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Dynamic Case Formulation of Child and Adolescent Personality: Meta-emotions and Defense Mechanisms

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Abstract

Behavioral Case Formulation (BCF) is one of the most important element of the empirical hypothesis-testing approach to clinical practice. The BCF as the second element of the clinical intervention (Assessing/diagnosing, Formulation, and Treatment) has two important level: [1] the level of symptoms/disorder or problem, and [2] level of the case or state. The aim of this review is to investigating and highlighting the dynamic formulation of defense mechanisms and meat emotions of child and adolescent personality. This is the essential object that has been neglected in the clinical practice of case formulation in psychotherapy and psychological counseling. The final conclusion is that, If the main purpose of the assessment is to allow the collaborative development of a formulation of the different biological, psychological and social factors into a description of the child's/adolescent's life and personality, it is very necessary to concentrate on defense mechanisms and meta-emotion in the dynamic case formulation (DCF) for successful treatment

Keywords: *Dynamic Case Formulation; Defense Mechanisms; Meta-emotions; Child and Adolescent Personality*

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Introduction

It has been described that maximally effective clinical intervention is dependent upon a accurate understanding of the factors and variables that cause and maintain disordered behavior. The behavioral formulation of clinical phenomena that provides the framework for idiographic adaptation of empirical procedures and approaches. Theoretical understanding is necessary but by itself is in sufficient, for a thorough conceptual consideration the reader is referred to earlier publications and researches (Wolpe, 1982). The practice of behavior therapy is an idiographic approach to clinical phenomena based on scientific principles, and before the specialist can test a hypothesis in the laboratory, he must first be able to specify the relevant independent and dependent variables in precise detail. In clinical arena, one must do the same in order to develop an appropriate intervention methodology. Thus, the major prerequisite for successful treatment is an accurate understanding of the client's problems. The framework for behavioral case formulation (BCF) demands that the clinician "put himself in the line" by continually creating and evaluating specific testable hypothesis concerning the client's problem (Wolpe, & Turkat,1985).

Formulation is a topic that is attracting an increasing amount of attention in psychotherapy and counseling. Although it is arguably central to the implementation of any psychological intervention, it has until recently been a neglected area of research, Publication and psychological training. A formulation has to convey relevant signs and symptoms as well as pertinent negatives (i.e., key absent symptoms) ; provide meaningful, explanatory contexts for these signs and symptoms, including familial, social, educational, and cultural contexts; justify diagnoses (or no diagnosis, if warranted); and describe treatment options based on the diagnostic considerations (Johnstone L and Dallos 2006).

The core components informing a diagnostic formulation tend to follow a standard trajectory with common signposts to guide the reader: referral source, identifying information, history of present illness, significant past psychiatric and medical histories, psychosocial contexts, mental status, diagnostic considerations, and treatment planning.

BCF is one of the most important element of the empirical hypothesis-testing approach to clinical practice. BCF has three key elements, assessment, formulation, and intervention. Information obtained during assessment is used to develop a formulation, which is a hypothesis about the causes of the patient's disorders and problems, and which is used as the basis for intervention. As the treatment proceeds, the therapist doubles back repeatedly to the assessment phase, collecting data to monitor the process and progress of the therapy and using those data to revise the formulation and intervention as needed. The BCF as the second element of the clinical intervention has two important level: [1] the level of symptoms (such as auditory hallucinations), disorder such as (major depressive disorder) or problem (such as, non-treatment compliance), and [4] level of the case, (Crellin, 1998, Tarrier, and Calam, 2002).

A useful method of formulation involves developing an understanding of the following five areas:

- **Problems:** shared view of the main difficulties with the patient wishes help
- **Predisposing factors:** factors from earlier life, which increase vulnerability in adult life
- **Precipitating factors:** factors currently or recently present in the patient's life, which can or have contributed to triggering the problems
- **Perpetuating factors:** factors, which contribute to maintaining the problems
- **Protective factors:** factors, which contribute to resilience and the ability to cope with adversity. (McGrath, and Margison, 2000, Johnstone,L and Dallos, 2006).

The main purpose of assessment is to allow the collaborative development of a formulation of the different biological, psychological and social factors into a description of the patient's life and personality which helps explain current problems and symptoms and identifies which problems, themes and goals will be the focus of treatment. The style and emphasis of formulation will vary according to the specific purpose or intervention but relevant information for the formulation includes:

A- Clinical formulation including: 1-Symptoms (Cognitive/perceptual, Affective, Interpersonal), 2-Relationship with self/sense of self, 3- Interpersonal relationships

4-Relationship with society.

B- *Behavioral/impulse control* (Important personality traits, Personal strengths, Over- and under-developed behaviors, Relevant core beliefs, Relevant, developmental events such as childhood trauma).

C- *Treatment plan:* (Interventions and approaches by phase of recovery (including self-management approaches, Short term and long term goals, Risk management plans, crisis plans). (Tarrier, and Calam, 2002, Aveline, 1999).

The quality of specific clinical formulations, and the quality of the general theoretical models used in those formulations, can be evaluated with criteria such as: [21]

- *Clarity and parsimony:* Is the model understandable and internally consistent, and are key concepts discrete, specific, and non-redundant?
- *Precision and testability:* Does the model produce testable hypotheses, with operationally defined and measurable concepts?
- *Empirical adequacy:* Are the posited mechanisms within the model empirically validated?
- *Comprehensiveness and generalizability:* Is the model holistic enough to apply across a range of clinical phenomena?

Utility and applied value: Does it facilitate shared meaning making between clinician and client, and are interventions based on the model shown to be effective?

The ways that psychodynamic therapists interact with the parents of children in psychotherapy take many forms. Goals of parent guidance are to assist parents to provide the frame for the child's treatment and to support parents 'capacities through helping them increase their understanding of their child's internal world and developmental needs. Although I am focusing on psychodynamic child therapy (rather than child analysis), I start by examining the psychoanalytic roots of parent work. There are a few comprehensive reviews of the history of psychoanalytic parent work that highlight the relative neglect of parents in the literature on child psychotherapy, suggesting that a combination of factors led to a minimizing of parent work in clinical theory development (McGrath, and Margison, 2000).

One factor was that the intrapsychic nature of early psychoanalytic theory did not emphasize the influence of parents (and the external world) on the child's psyche. In addition, early child analysts tended to model their theories after emerging adult models of psychoanalysis, leaving little room for the exploration of parent roles and family dynamics (Crellin, 1998, Tarrier, and Calam, 2002).

This translated into a historical tendency within psychoanalytic training programs to minimize parent work. When parent work is minimized in theory and training, it is evidently followed by a lack of focus in seminars, scholarly articles, and supervision emphasizing parent work-ultimately influencing clinical work with children (Siskind, 1997). Without a framework within which to conceptualize the role of parents in a child's life and in child psychotherapy, powerful counter transference's can emerge, such as rescue fantasies on the part of the therapist or a desire to be a "better parent" to the child than the real parents.

Personality component includes two primary constructs:

First, Functional construct: [1] Physical/somatic elements (Physiological systems such as nervous system and brain function, endocrine systems…), [2] Cognitive processes (mental functions such as memory, perception, attention, problems-solving…), [3] Emotions/affects (such as anger, fear, pleasure…), Social elements (such as social interaction, attitudes, Friends…).

Second, dynamic construct, which includes Needs/motivation, conflicts, stage of consciousness, and unconsciousness, anxiety, defense mechanisms. (Abdulla, 2016). Case formulation should be contain all elements aspects/determinants of personality when we go on for assessing the case of the client. On the other hand, diagnosis defined as "full understanding of the client". Psychotherapists and interviewer through behavioral case formulation should implement assessing instrument of the dynamic foundations and elements of child and adolescent personality (Abdullah, 2014). When the formulation should be included the thought, emotions, behaviors and social context of client in integrated form and scientific model, it is very important to refer to psychodynamic of defense mechanisms and meta emotions of the client case that have been neglected in psychological research and investigations. The central aim of this study is to examine and review the Dynamic Case Formulation (DCF) of defense mechanisms and meta-emotions of children and adolescent in psychotherapy and counseling practice.

Dynamic case formulation of defense mechanisms in child and adolescent personality:

Defense mechanisms: Defense mechanisms are related to emotions, needs, conflicts, and other elements in psychodynamic construct of personality. Brenner (1982) clarified that, clinically, every affect is made up of [1] a sensation, and [2] a thought. We then define defense as the mental operation that shuts out of consciousness the sensation, the thought, or sometimes both. Shutting the thought

content out of consciousness is called "*repression*" (if you do not realize you are forgetting). Shutting out the sensation is termed "*isolation*" or "isolation of affect" (again, if you don't know you redoing this). If you are aware of trying to forget, most analysts name this "*suppression*".

The concept of defense starts with the common-sense observation that most people tend to avoid things that are unpleasant unless they, for some reason, cannot do so. We can then define defense as a sort of circuit breaker brought into play by the brain to guard against pleasurable affects associated with reality or with unconscious inner conflict. Defense (everything from *garrulousness to reticence*) acts to shut some aspect of mental contents out of consciousness. When those contents are stored in memory, they can often be retrieved, as during interpretive therapy.

Defenses, although present in severe mental illnesses (psychoses and near psychoses), are not the cause of such disturbances, and interpretation of them is generally not part of the treatment approach. Defense theory, on the other hand, facilitates diagnosis of people who do not show much deficit in basic mental functions; highlighting defenses for those people can be extremely useful to them in rethinking their problems and reorganizing their thoughts and actions (Blackman, 2011).

Mature defense mechanisms are often the most constructive and helpful to most adults, but may require practice and effort to put into daily use. While primitive defense mechanisms do little to try to resolve underlying issues or problems, mature defenses are more focused on, helping person be a more constructive component of their environment. People with more mature defenses tend to be more at peace with themselves and those around them.

Dynamic case formulation of defense mechanisms in personality: Psychologists have categorized defense mechanisms based upon how primitive they are. The more primitive a defense mechanism, the less effective it works for a person over the long-term. However, more primitive defense mechanisms are usually very effective short-term, and hence are favored by many people and children especially (when such primitive defense mechanisms are first learned). Adults who do not learn better ways of coping with stress or traumatic events in their lives will often resort to such primitive defense mechanisms as well. Most defense mechanisms are unconscious – that means most of us do not realize we 'reusing them in the moment. Some types of psychotherapy can help a person become aware of what defense mechanisms they are using, how effective they are, and how to use less primitive and more effective mechanisms in the future (Grohol, 2017).

When formulating the dynamic case, the clinician should be realize the following properties of defense mechanisms (Abdulla, 2016):

1. Universal.
2. Undirected coping responses.
3. Unconsciousness.
4. Have two levels: (1) Normal (2) Abnormal. Defense mechanisms when have been used extremely, can lead to abnormality and be unadaptive behavior and predisposing child/adolescent to mental disorders.
5. Responses to cope with:
    - Anxiety (fear, and unknown threaten objects).
    - Conflicts (Approach-Approach Conflict, Avoidance-Avoidance Conflict, Approach-Avoidance Conflict, Double Approach-Avoidance Conflicts, unconsciousness conflict).
    - Frustration (Internal/External, Primary/Secondary, Positive/Negative).

The most implemented mechanisms among children and adolescents are: regression, repression, displacement, undoing, daydreaming, identification, intellectualization, denial, projection, sublimation, reaction formation, rationalization, compensation. These mechanisms have been illustrated in table (1), with description and examples.

Mechanism	Description	Example
Repression	-Repression is an unconscious mechanism employed by ego to disturbing or threatening thoughts from becoming conscious. It is unknowingly placing an unpleasant memory or thought in the unconsciousness	-During the oedipus complex aggressive thoughts about the same parents are repressed. -Not remembering a traumatic incident in which you witnessed a crime
Denial	Denial involves blocking external events from awareness. If some situation is just too much to handle, the person just refuses to experience it	Smokers may refuse to admit to themselves that smoking is bad for health
Projection	This involves individual attributing their own unacceptable thoughts, feeling and motives to another person. It is attributing one's own unacceptable feeling and thought to other and not yourself.	- You might hate someone, but your superego tells you that such hatred is unacceptable. You can "solve" the problem by believing that they hate you. - Accusing your boyfriend of cheating on you because you have felt like cheating on him
Displacement	Satisfying an impulse (e.g. aggression) with a substitute object. Redirecting unacceptable feeling from the original source to safer, substitute target.	- Someone who is frustrated by his /her boss at work may go home and kick the dog. - Taking your anger toward your boss out on your spouse or children by yelling at them and not your boss.
Sublimation	Satisfying an impulse (e.g. aggression) with substitute object. In socially acceptable way. It is replacing socially unacceptable impulses or motives with socially acceptable behaviors.	-Sport is an example of putting our emotion or aggression into something constructive. - channeling aggressive drives into playing football or inappropriate sexual desires into art.
Repression	This is the movement back in psychological time when one is faced with stress and anxiety. It is reverting to immature behavior from an earlier stage of development.	- A child may begin to suck their thumb again or wet the bed when they need to spend some time in the hospital. - Throwing temper tantrums as an adult when you do not get your way.
Reaction formation	Acting in exactly the opposite way to one's unacceptable impulses or drives.	Being overprotective of and lavishing attention on an unwanted child
Rationalization	Creating false excuses for one's unacceptable feeling, thoughts, or behaviors. The person creates a socially acceptable reason for an action that actually reflects unacceptable object of motives	-Justifying cheating on an exam by saying that everyone else cheats. - A students explains away poor by citing the importance of the total experience of doing to college and claiming that too much emphasis on grades would actually interfere with a well-rounded education.
Identification	It is process of borrowing or merging one's identity with that of someone else.	The abused child identifies himself with an abuser.
Undoing	A form of unconscious repentance that involves neutralizing or atoning for an unacceptable action or thought with a second action or thought.	A women who gets a tax refund by cheating on her taxes makes a larger-than-usual donation to the church collection on the following Sunday.
Intellectualization	Person represses emotional reactions in favor of overly logical response to a problem.	A woman who has been beaten and raped gives a detached, methodical description of the effects that such attacks may have on victims.
Compensation	Making up for weakness in one area by achieving in another	Trying to get an in your other classes because you are doing poorly in math.
Daydreaming	Imagining pleasant things or objects/events that take your mind off the unpleasant reality.	Daydreaming in detention about what it will be like when you graduate and when teachers tell you what to do anymore.

Table 1: *Child and Adolescent's Defenses Mechanisms, Description and Examples.*

Pinterest: Explore Psychology Experiments, AP Psychology and more (2017), Grohol, (2017), Abdullah (2016).

Applying a complex theory such as psychoanalysis on a daily basis contains its own set of risks, but its value is undeniable. Psychoanalysis makes it easier to grasp and understand (in itself a difficult task) our behavior. Analyzing human behavior through the defense mechanisms expressed by others allows us to acquire a great deal of knowledge about ourselves and to mediate unproductive aspects of our own personality to achieve personal growth. Dominique Friard defended this approach when he wrote: "The study of defense mechanisms goes beyond that of psychopathology and psychotherapy. The study of defense mechanisms is common in areas such as prevention (including that of aggressive behavior and violence), health education, medicine for physical disorders or the hiring of human resources." (Friard, 2007).

Identifying and measuring defense mechanisms are important elements in psychotherapy for dealing with personality disorders. The expression of defense mechanisms reflects the hypothesis that they obnubilate significant problems.

Various scales exist to measure defense mechanisms. Perry's Defense Mechanism Rating Scale (DMRS) makes it possible to monitor the evolution of patients undergoing therapy based on the expression and intensity of defense mechanisms. These tools allow for a more thorough clinical assessment.

Each type of mechanism expressed exposes its own set of character features, needs and behaviors. For example, projection reveals a suspicious personality expressed through excessive sensitivity, an inability to forgive others' mistakes, negatively interpreting events or other people's behavior, unjustifiable suspicion towards others, and overemphasizing one's rights and self-importance.

Certain defense mechanisms have an adaptive function and are thus identified as mature mechanisms. "Healthy" individuals in normal situations use them. On the other hand, immature defense mechanisms are more defensive in general and are characteristic of higher levels of distress.

Certain defense mechanisms are effective in controlling anxiety and protecting individuals from suffering, whereas others are inadequate and when used in a repetitive, compulsive manner. They thus become counter-productive. Defense mechanisms are not the cause of a given pathology; the individual's use of the mechanisms is (i.e. frequency, intensity or context). Defense mechanisms are beneficial when they help an individual adapt to or tolerate difficult situations. These mechanisms become counter-productive when they cloud an individual's awareness, cut him off from reality, or undermine his functioning and relationships (Phaneuf, 2006).

From neurobiological perspective, it has been described that affects, generated in the limbic system and hippocampus, are shut off by the defense mechanisms (of suppression and repression) in the prefrontal (cerebral) cortex. On the other hand, it has been evidenced that neural correlates of attachment, as well as brain mechanisms associated with anxiety, and the limbic system and the hippocampal gyrus are implicated regarding affects or emotions (Berlin & Kock, 2011).

Dynamic Case formulation (DCF) of meta-emotion in child & adolescent personality:

Meta-emotions: Meta-emotion is "an organized and structured set of emotions and cognitions about the emotions, both one's own emotions and the emotions of others". This broad definition of meta-emotion sparked psychologists' interest in the topic, particularly regarding parental meta-emotion philosophy.

The concept of "met-emotion" is "emotion about emotion," and is parallel to meta-cognition, "cognition about cognition," in that they are involved in the executive control of emotion and cognition, respectively. However, few attempts have been made to explicitly draw parallels between the two research areas. Broadly define meta-emotion as emotional reactions about one's "emotional self." Meta-emotion has a regulatory function, and that its phenomenological quality (e.g., anxiety, anger, compassion) reflects qualities of self-regulation, for example, its associated motivation and action tendency. Gottman J. M., Katz L. F., Hooven C. (1996). In a nonclinical sample, they found that individual differences in meta-emotion predicted subjective well-being over and above the related variables trait mindfulness and experiential avoidance. In this study, meta-emotion was measured with the Meta-Emotion Scale, a self-report

questionnaire assessing six components of meta-emotion (anger, compassionate care, interest, contempt/shame, thought control, and suppression) (Norman & Fumes, 2014).

We all have an emotional history, which comes from our upbringing and the emotional climate in that home. Some grew up in an "emotion coaching" home where feelings were encouraged and validated, where it was okay to cry and be sad, and where it was okay to be angry. Others grew up in an "emotion dismissing" home where feelings were discouraged. These kids are told, "don't be sad" or "you'll get over it" or "boys don't cry." This emotional climate makes it difficult for people to connect with their own emotions as adults, and makes it difficult to validate emotions in others. One thing that can create major problems in a relationship is a meta-emotion mismatch between partners. Meta-emotions are how you feel about your feelings. (Gottman J. M., Katz L. F., Hooven C. (1996)

Meta-emotion refers to the idea that whenever we elicit a certain emotion, we also deal with subsequent emotions regarding how we experienced the primary emotion. While some psychologists have examined the influence of meta-emotions on how individuals interpret and deal with their own and others' emotions, much of the literature regarding meta-emotion has focused on how parental meta-emotion influences the social-emotional development of their children. Meta-emotions can be short-term or long-term. (Bartsch, Vorderer, Mangold, Viehoff, 2008).

Dynamic Case formulation of meta-emotions: The formulation of case meta-emtion construct focused on the three proposed facets are taken into account:

1. Meta-emotion experiences: meta-emotion is often described as a "meta-level) experience in ongoing emotional experiences, with its phenomenological qualities being as differentiated as those of primary emotional experience.e.g., "I repeatedly get angry about my emotional reactions").
2. Emotional strategies: it is focused on the control/regulatory function of meta-emotion that play an important role in control of emotion, regulatory and reflexivity." (e.g., "I repeatedly force myself to pull myself together") and suppression (e.g., "I cannot come to grips with strong emotions").
3. Meta-emotional Knowledge: An organized set of thoughts about emotions seems parallel to meta-cognitive knowledge, which refers to people's declarative knowledge about cognitive processes. One suggestion would therefore be to categorize this form of meta-emotion as meta-emotional knowledge. Declarative meta-cognitive knowledge can further be subdivided into different knowledge areas, for example, between knowledge of self and others, and knowledge of task and context. For example, teach and give children feedback about the duration and progression of emotions, and which emotions are appropriate or normal in a given situation, (Norman & Fumes, 2014).

DCF of menta-emotion for assessing child and adolescent should contain self-report terms such as the following: " I generally view being emotional as being out of control", " I try not to think much about my own emotional states."," I try to get over sadness quickly so I can move on to better things"," People cannot be very rational if they are being emotional"," I think expressing emotion is okay only if it is in control"," I just don't think people should ever show their anger"," Anger is always a very toxic emotion"," sadness is form of weakness"," I don't feel comfortable with outward displays of love".

When assessing child and adolescent in DCF, the clinician /psychologist must understand the philosophy and the history of basic emotions:

1. **Anger:** What is the history of your experience with the emotion of anger? Could you tell if your parents were angry? What was this experience like for you? Could your parents tell if you were angry? How did they react to your anger? Who could be angry in your family? Who was the "angriest" person? What was it like in your family growing up?
2. **Sadness:** What is the history of your experience with the emotion of sadness? Could you tell if your parents were sad? What was this experience like for you? Could your parents tell if you were sad? How did they react to your sadness? Who could be sad in your family? Who was the "saddest" person? How do you deal with one another's sadness or when one of you is a little blue in this partnership? What was it like in your family growing up?

3. **Fear:** What is the history of your experience with the emotion of fear? How did your family respond when you felt insecure? Could you tell if your parents were afraid? What was this experience like for you? Could your parents tell if you were afraid or worried? How did they react to your fears? Who could be frightened in your family? Who was the "most afraid" person in your family? How do you deal with one another's worries and fears in this partnership? What was it like in your family growing up?
4. **Love:** What is the history of your experience with the emotion of love? How did your parents show you that they loved you? Was your family growing up very affectionate? What was this experience like for you? Could your parents tell if you needed affection? How did they react to your need for affection and love? How do you show each other that you love one another in this relationship? What was it like in your family growing up?
5. **Pride:** What is the history of your experience with the emotion of pride? How did your parents show you that they were proud of you? Could your parents tell if your parents were proud of your accomplishments? What was this experience like for you?? Could your parents tell if you wanted them to be proud of you? How did they react to your achievements and triumphs? How does your partner express pride in you? Do you express pride in your partner? What was it like in your family growing up? (John & Gottman, 2011).

Someone who is comfortable with emotion will be able to support and validate their partner's feelings, while also freely expressing their own sadness, fear, disappointment, and joy.

This area of meta-emotion is probably characterized by great variability even in laboratory experiments that elicit emotions. Researchers have reported large variability in results from laboratory experiments designed to elicit emotion, such as the startle response. Ekman, Friesen, and Simons (1985) reported a consistent set of responses across participants to being startled, but there were huge individual differences in the emotional response to having been startled, that is, in people's meta-emotions to the startle, other researchers reported a similar set of results. Meta-emotion may be a pervasive and understudied dimension in emotion research, (Efklides) (2008).

Conclusions & Recommendations

Behavioral case formulation first described by psychotherapist for assessing and diagnosing the client's personality and understanding the factors influence them. It has been implemented in behavioral-cognitive therapy for treating mental disorders especially "anxiety disorders". The precisely and good understanding personality in clinical and social practice encourage clinician to direct attention to the dynamic foundation and construct of child and adolescent personality. This research review has important implications for child and adolescent psychotherapy and good understanding of their personality in the social context.

The review direct our attention to the dynamic elements of child and adolescent personality in social, educational and clinical practice, and many variable and factors should be impact on this state or case formulation. Finally, the assessing child and adolescent metal health and well-being rest on scoring the adolescent manner, emotional experience and defense responses and behaviors.

I propose to use "Dynamic Case Formulation" when concentrating on the defense mechanisms and meta-emotion as essential factors that predisposing and maintaining the symptoms of the disorders/problems in the child and adolescent personality.

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