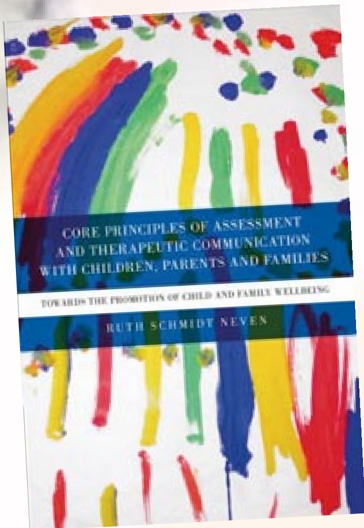
On assessment and other matters

CCYP interviews Ruth Schmidt Neven, Director of the Centre for Child and Family Development in Melbourne, Australia, and author of a new book, *Core Principles of Assessment and Therapeutic Communication with Children, Parents and Families*[1]



You have more than four decades of experience in the UK and Australia to draw on. One thing that struck me forcefully as I read your book is that you are opposed to the current trend of assessing to the rulebook, which tends to pathologise the behaviour of children. Can you tell us briefly what you see as the negative implications of deficit and reductionist models in assessment?

I think these models fly in the face of any good assessment, and particularly good *therapeutic* communication, because a good assessment should not start with uncovering pathology but with understanding the meaning of behaviour. So the trend in child and adolescent mental health services of giving everyone a diagnosis is very worrying, because it has little to do with the child and a great deal to do with economic rationalism.

Another thing is that it introduces a conservative medical model that is perfectly appropriate for thinking about illnesses in the body but is absolutely not appropriate for thinking about a child in the context of the family and the wider environment. Rather than struggling to fit a child into an existing diagnosis, what we want to be looking to do – and this has somehow flown out of the window – is, first of all, to ask about the meaning of their behaviour and then arrive at a formulation rather than a diagnosis. What is actually going on? Why is the child behaving the way they are? How can we understand that in terms of their personal relationships with the most important people in their lives, namely their family?

The other important feature of working towards a formulation of the problem is that we can create a hypothesis that doesn't have to be proven every moment as being totally correct. We can discard the initial hypothesis or it can be enriched by our further experience of the child and the family. The idea that you're going to have a diagnosis that is infallible on the basis of seeing the child once or twice is completely unrealistic. I'd go as far as to say that a medical-type diagnosis – and a lot of child and adolescent mental health services go down the road of what I'd say was a 1950s medical model – really has no place in our work. I believe it actually promotes mental ill health because it doesn't get to the bottom of the problem. And of course the other thing is that if these diagnoses were truly accurate, we'd find a reduction in mental health problems. But there's an increase. That's partly because we're living in a changing world and there are many challenging issues, but also it's because we're not working in the right way. We're not offering the right sort of service to children and adolescents, or to their parents and families.

Is this as widespread in Australia as it is in the UK?

Absolutely. Psychology in Australia is mainly seen in terms of the behavioural. Australia is a very pragmatic society, very good at inventing practical things; they see themselves as down-to-earth. So there's not a lot of psychodynamic work, although where it's around, there's actually a lot of interest. But certainly, the child and adolescent mental health services are dominated by 'all children must have a diagnosis'. And, of course, the diagnosis is very limited, reductionist and old-fashioned.

Is this in any way related to the current pressure to use so-called evidence-based practice? Approved treatments for stated diagnoses etc.

I've always assumed that 'evidence' needed to be understood as 'truth'; that it was really about understanding what we see and the truth of our experience. But I think a lot of evidence-based practice is actually old hat – reconstituted 1950s old-fashioned notions about children. It's about privileging a very limited form of evidence. One of the worrying things I find is, for example, that family therapy evidence hardly seems to be around any more. When we talk about ADD and other abbreviated terms for children's disorders, such as ODD, it sounds as if being naughty has to have a syndrome! We don't seem to be using 50 to 60 years of evidence from family therapy about the role of the child, the role of the scapegoat etc. There's a huge amount of literature on that.

We've also got more than 100 years of good sound *clinical* evidence, a huge amount of understanding about developmental psychology. There's also a lot of interest in the brain concerning the impact of developmental and environmental experience, but this does not seem to have filtered through to evidence-based practice. One of the main reasons for this is that there is a worrying tendency to want to split the brain from the mind, as though we're talking about a machine rather than consciousness or the unconscious, or invention or creativity, or

fantasy or motivation or connecting things up. So in a sense we're living in a very reductionist world where things are broken down into their smallest element and highly fragmented.

Which is presumably why you advocate broadening the assessment to the child's wider family and social context. I was intrigued by your phrase 'the child speaks the family'. Can you elaborate?

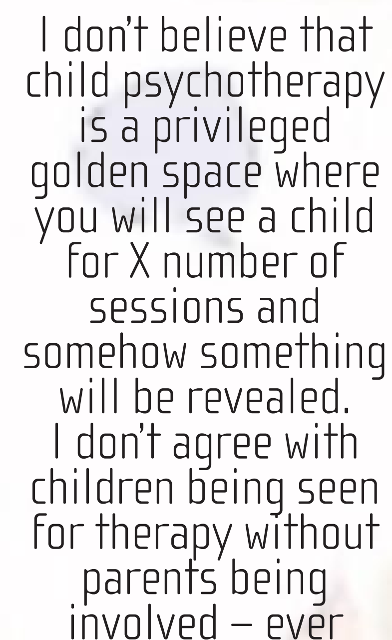
I believe that the child always speaks the family, which is why the child's behaviour, however annoying and irritating, always has meaning, because the child lives in the family and is utterly dependent on them. It's a bit like Winnicott's concept of the infant looking at the mother and seeing himself. The baby can't look in the mirror and say, 'Well I'm a fine figure of a baby and I'm really doing rather well.' This also extrapolates to older children. So the sense of self of the child is continually reflected in how the family reacts to them. The other thing, of course, is that the child often speaks through their behaviour the unpalatable truths about family tensions. When I first came to Australia, I worked at the Royal Children's Hospital. I was the inaugural chief psychotherapist, and I saw symptomatology that I'd only ever read about in Freud's case studies – examples of what I think he called conversion hysteria. Children who believed themselves to have an organic disease or paralysis would turn up in wheelchairs. Almost as a rule of thumb, we could deduce that the extent to which the child had to develop a physical symptom was in direct relation to how far emotional issues could not be talked about in the family. The child is left with only their body, and the body has to speak. In almost all these cases, we found the family had enormous secrets, some related to abusive experiences or family tensions they didn't want to have uncovered. You can work out from symptomatology that has no organic base that something extraordinary is going on in the family dynamic and the child's relationship with the parents. You might call it a gap in the discourse – so the child's behaviour can be seen as trying to fill that gap, trying to explain what is really going on, whether the family is too cut off from it, or secretive about it, or simply too busy to attend to it.

How far would you go, then, in saying that no effective therapy can be done one to one? You say in the book that the ultimate aim of therapy with a young person is to open up communication with caregivers.

Well, I don't believe you can ever, or should ever, see a child in isolation from their parents. I don't believe that child psychotherapy is a privileged golden space where you will see a child for X number of sessions and somehow something will be revealed. And I know, when saying that, that some of my colleagues may be horrified, but I have to say that I can't work in the way I was trained, much as I value that training. When I look back on those child clients, I think that so much more effective work could have been carried out if we'd worked with the child and parents together. We could have saved so much time and anguish and been more helpful to the child. That may be a sacrilegious thing to say but I'm going to say it because I do believe very strongly that we have to find a different way of conceptualising what's happening for children and parents. Some of my colleagues might say, 'If only this child had endless therapy, that would be the answer,' but I don't agree with that. I don't agree with children being seen for therapy without parents being involved – ever. I don't feel it's an authentic way to operate. There may be children in foster care, of course, where the parents are not available, but even then, you have to work with the people who are *in loco parentis*.

What about those who self-refer and are what we term 'Gillick competent' in the UK? They understand what therapy is and/or want to exercise their right to confidentiality.

I think we need to consider each case individually. I still believe that the best outcome is achieved when we engage parents wherever possible, because the young person will benefit most from an opportunity to resolve conflict or differences with their families in order to move on in their development. Even where this is not possible, there needs to be a reference point for the young person that acknowledges their need to be understood by the people who have been most important in their lives.



I don't believe that child psychotherapy is a privileged golden space where you will see a child for X number of sessions and somehow something will be revealed. I don't agree with children being seen for therapy without parents being involved – ever

> The child always speaks the family, which is why the child's behaviour, however annoying and irritating, always has meaning

OK, agreed, so good assessment hinges essentially on engaging the whole family, not just the child alone. Can you explain why you believe it's important for counsellors and other professionals to think psychodynamically and developmentally when assessing a presenting situation, even if they are not initially trained that way?

Developmental understanding is foundational to this work. No other profession would tolerate such an obvious gap in relevant knowledge. You can't be a doctor, for instance, without having a baseline understanding of anatomy and physiology, yet professionals who push children into boxes have no understanding of developmental psychology, which is essential. I think this has to be introduced into training and be a major feature for anyone who is going to specialise in child counselling. I'm referring to the emotional/psychological milestones of development, not the mechanical, physiological ones. The information is all out there; it just has to be pulled together and introduced into courses. I have been running a Foundation Course in Child and Family Development in Australia for many years, which I also ran this year at the University of Cambridge Child Wellbeing Forum in the Faculty of Education. I will be running a further course in Cambridge in April next year[2], based on the book.

I believe people shouldn't just jump into counselling, particularly with children, if they don't have that developmental understanding as a baseline. Otherwise, the child is at the mercy of whoever is attached to a particular treatment mode. The child or adolescent and their parents benefit most from a separate assessment process that does not conflate *assessment* and *treatment*. Both psychoanalysis and cognitive behavioural therapy do this. The psychoanalytically trained person may be viewing the child in terms of long-term therapy, which may not be appropriate. And the behavioural therapist tends to view things in relation to the presenting problem and how they can fix it or provide strategies. I saw a family about a child with a toileting problem. Other professionals had seen them and taken the problem at face value, instead of seeing it as resonating with what might be lying underneath. Behavioural therapy hadn't worked and the child was highly resistant. It turned out that the mother had major problems after the birth and this linked in with many other difficulties the child had, besides the toileting one. So you can't take one problem out of context. You have to see the problem all of a piece and also in terms of the history. It was an example of how an enormous amount of time had been wasted because of something very simple that hadn't been done – linking the present with the past in the most basic way. It's unethical, really, and I think we're going into an area where ethics and the rights of the child have to be considered and not compromised. With ADHD, for instance, we find that there may be very high levels of anxiety on the part of the child and very appropriate behaviour in response to intolerable situations. This is described in my book *Rethinking ADHD*[3], which I wrote with two neuro-psychologist colleagues and which exemplifies taking a wider perspective on the presenting problem.

So we need to look further than Ritalin initially! Can you give us some idea of what contributes to a good assessment?

I can give you some pointers but that doesn't mean it's the only way to do it. The first thing is it's enormously important to have the right people available. We don't want to have an 'immaculate conception' discourse! There are so many women involved in psychotherapy and counselling that they tend to feel that they'll just 'see the woman', and of course they then get only one slice of what's going on. Children need to have fathers as well as mothers present, and we work very hard for that. If you have a conviction about that, it's amazing how many fathers will come along. Where fathers are present, it's 'value added', and why would we not exploit that or take advantage of it? It helps the therapeutic process in leaps and bounds and makes a difference to the child. I always see the parents alone before I see them with the child, and I always try to get what I call an emotional history of the child and the parents. You get incredible things said such as, 'Oh nothing much happened to me; my father died and then my mother left…' – all said in a monotonous tone that we might miss. And that's their intention quite often – it's history that hasn't been metabolised, and therefore already has a bearing on the child's problem. So the child not only speaks the family but very often speaks the parents' history too.

So you want the right people there and an emotional history of the child and parents. What then?

We work out how to approach the assessment with the child, because by then the parents are hopefully already on side as allies of the therapeutic process rather than dependent people wanting me to provide an answer. We're already working as a team. Ultimately, my aim as a child psychotherapist and psychologist is not to have a wonderful relationship with the child but to help the child have a good relationship with the parents. I facilitate the communication with the parents. I'm not suggesting other forms of therapy are not appropriate, just that long-term psychoanalytic therapy, for instance, should not automatically be assumed to be the best option until we have assessed carefully that *only* that kind of therapy is needed. By the same token, sometimes we may find that *some* behavioural modification techniques could be useful. But they should follow as a *treatment* – neither of those positions should have a place in how one *assesses* the situation. Although, in the kind of assessment I talk about, I do take a psychodynamic view because it's about the meaning of behaviour, about what lies below the surface, history, early experience etc – and that isn't necessarily what you'd find in a cognitive-behavioural framework.

Attachment issues can present in the assessment phase. You are pretty fierce when writing about attachment, claiming that the word has become distorted in its popular incarnation. How so?

Attachment is an important bridging concept for people working in different modes. Many people in the behavioural, organic side of child psychiatry or psychology will accept the idea because it's been soundly researched. But it's very interesting that in all the evidence base that people talk about, it doesn't play a very big role, and I'm not quite sure why. There are so many people in the UK who promote it and write brilliantly about it, that it's got to get into the evidence base. I think it's irrefutable that there's not a lot of challenge to it and one can't undermine it as a concept.

So yes, I am a little bit fierce about it because I get a bit annoyed when I hear a mother say, 'I choose to be an attachment parent,' for instance, as though she's going to give the child the gift of attachment. If the child's not attached, the child's not going to live. It's not an add-on or a luxury! And it suggests the baby comes into the world as a blank space, and the mother or the father can make a decision. Whereas what I try to say in the book is that from the word go, and even before, the baby is a partner. Daniel Stern puts it very well when he points out that the baby is a partner in shaping his or her future relationships. So the baby comes into the world with a formidable capacity for relationship and connection. It's in the DNA – there's a physiological basis for all of this. It's the ultimate psychosomatic experience.

The idea of containment links in here, doesn't it, and comes up frequently in your book. You speak of this as offering an empathic transformative experience for the client. Can you unpack this a bit more?

It's about the task of the mother to be able to respond to everything the baby presents, including pain, anxiety, depression etc. It's not just feeding and watering, not just mechanical. It's about the mother transforming the distress of the baby into a more tolerable experience, as Wilfred Bion has described it. But it's not enough for the mother to contain her baby. She has to be contained by her partner and they in turn have to be contained by others – so we can see containment as a kind of emotional ecology. But when we transfer that to the professional setting, we therapists are burdened by the idea that we must provide an answer. And that is the problem. That is where assessment goes awry. Because, certainly in the assessment process, and I would say in the therapeutic process too, our job is never to provide an answer but to be able to assist families to find the answer or insight that is correct for them. It's very hard work and it's very active work. Not 'just listening' or 'witnessing' or 'bearing testament'. That's not enough, not at all what I'm suggesting. That has no place in psychotherapy or counselling. What we have to do – the hard work – is to *contain* their anxiety so they can listen to themselves and their children and do the work of therapy and find answers that are right for them. When we blurt out an answer or come up with a strategy, it's very short-lived. Its use-by date has expired by the time it leaves our lips! It suggests that behaviour can be frozen in time, whereas of course it can't.

So the assessment period is filled with anxiety (theirs and ours!) and needs containment. Because

My aim as a child psychotherapist and psychologist is not to have a wonderful relationship with the child but to help the child have a good relationship with the parents

The assessment period is filled with anxiety and needs containment. Because what we're hoping to open up is a process – which takes us completely away from the medical model of repair and cure

what we're hoping to open up is a *process* – which takes us completely away from the medical model of repair and cure. Fixing a broken arm is finite, but our work with children and families can't be finite. People come back to see me sometimes with younger children, sometimes to talk about some further aspect of the problem, but they never come back the way they were when they first arrived. They're building on the work they've already done. So we're talking about a life-cycle process where people begin to take responsibility for themselves, for their own experience and emotions, instead of expecting the professional to edit it away. Professionals can be frightened that they will lose the client if they don't give them a quick answer, but they will also lose the client if they do. To be able to hang in there and provide containment during therapeutic communication without offering solutions is essential.

So what exactly do you mean when you write of therapeutic communication that is 'transportable and not necessarily long term'?

People might feel that to think and understand in this way requires a physical setting, that you can only do it in a consulting room with the doors closed. A lot depends on experience, but what I'm suggesting is that if you build up experience you can actually transport the work elsewhere. So, for example, you can work in someone's home. I started off as a social worker and I learnt an enormous amount from that. I learnt that if we were going to do any family work, I had to do things like ask people to turn off the television. There's the notion that we're a guest in the home but we're not actually a guest; we're going there to help them and we have a right to expect a certain level of respectful participation. And we have to have the right tools to do the job, the right way of thinking, so that people feel valued. If you leave the television on and let people run in and out, you give the impression you're just part of the chaos. So it's possible to take a containing, boundaried session to the client in the home situation. But it also involves what I would call a way of thinking, a mind-set: you can be aware of exactly the same things you would be aware of in your own consulting room.

In the UK at the moment there is a move to place a counsellor in every school. I understand that you prefer the idea of a wellbeing centre within the school, rather than a lone counsellor. What are the advantages of such a set-up?

I think in many ways the UK is far in advance of Australia with regard to counsellors in schools. But I think a lone counsellor in a school is a problem. It's an abuse of the system and of the counsellor. It's about keeping people out. It's marginalising the whole area of what I prefer to call *child and family wellbeing* – as if it's such low priority that you just have one person coming in and you throw them all your problem children to be cleaned up and sorted out so they won't cause a fuss. What I would love to see are multidisciplinary services or psychotherapeutic counselling services on site that can be accessed by everybody including teachers, so that the whole process is normalised and it's not about individual pathology in the child. One of the things I've been doing is to try to help schools look at themselves as a system. A school with 500 pupils, for example, might have a community of 2,000 if you include families, which is a terrific resource that is never exploited. At the moment, parents are only let in to do certain very specific things such as fund raising and fetes, and their contact with school is highly circumscribed with an invisible boundary that discourages people. So my vision is for child and family wellbeing centres in schools, because schools are also fabulous physical spaces, and underused, especially in the holidays. They could be so much more. ■

Ruth Schmidt Neven is a child psychotherapist, psychologist and researcher, and currently Director of the Centre for Child and Family Development in Melbourne, Australia. Her book, Core Principles of Assessment and Therapeutic Communication with Children, Parents and Families: towards the promotion of child and family wellbeing, *is published by Routledge, 2010.*

References

1 Schmidt Neven R. Core principles of assessment and therapeutic communication with children, parents and families: towards the promotion of child and family wellbeing. London: Routledge; 2010.

2 For more information about this course in April 2011, please email Lindsay Upex: lju20@cam.ac.uk

3 Schmidt Neven R, Anderson V, Godber T. Rethinking ADHD: integrated approaches to helping children at home and at school. Crows Nest, Australia: Allen & Unwin; 2002.