		✓	PDM-2		✓	
Harwell, 2019							✓	
Kurdziel et al., 2018	✓						✓	
Levi, 2022	✓						✓	
Malone et al., 2018			✓	✓	PDM-2	✓	✓	
Sapountzis, 2020	✓						✓	
Sharp & Rossouw, 2019	✓					✓	✓	Mentalisation Based Therapy for Adolescents (MBT-A)
Sleiman et al., 2020	✓						✓	
Tselika & Anagnostaki, 2019	✓						✓	
<b>Total</b>	<b>9</b>	<b>3</b>	<b>3</b>	<b>4</b>		<b>5</b>	<b>18</b>	

**Table 3***Summary of Specialist Psychodynamic terms*

<b>Reference</b>	<b>Specialist Psychodynamic terms</b>
Atzil-Slonim, 2019	Internal representations
Bagattini, 2021	Self-esteem conflict
Bisgani, 2022	Reversal of the alpha function
Bizzi et al., 2022	Borderline level of personality severity
Bonfatto & Crasnow, 2018	Reality principle, Disavowal
Dawson, 2020	Symbolic communication
De Luca et al., 2021	Pathogenic beliefs
Drisko, 2020	The mother's ego ideal, Narcissistic
Eiron, 2021	Defences
Gershby, 2018	Fragmented, Separated object, Holding environment
Harwell, 2019	Fear of intrusion and engulfment
Kurdziel et al., 2018	Introjective depression
Levi, 2022	Halted ego development
Malone et al., 2018	Neurotic, Obsessional character style
Sapountzis, 2020	Enactment
Sharp & Rossouw, 2019	Hypermentalising
Sleiman et al., 2020	Psychotic functioning
Tselika & Anagnostaki, 2019	No entry defences, Omega function

**Table 4***Summary of Geographical Location of Clinical Material Presented in Case Studies Reviewed*

<b>Reference</b>	<b>Country</b>
Atzil-Slonim, 2019	Israel
Bagattini, 2021	Uruguay
Bisgani, 2022	Italy
Bizzi et al., 2022	Italy
Bonfatto & Crasnow, 2018	United Kingdom
Dawson, 2020	Scotland
De Luca et al., 2021	United States
Drisko, 2020	United States
Eiron, 2021	Israel
Gershby, 2018	Israel
Harwell, 2019	United States
Kurdziel et al., 2018	United States
Levi, 2022	United Kingdom
Malone et al., 2018	United States
Sapountzis, 2020	United States
Sharp & Rossouw, 2019	United Kingdom
Sleiman et al., 2020	France
Tselika & Anagnostaki, 2019	Greece

## Findings

### Use of Psychiatric Diagnoses

Nine of eighteen case studies reviewed referenced a DSM diagnosis. This indicates that practitioners offering psychodynamic therapy do consider psychiatric diagnoses and frameworks in relation to their client's presentations. It is not clear whether this consideration indicates the authors felt this was relevant and valuable information in conceptualising their client's presentation or if it is merely the author's due diligence in operating within a system where psychiatric diagnosis is primary, and reporting information that may be relevant to readers from the wider psychological community. However, the brevity with which DSM diagnoses were referenced indicates this may more likely be the latter. This finding is also supported by the additional three case studies that referenced psychiatric diagnosis more generally. All of which showed a preference for the structural and/or developmental conceptualisation of a child or adolescent's presentation over the psychiatric or biomedical<sup>5</sup>. Overall, this indicates that while practitioners offering psychodynamic therapy are versed in psychiatric frameworks and diagnoses, they do not contribute significantly to how clients' presentations are conceptualised.

This finding is also consistent with my personal experience training as a Child and Adolescent Psychotherapist, in which I was acquainted with a psychiatric approach to assessment and clinical diagnoses from the DSM-5 to inform our practice within multidisciplinary healthcare settings, rather than to encourage the use of this diagnostic approach within my own practice.

### Use of Psychodynamic Diagnostic Frameworks

Only three of the case studies reviewed referenced an explicit psychodynamic diagnosis. One of these was in addition to a psychiatric diagnosis (Bizzi et al., 2022) and two of these were the sole diagnosis offered (Bagattini, 2021; Malone et al., 2018).

One of these case studies used the OPD-CA-2 (Bagattini, 2021). Two case studies used the PDM-2 (Bizzi et al., 2022; Malone et al., 2018). Interestingly, despite two case studies using the PDM-2, these diagnoses were presented differently. Bizzi et al., (2022) presented the diagnosis more explicitly and with less explanation, "*...she (Anna) received by two experts of mental health a diagnosis of Somatic Symptom Disorder following a diagnostic assessment through several clinical interviews and*

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<sup>5</sup> In reviewing case studies which were psychodynamic in orientation, this is in many ways to be expected. The emphasis is not intended to be on which modality was preferred over another, rather on whether and how practitioners offering psychodynamic therapy interacted with psychiatric diagnoses in published case studies.

*measures...*" (p61). In contrast Malone et al., (2018) presented the diagnosis in a more narrative style with assessment information for each axis of diagnosis:

*Valerie's emerging personality shows most compatibility with the obsessional character style...Her conscientiousness at home and school are being challenged by her entrance into adolescence, in ways that leave her feeling she can never meet her own standards or those of others (p343).*

This may of course be as simple as a matter of brevity within a published case study, yet it may also illustrate how the same diagnostic system, psychodynamic or otherwise, can be utilised with varying degrees of detail and reference to the client's personal experience. As Johnstone (2017) stated, "*Like any intervention, it depends how it is done*" (p5).

Interestingly, a higher number of the reviewed case studies referenced a DSM diagnosis compared to a psychodynamic diagnosis, nine and two respectively. This may speak to the predominance of the DSM in the culture around mental health and raises further questions around the value of a psychodynamic diagnostic framework to psychodynamic therapists.

### **Use of Formulation**

Based on the following parameters: summarising core difficulties, making links to theory and timing, and inferring a treatment plan or making reflections on intervention; all eighteen case studies made a formulation about their client's presentation. However, these were in varying degrees of detail and presented in varying formats. Combined with the brevity with which DSM diagnoses were discussed and the low number of case studies that applied a psychodynamic diagnostic framework, this indicates that compared to a more explicit diagnostic system, a formulation-based approach may be the preferred diagnostic approach for practitioners offering psychodynamic therapy.

The variation in detail and format throughout the case studies suggests there is no standardised approach to formulation within psychodynamic therapy. However, standardised approaches are available and were used by four case studies to structure the formulation in their case study (Dawson, 2020; De Luca et al., 2021; Eiron, 2021; Sharp & Rossouw, 2020). The formulation review tool was developed to structure the formulation process, the emphasis appearing to be on developing the capacity to communicate the efficacy and contribution of psychotherapeutic work within a multidisciplinary CAMHS setting (Dawson, 2020). The PFM is an empirically validated tool developed by the San Francisco Psychotherapy Research Group (Curtis et al., 1994), which attempted to

standardise the psychotherapy formulation process to allow empirical research on psychotherapy process and outcomes (Silberschatz & Curtis, 1993). Eiron (2021) uses Malan's Triangles (Malan, 1979; McCullough et al., 2003) to visualise and identify the conflict occurring for the client. This provides the basis for the formulation, directs initial therapy goals, and outlines the expected therapy process. Eiron (2021) describes how the use of Malan's triangles and the associated evaluation process (involving four-five assessment sessions) helps to create initial understanding and shared conceptualisation of the emotional dynamics, familial relations, and treatment implications. Sharp & Rossouw (2020) use an assessment and formulation format used within Mentalisation Based Therapy for Adolescents (MBT-A) developed at the Menninger Clinic (Sharp et al., 2009). This approach to assessment and formulation was developed to provide clarity on the underlying theoretical framework informing work with patients; to operationalise each component of the assessment and formulation framework; and to support data collection for clinical and research use (Sharp et al., 2009). The format involves an initial two to three assessment sessions, based on which the therapist develops a formulation to discuss with the young person.

These four standardised formulation formats have both common and differing goals. All intend to help standardise the formulation process and aid the therapist in formulating their client's presentation. However, the reason for doing so ranges from supporting empirical research, inter-clinician communication, and therapeutic alliance; through to shared understanding of therapy goals and process.

Different from the four case studies that used a standardised framework, two additional studies presented their case studies in a structured way with a distinct section on formulation (Bonfatto & Crasnow, 2018; Kurdziel et al., 2018). Bonfatto & Crasnow (2018) discuss their formulations in a distinct section near the end of the case study. However, they discuss three young people seen at a specialist CAMHS, that offers only four to six sessions roughly one month apart. The formulations do seem to be conceptualised retrospectively, including content from the full length of therapy with the young person and their family. Therefore, this formulation appears to offer more of a summary of the process for publication, rather than formulation as a form of diagnosis used to contribute to treatment planning.

The structure of the case study in Kurdziel et al., (2018) suggests that the formulation was made during an assessment process before treatment proper began. However, this is an inference and the duration or number of assessment sessions and subsequent entry into a treatment phase is not clear. Kurdziel et al., (2018) does discuss the efficacy of a specific modality based on the formulation of the individual (long-term psychodynamic psychotherapy – LTPP for introjective depression). This suggests

that there was a phase of assessment, a decision made about the most appropriate treatment modality, and then an entry into treatment.

The distinction between assessment and diagnosis, and beginning treatment is a relevant consideration and holds importance in considering the value of a diagnostic system for informing treatment decisions. However, in psychodynamic therapy, rather than ending with the application of a diagnostic label, diagnostic process is ongoing. This is a key component of psychodynamic practice: of suspending judgement and maintaining a free-floating attention (Langan, 1997), negative capacity (Civitarese, 2019), a state of 'not knowing' and 'being with' (Paglia, 2016). A diagnostic label may never be applied and a distinction between assessment and treatment may be less relevant, both the assessment in itself being therapeutic (Weston et al., 2018) and long-term therapy involving ongoing assessment (Hook, 2020).

Between the psychodynamic diagnostic frameworks (Bagattini, 2021; Bizzi et al., 2022; Gershy, 2018; Malone et al., 2018), structured formulation tools (Dawson, 2020; De Luca et al., 2021; Eiron, 2021; Sharp & Rossouw, 2019), or use of an independent formulation structure (Bonfatto & Crasnow, 2018; Kurdziel et al., 2018); ten of the eighteen case studies used a more structured approach to conceptualising their client's presentations. The remaining eight case studies discussed their formulations in a narrative style, woven throughout the case study (Atzil-Slonim, 2019; Bisgani, 2022; Drisko, 2020; Harwell, 2019; Levi, 2022; Sapountzis, 2020; Sleiman et al., 2020; Tselika & Anagnostaki, 2019).

The use of a more structured approach to formulation in a published case study makes more clear for the reader: the phase of assessment, how the case was conceptualised, and what informed the decisions for treatment decisions. This does not mean the same did not apply to the unstructured formulations, however it does make a review of the use of diagnosis more difficult as it is not clear what aspects of the formulation are being discussed retrospectively after the therapy had ended. To elucidate this further I reviewed the number of articles that made links between their formulation and treatment decisions. Thirteen of the eighteen case studies did make clear links, where five papers did not. Of these five papers that did not make links between formulation and treatment decisions, four followed an unstructured approach (Atzil-Slonim, 2019; Bisgani, 2022; Sleiman et al., 2020; Tselika & Anagnostaki, 2019) and one a structured approach (Bagattini, 2021). This indicates that an unstructured approach to formulation may provide less clarity about the decisions between assessment and treatment. These considerations raise the question of whether a standardised approach to formulation is more beneficial for treatment planning and process, outcomes, inter-clinician communication, research, or publication.

### Specialist Psychodynamic Terms

All of the case studies reviewed utilised specialist psychodynamic terms that have the possibility of functioning in the same way as a diagnostic label: improving inter-clinician communication, or potentially collapsing an individual's experience into a single term or label, or foreclosing therapeutic process. As with psychiatric diagnoses specialist psychodynamic terms have the possibility of leading to stigmatisation, prejudice, or invalidation. This may be evident in the example of the term *borderline*, which anecdotally, therapists may use to indicate a difficult patient or presentation to work with.

A formulation-based approach offers the advantage of providing a forum for further discussion of the term, with links to explanatory theory and clinical material. In many of the case studies reviewed, the terms were part of a broader discussion of aetiology and the links being made between theory and presentation. This suggests rather than explicit labels, the terms were being used descriptively as a part of a broader formulation. The simple collation of specialist psychodynamic terms from case studies is rudimentary and offers minimal insight into the use of these terms clinically, however it does evidence the use of some form of diagnostic 'label' by psychodynamic therapists.

### Discussion

In the eighteen case studies reviewed, all of them referred to either a DSM or PDT diagnosis, or used formulation to conceptualise their client's presentation. In other words, some form of diagnostic process, in comparison to diagnostic label, was used. Based on this review, it is indicated that diagnostic process is an important part of clinical practice in psychodynamic therapy with children and adolescents.

While there are differing views in the literature, the case studies in this scoping review indicate that within psychodynamic therapy, diagnosis and formulation can be used harmoniously to support treatment planning and outcomes. In six of the case studies in this review, only the diagnostic process was undertaken, either with the use of a specific framework to structure the formulation or a more unstructured approach. While, in twelve case studies this also included reference too or application of a diagnostic label from the DSM, PDT, OPD; or in all case studies with the use of specialist psychodynamic terms which may have a similar function to diagnostic labels.

At least terminologically, diagnosis and formulation do speak to separate processes. However, in practice formulation is more akin to the diagnostic process; whereas what has come to be known as 'diagnosis' is more specifically the application of the diagnostic label. The conflation of a diagnostic

label with the concept of diagnosis overall, may simply represent an imprecise use of language. Yet it may have also contributed to the aversion or withdrawal of psychodynamic practitioners from identifying with diagnostic practice, when in actuality it is a fundamental process in clinical work and evident throughout psychodynamic practice under the umbrella of formulation.

The distinction between a diagnostic label, a diagnosis, and a diagnostic statement may be an important one. In our current mental health culture diagnosis may have come to mean a categorical, descriptive, DSM based label. Where in fact if we can expand our understanding of this terminology, diagnosis is a much broader umbrella, under which formulation or diagnostic formulation falls.

The possibility that specialist psychodynamic terms act as diagnostic labels is worthy of consideration. This acknowledges the importance of diagnostic process in psychodynamic therapy. It also points to the possibility that psychodynamic 'labels' have the possibility of functioning in a similar way that DSM diagnoses can be used, foreclosing client experience, or being experienced as stigmatising or pathologising.

The results of this scoping review indicate there is no ubiquitous approach to diagnosis within psychodynamic therapy with young people. This may speak to the value placed on aetiology over symptom description in psychodynamic therapy. Due to the inherently subjective nature of psychological experience, this supports greater emphasis being placed on the patient's perspective and experience, rather than that of the 'expert'. While an expert is able to proficiently list the symptoms of a condition, the patient is the only person who is truly able to meaningfully communicate their experience, which then provides direction for treatment planning. In the Power Threat Meaning Framework, Johnstone and Boyle (2018, p187) typify this distinction in asking, "*The core question is not " 'What is wrong with you?' but 'What has happened to you?' "*". The former referring to a descriptive approach and the latter aetiological.

The absence of a standardised or universal approach to diagnosis within psychodynamic therapy is also in stark contrast to the approach offered by the DSM, which is currently the predominant system within mental healthcare and diagnostic practice for children and adolescents in Aotearoa New Zealand. The DSM offers a standardised approach to diagnosis, with a focus on diagnostic label over diagnostic process. The provision of a diagnostic label, DSM or otherwise, can be therapeutic and it can also be harmful. The absence of a diagnostic label and a focus on only diagnostic process may allow for a client-centered process, however it may also at times feel confusing or directionless for patient and/or therapist. This underlines the need for an individually tailored approach that meets the specific needs of each patient and their whānau. What is beneficial for one, may be harmful for

another. The clinical implication being, rather than a focus on which diagnostic framework, a more productive position may instead focus on a renewed balance between diagnostic label and diagnostic process. Similar to an appreciation of the individual needs of the patient, this allows for the individual needs of the practitioner. Some practitioners may need to increase their focus on diagnostic process and being with the experience of the patient. Others may need to increase their focus on a diagnostic label or a diagnostic statement, which can offer containment and an anchor in the face of overwhelm for patient and therapist.

Encouraging a multiplicity of approaches from different fields of thought, cultures, or worldviews does come with a level of uncertainty and ambiguity. In our quest for security, certainty, and standardisation, this may at times feel intolerable. However, it does offer an opportunity to more fully enter into the world of the patient and to confront insecurities which may be preventing us from meeting the present experience more fully. A degree of maturity and a capacity to tolerate the intolerable is required in the face of distress. To hold complexity, rather than falling into reduction to a diagnostic label and the illusion of sure footing.

An important acknowledgement in naming the need for a balanced and well-considered diagnostic practice from practitioners, is the need for adequate resources. This includes an internal capacity of withholding judgement and maintaining a free-floating attention, a negative capacity. However, it also requires external resourcing: to be given adequate time to be able to be with patients and maintain a position of curiosity; to be in a culture which humbly acknowledges the need for revision and reformulation rather than the provision of a quick and confident answer. Both best practice psychiatric diagnosis (Huda, 2021; Puder, 2018) and best practice psychodynamic formulation (Johnstone & Dallos, 2013) hold ongoing assessment and an openness to revision as an ideal. Working within under-resourced and over-burdened healthcare systems may then be an important factor in the consideration of diagnostic best practice.

### **Clinical Implications**

This dissertation evidences the use of diagnostic practice throughout psychodynamic therapy with young people. This takes many forms, from the use of structured systems such as the PDM or OPD, a formulation-based approach (structured or unstructured), or the use of aetiological psychodynamic concepts. It offers a broad overview of diagnostic practice within psychodynamic therapy with young people which may help to orient the psychodynamic therapist to some of the available diagnostic frameworks and practices available for clinical use.

The distinction between the application of a diagnostic label and engagement in a diagnostic process is significant. Diagnosis in the current milieu of mental health largely refers to the former, which is

philosophically less compatible with a psychodynamic approach to therapy. This is due to biological psychiatry's emphasis on empiricism and the description of symptoms, compared to the aetiological focus of a psychodynamic approach. A focus on label over process may have led to the withdrawal of some psychodynamic therapists from an overt diagnostic practice. This dissertation speaks to the need for a renewed balance between label and process in diagnostic practice. This may represent a similar dichotomy to the discussion of categorical or dimensional, nomothetic or idiographic, objective or subjective. Independent of terminology, this need for renewed balance is evident within mental health overall, where international calls for a paradigm shift in diagnostic practice are long standing (Suris et al., 2016).

A personal clinical implication is the acknowledgement of the need for multiplicity in diagnostic practice. There have been times in my clinical work where a client has sought some form of diagnostic label that they have experienced as soothing, there have been other times where this has been distressing. Rather than attachment to any preferred diagnostic system or process, which all have their benefits and disadvantages, the unique needs of the patient should be the primary indicator of diagnostic decisions.

### **Limitations**

An assumption is made that the authors of the case studies reviewed are practising psychodynamically. To minimise this assumption the case studies all met the criteria of consisting of psychodynamic clinical work; and the training, professional memberships, and/or positions held indicate the first authors do practice psychodynamically. However, some authors were also trained in other modalities such as psychology or psychiatry and may utilise other psychological modalities. This may have influenced their diagnostic practice, and therefore the diagnostic practice reviewed within the case studies.

Both biomedical psychiatry and psychodynamic therapy are knowledgebases founded in WEIRD societies (Henrich, 2020). Approaches to diagnosis and diagnostic practice from a more representative range of cultures and fields of thought were not explored within this dissertation. Similarly, none of the case studies reviewed were from non-western populations or based in Aotearoa New Zealand. The scope to consider diagnostic practice within Te Ao Māori and indigenous healing would have greatly enriched this discussion.

There may be a bias within the case studies that have been published, compared to the majority of unpublished clinical work and diagnostic practice in day-to-day clinical work. Published case studies and/or practitioners that publish case studies may be more likely to use structured approaches to diagnostic practice, or more likely to include a conventional diagnostic label for the publication and inter-clinician communication.

Only a small number of case studies were reviewed and these were all case studies of clinical work with children and adolescents. There are aspects of the findings that therefore may not be generalisable to psychodynamic therapy with adults.

### **Indications for future research**

Further understanding the experience of children and adolescents who had been through a diagnostic process (DSM, PDT, or formulation based), at their current age and retrospectively from adulthood, would provide more understanding of the relative benefits and difficulties of diagnostic practice.

Exploration of diagnostic practice more specifically within Aotearoa New Zealand and Māori or Pasifika patients who have experienced a Westernised approach to diagnosis would provide value in decolonising mental health assessment and treatment, in addition to deepening our understanding of diagnostic best practice.

Case studies in this review used both structured and unstructured approaches to formulation. Similar to consideration of the balance between label and process, this raises the question of what level of structure may be favourable for treatment planning and process, outcomes, inter-clinician communication, research, or publication.

Surveying psychodynamic therapists directly may offer more direct insight into their diagnostic practice. This would also allow the elucidation of psychodynamic concepts that are used diagnostically, such as Melanie Klein's positions (Reubins & Reubins, 2018) or Anna Freud's levels of defence (McWilliams, 1994).

### **Conclusion**

This shift from dynamic to biological psychiatry and the hegemony of a categorical and symptom-based approach to diagnosis has had significant implications for mental health assessment and treatment globally, for practitioners from all training orientations. The hope for a genetic or biology

based treatment for mental illness held promise, and may still provide positive treatment developments (RDoC, 2023). However, the importance of a holistic or dynamic conceptualisation of mental health, and subsequently of assessment and treatment is evident in the negative experiences of many in our mental health system (Paterson et al., 2018) and the calls for change in diagnostic practice (Suris et al., 2016).

Throughout this process my rigidity has softened and I have found myself in a much more balanced position in regards to the utility of differing diagnostic systems. I feel this is in large part due to the loosening of the tight association I had between diagnosis and biomedical psychiatry. Rather than some concrete or objective quantification of mental illness and all of the possible presentations, I have come to view diagnosis more phenomenologically. As a description of something that is observed to be happening, a summary of the personal experience of the individual entwined with the training and experience of the practitioner. Subsequently I have been able to witness all the ways I use both a diagnostic process and diagnostic labels in my own practice with children and adolescents, as does the world of psychodynamic therapy. Unimpeded by the discussion of psychiatric or psychodynamic, the distinction between diagnostic process and label may provide a way forward.

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